FY 2017 Room, Board and Watchful Oversight

Minimum Standards for Child Placing Agencies and Child Caring Institutions

Division of Family and Children Services, Office of Provider Management

7/1/2016

The FY 2017 RBWO Minimum Standards are effective July 1, 2016.

The Office of Provider Management recognizes that certain standards will require time for providers to come into full compliance. For example, providers may need planning time to create new policies or protocols. New standards only apply to new placements starting after July 1st. Please be assured that all reasonable allowances will be made during monitoring reviews and support provided to ensure that providers understand and can adhere to the standards, particularly newly created or revised standards.

Thank you for your continued service to children and families.

Please direct any questions, comments or requests for technical assistance to the appropriate OPM Monitoring Team Manager. A staff contact list is located in the Appendix.

Table of Content

Introduction to RBWO Minimum Standards

RBWO Minimum Standards for Child Caring Institutions and Child Placing Agencies

The mission of the Division of Family and Children Services (DFCS) Foster Care program is to strengthen families, protect children from further abuse and neglect and to assure that every child has a permanent family. The private provider community is an important and integral part of DFCS's ability to achieve its mission. The Room Board and Watchful Oversight (RBWO) Minimum Standards follows and support the DFCS mission and provides guidance to Child Caring Institutions (CCI) and Child Placing Agencies (CPA) contracted with DFCS.

The RBWO Minimum Standards apply to all providers with the exception of sections which apply specifically to only CCI's or CPA's. Compliance with all Residential Child Care (RCCL) rules and regulations are required of all providers that have entered into a contract with DFCS.

RBWO Minimum Standards are focused on securing positive permanency, health and education outcomes for children and to reduce risks to their welfare and safety. Providers must aim to provide the best care possible for the children in their care; observing the Standards is an essential part, but only a part, of the overall responsibility to safeguard and promote the welfare of each individual child placed. The Standards are presented as "minimum" requirements rather than as best practices. Thus, providers should strive to exceed these minimum requirements.

Having Minimum Standards does not mean that providers must standardize their services. The Standards are designed to be applicable to a wide variety of different types of RBWO provider programs and to enable, rather than prevent, providers to develop their own particular best practice approaches to meeting the safety, permanency and well-being needs of children[1] placed.

The Standards are intended to be qualitative, in that they provide a tool for judging the quality of care provided and are also designed to be measurable. The Office of Provider Management (OPM) will monitor providers against these standards during its annual comprehensive reviews and through randomly occurring Safety Reviews. During monitoring visits, OPM will look for evidence that the requirements are being met. Provider practices which exceed the requirements of the Minimum Standards will also be identified and documented in the OPM monitoring report.

There are six broad areas comprising the Standards. They are as follows:

- **Safety;**
- **Quality of Care;**
- **Permanency Support;**
- **Family Foster Homes;**
- **Child Caring Institutions; and**

[1] The word child or children refers to anyone in RBWO care. The terms "youth" or "adolescent" refers to those aged 14 years to 21 years.

- **General Administrative Matters.**

Additionally, standards for medically-fragile placements, Independent Living and Transitional Living Programs, Maternity Homes and Parenting Support Programs (Second Chance Homes) are included.

Room, Board and Watchful Oversight (R.B.W.O.) is the provision of lodging, food, and attentive responsible care to children. Providers shall be responsible for the provision or acquisition of services to ensure that each child's physical, social, emotional, educational/vocational, nutritional, spiritual/cultural and permanency needs are met. These services are defined as follows:

1. **Physical** – all health services pertaining to the body (medical and dental). Includes medication monitoring, documenting and administering by staff or foster parents trained in medication dispensing.

2. **Social** – the provision of an environment in which the child's relationships with peers, staff, significant others, and community are improved through the use of recreational and leisure activities.

3. **Emotional** – a support network that implements recommendations of treatment providers; provides access to treatment; and recognizes behaviors such as anger, negative and positive stress, often accompanied by physiological or psychological changes.

4. **Educational/Vocational** – enrollment of youth in an accredited educational school system; monitoring of progress and support of the youth's education by participation in student support team (SST) meetings, Individual Education Planning (IEP) meetings, parent/teacher conferences and disciplinary meetings. Opportunities for participation in school related extra-curricular activities. For those youth who have completed high school or who have achieved a high school diploma or GED, access to academic or vocational classes/opportunities that will prepare them to lead self-sufficient lives.

5. **Nutritional** – the provision or acquisition of food services to ensure healthy physical and emotional development which is inclusive of the child's religious, cultural, and health needs in accordance with the United States Department of Agriculture (USDA) guidelines for servings per child. Please refer to RCCL's policy section 290-2-6-.21 & section 290-2-5-.17 for guidelines on food consumption and preparation.

6. **Spiritual/Cultural** – awareness, sensitivity, and competence in understanding the child and family's religious values, belief system, mores, customs, training, social growth or development.

7. **Permanency** – providing the child with continuous and guided interaction with family members and significant others for the purpose of transitioning the child back to the home and community. Where return home is not possible, working to secure another permanent option for the child. Permanency planning begins at the admission process and continues through discharge.

SAFETY

Standard 1: Safety of Children in Care

The safety of children in care is paramount; no child will be abused or neglected in foster care.

1.0 Providers must have policy and procedures in place to promote the safety and welfare of children and to ensure that children are protected from abuse and neglect.

1.1 Providers (which includes all staff, caregivers, volunteers etc.) will adhere to the requirements of the Taylor vs Ledbetter Consent Decree which prohibits the improper punishment of children in care. Improper punishment includes any physical or emotional act to deliberately inflict pain to the body or which creates undue fear, anxiety or feelings of humiliation or degradation.

1.2 Staff and caregivers must understand the Mandated Reporting law and procedures to report concerns about abuse and neglect.

a. Providers must immediately notify the DFCS Central CPS Intake Line (855-422-4453) or https://cps.dhs.ga.gov/Main/Default.aspx as well as the custodial county of any child involved when there is an allegation or suspicion of abuse, neglect, or corporal punishment of any child/children being served.

1.3 Providers must ensure that employees in positions or classes of positions have direct care, treatment, custodial care, access to confidential information of clients or any combination thereof (to include administrative support staff, janitorial/housekeeping staff, maintenance/grounds keeping staff and security guards) shall undergo a criminal history investigation prior to being hired and every five years thereafter (based upon hire date anniversary). This requirement became effective July 1, 2014. Staff hired prior to July 1, 2009 but before July 1, 2014 must have their 5-year criminal records check completed by their anniversary date as they reach their fifth (5^{th}) year of service. The criminal history investigation shall include fingerprint record check pursuant to the provisions of Section 49-2-14 of the Official Code of Georgia, Annotated (O.C.G.A). Providers shall maintain and upon request, provide DHS with evidence of a satisfactory criminal record check of any members of its staff or a subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this contract. Providers must utilize the Georgia Applicant Processing Services (GAPS) at www.ga.cogentid.com to comply with this requirement.

1.4 Providers must identify the child's vulnerabilities and develop an individualized service plan to maintain the child safely in his/her living environment. As new vulnerabilities are identified, the plan must be reviewed and updated to ensure that emerging needs are met.

1.5 Providers must have a process for identifying individual triggers, coping behaviors, calming measures, interventions, and effective behavior management / prevention strategies for each child in order to de-escalate and avoid full-blown crises.
   a. Staff and/or foster parents should be trained to identify danger signals, potential triggers, and possible medical emergencies for the child.
   b. Decisions about the child's long-term or continued placement in the program should not be made during a crisis.

1.6 Providers must have two face-to-face contacts a month with each child placed. One of those contacts must be an Every Child Every Month (ECEM) contact. The other contact is called a general contact. A General Contact is a purposeful visit; however it does not have to occur in the home. The General Contact must be conducted by the CCI Human Services Professional (HSP) or the CPA Case Support Worker (CSW) or Case Support Supervisor (CSS) and generally focuses on safety and well-being. The General Contact will be documented in the standard narrative type in Georgia SHINES or the Safety, Permanency, and Well-being narrative type. All documentation must be entered into GA SHINES within 72 hours of the contact. Some of these contacts should be unannounced visits. (For details on ECEM contacts, review RBWO Minimum Standard ECEM 6.20)

1.7 Children and caregivers must be visited by the provider within one week of a new placement and more frequently in the early stages of any placement or when there are particular issues which warrant more frequent contact. These visits must be documented into GA SHINES as a general contact within 72 hours.

1.8 Providers must ensure that children in their care are protected from bullying by other children placed and staff.

1.9 Providers (staff and caregivers) must create an atmosphere where bullying is known to be unacceptable.

1.10 Providers must have a policy on bullying, which includes the following: a definition of bullying, types of bullying, training for staff and caregivers, measures to prevent bullying, responses to and reporting of bullying.

1.11 Providers must identify an agency staff person or subcontracted agency representative to receive reports from children in R.B.W.O. placements about any concerns, grievances or complaints. The *child ombudsmen* must not have any direct care or oversight responsibility for the child (such as client advocates, clergymen, therapists, etc.). All children in the program shall receive clear communication regarding the identification of the ombudsmen and the method to be used to contact this individual. The contact process should reflect the age and developmental abilities of the children being served.

1.12 Providers must notify OPM whenever there is a Significant Event relating to the provider's operation or to the care or protection of children in its care and/or supervision. Notification must be made as soon as possible but within one business day via GA+SCORE. Additionally, based on circumstances and the severity of situations,

providers should use good judgment in determining which Significant Events should also be reported verbally to OPM.

1.13 Providers must notify OPM Manager or Supervisor immediately when there has been a significant injury or death of any child placed in any facility, group home, or foster home operated by the provider, whether or not the injured or deceased child is in the custody of the Department. Notification must be reported verbally to OPM followed by input into the GA+SCORE system.

1.14 Providers must have and follow their protocol for children who are considered runaways or otherwise absent without permission.

1.15 Provider's must have a policy for addressing the issue of staff or caregivers who become the subject of a CPS investigation. The policy must include an assessment of any safety or risk factors that may impact children as a result of the allegation. The policy must include what actions the provider will take when CPS investigations are initiated and a review all CPS investigations whether the allegation was unsubstantiated or substantiated to assess the need for further action such as Corrective Action Plans. Staff who have substantiated CPS cases during their employment tenure must be staffed with OPM to determine if they may continue to be in a caretaking role with children in DFCS custody. (Note: DFCS Child Welfare Policy 14.8 addresses managing CPS allegations in foster homes.)

1.16 Providers must conduct and document the results of a Child Protective Services history check through the Georgia Child Abuse Registry for all staff before hiring and annually within 30 days of the staff's anniversary date. Each provider must have a policy on checking the registry and how, if the results of the registry reveal a substantiated case, the provider's procedure for assessing the information and determining whether or not the individual should be hired or continue their employment. For staff with substantiated history, the assessment must be reviewed by OPM for concurrence prior to the staff person beginning work and for veteran staff, the assessment must be submitted to OPM for concurrence within five (5) days of completion of the assessment.

1.17 Providers must conduct and document, a Sex Offenders Registry, Pardons and Parole and Department of Corrections check on all staff prior to hiring. Each provider must have policy on checking the databases and how information found in the databases will be used in determining an individual's anniversary date. The links for the registries follow:
http://gbi.georgia.gov/georgia-sex-offender-registry;
https://papapps.pap.state.ga.us/paroleesearch/search/searchPage; and
http://www.dcor.state.ga.us/GDC/OffenderQuery/isp/OffQryForm.jsp .

Standard 2: Safe and Appropriate Behavior Management

Use of corporal (physical or emotional) punishment is strictly prohibited.

2.0 Providers are prohibited from using or authorizing the use of corporal punishment with any child in the Department's custody.

2.1 Providers must have a behavior support and intervention policy that reinforces the

banning of all physical or emotional punishment. Providers must ensure, through appropriate training, that staff and caregivers are aware of the corporal punishment prohibition and follow the policy prohibiting the use of corporal punishment with any child in the Department's custody.

2.2 Providers must establish practices to manage children who exhibit difficult or aggressive behaviors and ensure that their staff and caregivers are trained to understand such behaviors and can safely respond.

2.3 Providers must ensure that staff and caregivers understand and have the necessary skills to carry out the agency's behavior management policies. The behavior management strategy or practice must be effective and appropriate for the types of children served, understood by staff and caregivers, and explained to children.

2.4 If corporal punishment is used with any child in the Department's custody, the incident must be reported to county CPS and the provider must take appropriate actions to prevent a recurrence. Providers must cooperate fully with the Department in assessing alleged incidents of the use of corporal punishment.

2.5 If the provider is a CPA and corporal punishment has occurred in a foster home placement operated by the provider, the provider agrees that the Department may choose, in its sole discretion, to move a child from the provider's foster home and/or to discontinue use of the foster home placement for children in the Department's custody.

2.6 As a result of a corporal punishment incident, if children in the Department's custody remain in the foster home, the provider must develop a corrective action plan with the foster parent, which must be signed by all parties involved and monitored to make sure the foster parents are in compliance. Children must be removed and the home closed to DFCS placements if any of the following apply:

a. The foster parents are not amenable to change or correct their disciplinary practices, or to Department intervention;
b. The incident of corporal punishment had a direct impact on the safety and well-being of a child, or posed a serious risk to the safety of a child; or
c. A second incident of corporal punishment occurs in the foster home placement.

2.7 If the provider is a CCI and an instance of corporal punishment occurs, an organizational corrective action plan must be submitted (even if the staff person in question is terminated) and approved by OPM. A corrective action plan for an individual staff member is acceptable when:

a. it is the first incident involving the staff member;
b. the staff person is amenable to change and it is clearly documented that the individual has demonstrated a willingness to use appropriate disciplinary practices going forward; and
c. the incident of corporal punishment has not posed a serious risk that directly impacts the child's safety and well-being.

If one or more of the preceding conditions does not apply, the provider must ensure that the staff person in question no longer has any direct or indirect contact with the child population where DFCS is responsible for their care, custody or control of.

2.8 Providers must develop and implement policies and procedures describing their Behavior Management Plan. Behavior Management is defined as those principles and techniques used to assist a child in facilitating self-control, addressing inappropriate behavior, and achieving positive outcomes in a constructive and safe manner. The policies and procedures for Behavior Management shall include a description of the principles and techniques that are approved for use, as well as any techniques that are prohibited. In addition, such policies and procedures shall set forth the types of children served in accordance with the program purpose, the anticipated problems of the children, and acceptable methods of managing such problems.

Policies and procedures must indicate that the following forms of Behavior Management are prohibited:

a. Assignment of excessive or unreasonable work tasks that are not related to the resident's misbehavior;
b. Denial of meals or hydration;
c. Denial of sleep;
d. Denial of shelter, clothing, or essential personal needs;
e. Denial of essential program services;
f. Verbal abuse, ridicule, or humiliation;
g. Manual holds, chemical restraints, or mechanical restraints when not used appropriately by adequately trained staff in accordance with policy, RCCL rules and regulations and all applicable guidelines as emergency safety interventions;
h. Denial of contact, communication and visits with approved family members and other visiting resources.
i. Seclusion, when not used appropriately and in accordance with policy and RCCL rules and regulations and all applicable guidelines as an emergency safety intervention;
j. Children in care shall not be permitted to participate in the behavior management of other children or to discipline other children, except as part of an organized therapeutic self-governing program in keeping with accepted standards of practice that is conducted in accordance with written policy and by designated staff.

2.9 Behavior Management shall be used in accordance with the child's Individual Service Plan (ISP), agency policies and procedures, and licensing rules and regulations.

2.10 Referrals to Law Enforcement, including the Department of Juvenile Justice (DJJ), local police or sheriff's departments, and the juvenile court, may not be a part of the routine Behavior Management Plan. Law Enforcement should be used only for emergencies when the Behavior Management Plan is unsuccessful. Calming measures, preventive and behavior management strategies identified for the child must be utilized without success before Law Enforcement is involved. If appropriate, an emergency safety intervention must also be utilized without success before Law Enforcement is involved. Intervention by Law Enforcement is appropriate only if the child's behaviors escalate to the point of exceeding the ability of properly trained staff to manage the child safely and the issues poses a physical danger to the child, staff, or other children.

2.11 An emergency safety intervention (ESI) plan may not be a component of a provider's Behavior Management Plan. It is a plan for the manner in which staff will respond

when the Behavior Management Plan is unsuccessful and a child escalates to a point that requires implementation of an emergency safety intervention.

2.12 ESI may not be utilized by CPA staff or foster parents. CPA providers must establish protocols and supports that assist foster parents in developing or strengthening their skills in managing children who exhibit difficult or aggressive behaviors. Foster parents must be trained and supported to safely and appropriately respond to behavioral issues.

2.13 CCI providers (who use ESI) must ensure that all direct care staff are trained in the provider's ESI protocol within 90 days of the employment start date. ESI training must be approved by RCCL. Provider staff must be trained in the proper use of emergency safety interventions before they are allowed to use them and may be used only when a child exhibits a dangerous behavior reasonably expected to lead to immediate physical harm to the child or others and less restrictive means of dealing with the injurious behavior have not proven successful or may subject the child or others to greater risk of injury.

2.14 Providers must have written policies for the use of any emergency safety interventions that will be authorized, a copy of which shall be provided to and discussed with each child and the child's parents/or legal guardian prior to or at the time of admission. The policies and procedures must indicate whether any form of manual holds will be a part of that emergency safety intervention plan. Policies and Procedures for emergency safety interventions shall include:

a. Provisions for documentation of an assessment at admission and at each annual exam by the child's physician or authorized medical professional that there are no medical issues that would be incompatible with the appropriate use of emergency safety interventions on that child. Such assessment and documentation must be re-evaluated following any significant change in the child's medical condition;
b. Provisions for the documentation of each use of an emergency safety intervention including:
    i. Date and description of the precipitating incident;
    ii. Description of the de-escalation techniques used prior to the emergency safety intervention, if applicable;
    iii. Environmental considerations;
    iv. Names of staff participating in the emergency safety intervention;
    v. Any witnesses to the precipitating incident and subsequent intervention;
    vi. Exact emergency safety intervention used;
    vii. Documentation of the 15 minute interval visual monitoring of a child in seclusion;
    viii. Beginning and ending time of the intervention;
    ix. Outcome of the intervention;
    x. Description of any injury arising from the incident or intervention;
    xi. Summary of any medical care provided.

2.15 Policies and Procedures for emergency safety interventions shall include the following regarding manual holds:

a. Provisions for prohibiting manual hold use by any employee not trained in prevention and use of emergency safety interventions;

b. Provisions for assessing and monitoring the child's behavior after an emergency safety intervention has been used;
c. Provisions for reporting incidents of emergency safety interventions to the RCCL as required by the rules and regulations under which the provider is licensed;
d. Provision for review of emergency safety interventions by a staff member responsible for quality assurance and ensuring that staff are correctly using the interventions;
e. Provision for the use of a manual hold with any child whose primary method of communication is sign language, allowing the child to have his/her hands free from restraint sufficiently during the intervention to communicate for brief periods except when such freedom may result in physical harm to the child or others.
f. Provisions that specify when manual holds are authorized to be used, which staff are authorized to use them, a description of the holds that are approved by the provider, the time limit allowed on any manual hold, and the policies on documenting the holds;
g. Provision for continuous monitoring during manual holds of the child's breathing, verbal responsiveness, and motor control.

2.16 Policies and procedures for emergency safety interventions must include the following prohibitions:
a. Manual holds may not be used to prevent runaways unless the child presents an imminent threat of physical harm to self or others or is specified in the child's service plan;
b. Manual holds shall not be used by staff that are not trained and authorized by the provider to utilize the manual holds or by staff that are unfamiliar with the child's medical and psychological conditions;
c. Children in care shall not be allowed to participate in emergency safety interventions of other children in care;
d. Emergency safety interventions utilizing prone restraints require at least two trained staff members to carry out the hold;
e. Emergency safety interventions shall not include the use of any restraint or manual hold that would potentially impair the child's ability to breathe or has been determined to be inappropriate for use on a particular child due to a documented medical or psychological condition.

2.17 If the use of a seclusion room is a part of the provider's emergency safety intervention plan, then policies and procedures must include a description of the circumstances under which seclusion may be used and the policies and procedures governing its use. These policies and procedures must include the following:
a. If seclusion is used, procedures must be in place requiring seclusion of more than 30 minutes duration being approved by the Director or Designee. No child shall be placed in a seclusion room in excess of one hour within any twenty-four hour period without obtaining authorization for continuing such seclusion from the child's physician, psychiatrist, or licensed psychologist and documenting such authorization in the child's record.
b. A seclusion room shall only be used if a child is in danger of harming himself /herself or others.
c. A child placed in a seclusion room shall be visually monitored at least every 15 minutes.

d. A room used for the purposes of seclusion must meet the following criteria:
   i. Room shall be constructed and used in such way that the risk of harm to the child is minimized;
   ii. Room shall be equipped with a viewing window on the door so that staff can monitor the child;
   iii. Room shall be lighted and well ventilated;
   iv. Room shall be a minimum of 50 square feet in area; and
   v. Room must be free of any item that may be used by the child to cause physical harm to himself/herself or others.
e. No more than one child shall be placed in a seclusion room at a time.
f. A seclusion room monitoring log shall be maintained and used to record the following information: child's name, date of seclusion, reason for seclusion, time placed in seclusion, name and signature of staff that conducted visual monitoring, signed observation notes, and time of child's removal from seclusion.

2.18 All forms of behavior management and Emergency Safety Intervention must be limited to the least restrictive appropriate method.

2.19 Provider policies and procedures will include the requirements and method of training that will be used for orientation and ongoing training of staff regarding behavior management and Emergency Safety Interventions. All training shall be clearly documented in the staff member's personnel record.

2.20 Within 24 hours of an incident of restraint or seclusion or other serious behavior management issue, a staff debriefing must occur and a debriefing with the child must also occur. The debriefing, which provides an opportunity for staff and children to discuss their feelings and perceptions about the issue and establish a plan for the future must be documented and filed in the child's record. Any changes in the behavioral management plan must be documented in the service plan immediately following the debriefing.

Note: RCCL rules also require that following an incident of restraint or seclusion, the child must be assessed and monitored immediately and hourly thereafter for a period of 4 hours.

Quality of Care

Standard 3: Comprehensive and Family-Centered Services

Provider service planning and delivery is comprehensive and family-centered; children, families, DFCS and other stakeholders have the opportunity to participate in all aspects.

3.0 Every child must have an ISP that is strength-based and reflective of assessment findings. It must promote the welfare, permanency, education, interests and health needs of the child and address emotional and psychological needs. Assessments, service plans, and service delivery must reflect and be tailored to the needs, strengths and resources of the child and family. The issue of permanency must be addressed in every service plan. All ISP's must be in accordance with recognized professional child welfare standards; shall

provide for the participation of the family in the plan; and shall be appropriate given the child's needs.

3.1 The provider must carefully and immediately assess the needs of all children placed and develop a 7-Day ISP within seven days of admission. The 7-Day ISP is an extension of the admissions assessment whereby immediate safety, health and placement adjustment needs are considered and a plan developed to address immediate needs. The 7-Day ISP sets goals and objectives through the first 30 days of placement.

The 7-Day should address at a minimum immediate placement issues such as:

- Increased Placement Supervision or Contacts by Case Support Worker or HSP
- Precautions or Other Safety Measures
- Immediate needs related to:
    - Health (including medication management)
    - Behavioral Management
    - Educational/Vocational
    - Personal/Social
    - Family Visitation/Contact
    - Placement Adjustment
    - Scheduled Court, FTMs or other Case Related Appointments

The 7-Day ISP must be submitted to the child's County DFCS Case Manager within 5 business days of completion. Providers must maintain documentation verification of submission to the Case Manager.

3.2 The first comprehensive ISP is due by the 30th day of the placement. Providers will update ISPs at least every six months or whenever needs assessments warrant a change in the service plan. Providers must set a timeframe for regular, periodic review of the ISP. The review should involve the child, family, DFCS and other stakeholders as appropriate. Provider must submit to DFCS Case Manager within 5 business days.

3.3 General requirements of providers regarding service planning include:

a. Each ISP identifies the needs of the child, the steps and measures to meet those needs.
b. Family members are included in the development of the ISP.
c. Family members and the child help to define their goals and outcomes, with input from the custody holder. There are times when DFCS or the courts will require that certain issues be addressed in the service plan.
d. DFCS, parents or other people who are significant in the child's life are given adequate information and assistance to enable participation in service planning.
e. Cultural, ethnic or religious identity is taken into account when determining individual plans. Decisions are consistent with cultural, ethnic and religious values and traditions relevant to the child.
f. Both needs and strengths are identified and linked in the assessment and service plan.
g. Service plans are tailored to the needs and strengths of each child and family and are a mix of traditional and non-traditional services.
h. Family members, local case managers and other caring adults are included in the service plan reviews.

i. When returning to family is not possible, the provider works with the custodial agency to pursue adoption or transition to another permanency option. For older teens the emphasis is on the development of independent living skills and achieving the optimum level of family involvement that is possible.

3.4 Children are given an opportunity and assistance to participate in decisions and planning that affect them, taking into account their age and understanding.

3.5 Decision making and planning are based on a detailed and thorough assessment and are clear in respect to the reasons for decisions or plans. Both are documented and communicated to the appropriate family members and DFCS.

3.6 A copy of the ISP is provided to the child (when developmentally and age appropriate), any caregiver of the child and DFCS.

3.7 The provider must maintain records to document the provision of services:

a. Providers must permit authorized representatives of the Department access to all records and information at any time.
b. The case record must contain a monthly summary of the services provided to the child and the progress being made by the child in achieving the goals as outlined in the ISP.

3.8 The provider must ensure that all services to the child and the family that are identified in the child's ISP are implemented and documented.

3.9 Each ISP is managed by a case support worker or HSP who ensures that the requirements of the plan are implemented in the day-to-day care of the child.

3.10 Children and young people are supported and encouraged to maintain and strengthen connections with their birth families, especially their parents and siblings. Children are provided with practical support to maintain contact with parents, family and other significant people unless expressly prohibited by DFCS.

3.11 If the child placed has siblings in care with whom they are not placed, the ISP must include a sibling visitation plan unless in accordance with the DFCS case manager, a provider sibling visitation plan is not required. If a sibling visitation is not required, the reason(s) why must be documented in the case record. Sibling visitation plans should be coordinated and agreed upon with the DFCS case manager.

Standard 4: Appropriateness of Admissions

Providers admit for care only those children for whom the admission evaluation indicates that the provider can meet the child's needs.

4.0 Providers must ensure that children are placed in accordance with their individual needs, taking into account the closeness of the placement to the child's home and community, sibling's location, relative resource and the least restrictive setting. Providers must ensure that siblings who enter placement at or near the same time shall be placed together unless it is not in the best interest of the child.

4.1 Providers must only accept referrals for children with program designations for which they have been approved unless a waiver has been granted by OPM.

4.2 Providers must have clear criteria for admissions and must evaluate each referral for service against those criteria. Providers must have a written intake process which includes the steps and processes used to evaluate the appropriateness of admissions and support the decision made.

4.3 Providers will give DFCS notice of its decision to accept or reject referrals upon receipt of completed admissions packet as soon as possible, but no longer than two calendar days. Placement of children accepted for admission should occur as soon as possible or within a timeframe negotiated with the DFCS case manager.

4.4 For children referred by Fulton or DeKalb County, these admission decisions must be made via written notice within 8 hours of the referral. For children admitted, they must be placed within 23 hours of the approved admission.

4.5 Providers must admit all children accepted for emergency admission within 23 hours of the time the provider receives the referral information.

4.6 Providers must ensure that CCI admissions or foster home placement matches include the following:

a. An assessment of the home environment to include; physical space, supervision practices, and all current household members (biological children, adoptive children, fictive kin, and adult relatives);
b. A safe environment for children which includes emotional, psychological, physical and environmental safety; and takes into consideration their age and any specific needs of the child.

4.7 Providers must have and follow their admission protocol for children placed in CCIs or in foster homes. The admissions protocol must outline the provider's process for incorporating the child into the milieu or foster family and include an introduction to the program (orientation) and such things as family rules and operations.

4.8 Providers must comply with the following placement conditions and requirements regarding each of the identified care settings:

Foster Homes

a. No child will be placed in a foster home if that placement will result in more than three (3) foster children in that home or, a total of six (6) children in the home, including the foster family's biological and/or adopted children, without the written approval of the DFCS Senior Manager-Placement Services.
b. No child will be in a placement that will result in more than three (3) children under the age of three (3) residing in a foster home.

Group Care or CCI Settings

a. No child younger than twelve (12) years of age (0-11) in the custody of Fulton or DeKalb County will be placed in a group care setting without the express written approval of the state DFCS Senior Manager-Placement Services based upon his or her certification and specific finding that the individual child has needs which can be met

by the particular group care setting and that the particular group setting is the least restrictive placement that can meet such needs.

b. For the other 157 counties, no child younger than 11 (0-10) will be placed in a group care setting without the express written approval of the DFCS Senior Manager-Placement Services based upon his or her certification and specific finding that the individual child has needs which can be met by the particular group care setting and that the particular group setting is the least restrictive placement that can meet such needs. Regional Directors can approve placements for children age eleven (11).

c. No child under age twelve (12) that has been appropriately approved for a CCI placement will be placed in any group care setting that has a capacity in excess of twelve (12) children. This will not apply to a child who is under six (6) years of age (0-5) and who is also the son or daughter of another child placed in a group care setting.

NOTE: The Regional Director has night and weekend approval authority until the next business day for waivers requiring the State Senior Manager-Placement Services.

4.9 Where co-placement of siblings is not possible, providers must assist the Department in ensuring that regular contact between siblings in care is maintained. (Please refer to **Child Welfare Policy Manual 10.20 Preserving Sibling Connections.)**

4.10 Providers must have a plan for admissions, which includes having a qualified staff on call, seven days a week, 24 hours a day, to receive and assess admissions.

4.11 CPA providers must have a plan and policy regarding caregivers on accepting evening and weekend placements.

4.12 Providers who offer MWO services must include Psychiatric Residential Treatment Facilities (PRTF) step-downs as part of their inclusion criteria. CPA's with MWO program designations must have a plan to develop foster homes that accept PRTF step-down placements.

4.13 Providers must have and follow a non-discrimination policy. CPA providers must follow the Multi-Ethnic Placement Act (MEPA) and Inter-Ethnic Placement Act (IEPA). Provider must not use race, ethnicity or religion as a basis for a delay or denial in placement of a child, either with regard to matching with a family or with regard to placing a child in a CCI.

4.14 Providers must maintain a list in GA+SCORE of all admission requests and decisions made based on referrals to the agency where an admissions application was received. Inquiries made to the provider where an admissions application was not received should not be included on the list. The list must include the requesting county name, case manager's name, child's name, child's program designation, presenting issue and reason for accepting or denying admission.

4.15 For Maximum Watchful Oversight (MWO) beds where a MWO referral has been received, document within five (5) days of referral in the GA+SCORE System the

referral, disposition and reason. A referral is deemed to have been received if the RBWO MSS is received. All other placement referrals types for all providers must be documented within 15 business days of receipt in the GA+SCORE System.

4.16 Providers must provide youth with an age and developmentally appropriate orientation to their program. Orientation must include information on reporting personal boundary concerns, bullying, violence or other concerns. Orientation must also include information on the agency's child ombudsmen. (See Standard 1.11)

4.17 Providers must regularly assess the vulnerabilities of youth in making room and/or cottage assignments and use the assessment in making such matching decisions. Child vulnerability refers to the ability of a child to avoid, negate or modify threats. Vulnerabilities include such things as age, development, sexual stage of development, sexual orientation, disabilities, ability to communicate, provocative behaviors, and health.

4.18 The provider's intake process should include but is not limited to the following:

- Ensuring that the admission criteria includes that youth up to 21 years may be served.
- Utilization of the RBWO Match Screening Summary (RBWO MSS) as the sole referral documentation needed to determine whether a potential placement match exists. If a potential match exists, the provider will proceed with its own admission application package. The admission application package may not require a psychological evaluation report. However, the admission application package may ask if a psychological evaluation report exists and is available and if so, may require that the psychological evaluation report be provided as a part of the application.

Standard 5: Placement Stability

Children in care should have placement stability through permanency; moves in care are minimized.

5.0 A Family Team Meeting (FTM) should be conducted when potential disruption of a child's placement is threatened or imminent, including children returning from runaway or hospitalizations where they will not return to the same placement. Providers must alert DFCS of the need to hold an FTM when children in their care may experience a placement disruption. Providers must participate in these FTMs as invited by DFCS.

5.1 Providers must have a policy which addresses the importance of placement stability and how the agency will preserve placements, where the placement remains in the best interest of children, in its institutions or foster homes. Included in the policy, providers will have and follow a protocol on identifying and preserving placements that are at risk of disruption.

5.2 The decision for placement disruption is made only after all possible interventions to maintain the child in care have proven unsuccessful. Decisions about the child's long-term or continued placement in the program should not be made during a crisis. At best, a decision to discharge a child from a provider's placement should be made by mutual discussion between the provider and the Department concerning the child's situation, either in a face-to-face or telephone conference.

5.3 For placement disruptions that occur within 60 days of placement or admission to the provider, providers will document a review of the initial placement decision and identify any changes needed in the admissions review or placement matching process.

5.4 Providers will have and follow their protocol on addressing foster parents who have patterns of ejecting children within 60 days of placement or where other disruption patterns are identified.

5.5 DFCS must be provided with at least 14 calendar day notice of the need to move a child from a CCI or CPA foster home unless there is an impending threat of harm to the child or others.

5.6 In all cases where discharge is determined to be in the best interest of the child but due to safety issues a 14 day notice cannot be provided, a minimum of 72-hour notice shall be given prior to discharge. If the 72-hour notice is not possible, the reasons for the failure to notify in advance must be documented in the child's record.

5.7 Providers must ensure that no child will be moved from one placement site or home to another without prior approval of DFCS and the execution of a new institutional placement agreement as appropriate. For children in the custody of Fulton or DeKalb counties, an FTM may be required prior to placement changes.

5.8 Providers must ensure that in situations where a child's discharge is the result of a determination that the placement is not safe or appropriate for the child or other children, any remaining child(ren) must be removed unless there is another written agreement with DFCS to correct the situation.

5.9 A Discharge Summary must be provided to the DFCS case manager at the time of notification of placement move/disruption but no later than 24 hours from the provider. The Discharge Summary must include general information covering the child's placement, progress, challenges and recommendations for services and supports the child will need to be successful at home or in the next placement. If the discharge is a result of a placement disruption, the Discharge Summary must also include the following:

i. The circumstances leading to the disruption;
ii. The actions that were taken by the agency to prevent the disruption;
iii. The reasons for disruption decision;
iv. The services and supports the child will need to be successful in the next placement; and
v. Details of the child's transfer from the CCI or foster home to the DFCS case manager or other placement.

5.10 If a child is discharged because he is a threat to himself or others, the provider will accompany him to the receiving agency or person. Provider staff must remain with the child until admission is complete or the child's custodian arrives and takes responsibility. If the police or sheriff is transporting the child, the provider must send staff to the receiving point who will remain there until the admission is complete or the child's custodian arrives.

Standard 6: Meeting Well-Being Needs

Children's social, emotional, physical, mental and educational needs are regularly assessed and needs met.

6.0 Providers must regularly assess the behavioral, social, emotional, psychological and physical needs of children placed and develop an initial ISP to address the child's needs. Providers must ensure that all well-being services identified in the ISP are provided and must document the frequency and results of the services.

6.1 Providers must ascertain the health status of children at admission and take immediate steps to address emergency health care needs. Each ISP must include a health plan component which covers health history and needs. Providers must ensure that all children under age three are/ or have already been referred to Babies Can't Wait.

6.2 The ISP must include the provision of routine medical and dental services according to Medicaid's Early Prevention and Screening Diagnostic Test (EPSDT) standards, including at a minimum, the components identified in the Georgia Health check program and any related health services required by the RCCL rules and regulations.

The EPSDT is as follows:

a. Ages zero through six months: All children between the ages of zero to six months shall receive no less than three periodic EPSDT/Georgia Health Check Program health screenings.
b. Ages seven months through 18 months: All children between the ages of seven months through 18 months shall receive no less than four periodic EPSDT/Georgia Health Check Program health screenings performed at approximate three month intervals.
c. Ages 19 months through 30 months: All children between the ages of 18 months through 30 months shall receive no less than one periodic EPSDT/Georgia Health Check Program screening performed every six months. (This health check also provides for a 24 and 30 month visit. These visits include an autism screening at the 24 month visit and a developmental screening at the 30 month visit).
d. Ages three years and over: All children of three years of age and older shall receive no less than one periodic EPSDT/Georgia Health Check Program health screenings performed every year.
e. All children shall receive any follow-up treatment or care as directed by the physician who administered the periodic EPSDT/Georgia Health Check Program health screening.
f. All children age one (1) and over shall receive a dental screening within 10 days of entry into foster care (unless the dental screening was completed within the last six months) and every six months thereafter and shall receive any and all treatment as directed by the child's assessing dentist.

6.3 Providers must follow the DHS guidelines for Psychotropic Medication Use in Children and Adolescents, and they must have and follow their own medication management policy for other prescription and non-prescription medications.

I. Providers' medication management policy must include management medication refusal.

II. The provider shall designate, authorize and train staff to hand out and supervise the administering medications.
III. The providers' staff will maintain a thorough record of all medications taken by children in the program including the required documentation that medication was handed out by the authorized staff and taken by the children for whom it was prescribed.
IV. Providers must have a medication management policy that outlines the process to be used for inventorying each child's medication. At a minimum, the process should include documented medication inventory upon admission, at least monthly and upon discharge.

6.4 CPA providers must provide and document training regarding the Agency's policies and procedures for handling medical emergencies (conditions or situations which threaten life, limb, or continued functioning), and managing the use of medications by all children in care.

6.5 Providers must ensure that the following apply to the dispensing of psychotropic medications and follow the Guidelines for Psychotropic Medication Use in Children and Adolescents located on GA+SCORE:

a. No child will be given psychotropic medication unless its use is in accordance with the goals and objectives of the child's service plan.
b. Staff and/or foster parents shall be trained in detecting side effects of any medication prescribed for use by children in care.
c. Psychotropic medications shall be prescribed by the physician who has responsibility for the diagnosis and treatment of the child's condition necessitating the medication. The prescribing physician shall review continued use of psychotropic medications every sixty days.
d. Providers must follow the principles for *Informed Consent*
    a. *Informed Consent refers to agreement to undergo or obtain treatment after being informed of and having an understanding of risks and benefits involved.*
e. Psychotropic medications shall be used in concert with other interventions that will contribute to remediation of the problem and reduce the reliance on medication alone.
f. Psychotropic medication shall only be given to a child as ordered in the child's prescription. A provider shall not permit medications prescribed for one child to be given to another child.

6.6 Providers must maintain a first aid kit and instructions manual in each unit, cottage, and/or foster home. The first aid kit shall contain scissors, tweezers, gauze pads, adhesive tape, thermometer, assorted band-aids, antiseptic cleaning solution, and bandages.

6.7 Providers must not admit a child unless an educational program commensurate with the educational and vocational needs of the child can be provided.

6.8 Clear educational objectives should be developed for every child and should be a part of the ISP.

6.9 Providers must ensure that children are enrolled in a public school system or a GaDOE/LEA approved residential facility school within 2 days of placement. Providers must ensure that children have no more than five (5) unexcused absences per school year.

6.10 Providers will ensure that appropriate educational services are provided and shall include the following:

a. Documentation of the child's academic progress;
b. Documentation of each child's attendance, courses and grades at the time of withdrawal from school;
c. Immediate referral by the R.B.W.O. provider of the child to the appropriate educational agency, with the goal of placing each child in the educational program appropriate for his/her needs within 48 hours of admission to the R.B.W.O. provider;
d. Monitoring of the child's educational progress through regular contact with the local school personnel;
e. Participation in the annual Individualized Educational Plan (IEP) review and ensuring that any child determined to be eligible for special education has an IEP;
f. Ensuring that every child age 14 and older receiving special education services has an IEP that includes a section on Transition Services and that those services are being provided;
g. Notifying and inviting parents/guardians to attend any school-related conferences;
h. Ensuring that any child who is experiencing difficulty in school is considered for assistance through the Student Support Team (SST);
i. Providing and/or accessing vocational course work for each child determined to be eligible for vocational education and training;
j. Providing and/or accessing GED preparation classes for each child who meets the state and local eligibility standards in order to quality for GED testing; and
k. For providers with on-grounds schools, the school programs must be operated in accordance with all requirements of the State Department of Education (see state law O.C.G.A. Section 20-2-133) and all applicable state and federal guidelines.

6.11 For youth not enrolled in secondary education, providers will ensure that the youth has programming that focuses on the development of life skills, basic academic skills, GED preparation, and/or vocational skills. Vocational Services include provision or access to the following menu of services:

a. Counseling and guidance.
b. Referral and assistance to obtain services from other agencies.
c. Job search and placement assistance.
d. Vocational and other training services.
e. Transportation, if needed.
f. On-the-job or personal assistance services to teach good work habits.
g. Interpreter services.
h. Occupational licenses, tools, equipment, initial stocks and supplies.
i. Technical assistance for self-employment.
j. Rehabilitation assistive technology.

k. Supportive employment services.
l. For those youth who are not job-ready, opportunities to do structured and regular volunteer work.

6.12 For youth who are considering dropping-out of school or pursuing a GED, providers must follow the policy outlined in the DFCS Child Welfare Policy Manual 10.13, Educational Needs (see appendix for link to DFCS Child Welfare Policy Manual).

6.13 Providers must provide or arrange for tutoring or other academic assistance for children who are not achieving academically (i.e. performing below grade level, failing one or more classes and/or standardize test reveal deficiencies in any academic subject).

6.14 Providers must facilitate the provision of psychiatric services appropriate for the needs of all children.

6.15 Providers must coordinate community supports and service/treatment elements needed by the children served. This includes the provision or arrangement of transportation.

6.16 Providers must use Medicaid Rehab option (MRO) providers and/or private providers who have been pre-approved by the Department.

6.17 Whether or not the RBWO provider is an MRO provider, there may not be any rules implied or stated that require the use of any particular MRO as a condition of admission or continuing placement.

6.18 Providers must maintain up to date records on all MRO services provided to children.

6.19 Providers must coordinate with the External Review Organization (ERO) for short-term placements in PRTFs.

6.20 Providers must conduct an Every Child Every Month (ECEM) contact every month (starting the first full month of placement) for each child placed. The ECEM contact must occur in the child's residence (foster home or CCI). The ECEM visit must be conducted by the CCI Human Services Professional or the CPA Case Support Worker or Case Support Supervisor. Prior to conducting any ECEM visits, the staff person must have completed the ECEM webinar training which is posted on www.gascore.com. A copy of the completion certificate must be maintained in the staff's personnel and/or training file.

The documentation of the visit must be uploaded via the SHINES Portal within 72 hours of the contact. ECEM documentation includes the following:

a. Developmental, social, emotional progress and challenges
b. Progress on Individual Service Plan goals
c. Child's involvement in the permanency case plan
d. Issues pertinent to safety, permanency and well-being
e. Any concerns or red flags
f. Any need for follow-up and next steps.

Additional information on conducting and documenting ECEM contacts is posted at www.gascore.com.

6.21 Providers must incorporate the principles of trauma-informed knowledge into the daily living environments in CCI's and provide trauma-informed training to foster parents.

6.22 In partnership with DFCS, providers should make reasonable efforts to ensure that children remain in their same school that they were attending prior to removal and at any change in placement, unless continuation in that school is contrary to their best interest. (See Child Welfare Policy Manual 10.13)

6.23 CCI direct care staff are required to maintain First Aid and CPR certification. Initial training must be obtained during the first year of employment within the first 30 days of employment, if the employee is not already certified and this does not count toward annual training requirements.

6.24 Providers may not restrict for any reason or purpose approved contacts for children with siblings, family or other permanency individuals at any time during placement. (See also Standard 2.8)

6.25 Providers must develop and implement a policy on providing age and development appropriate sex education geared toward empowering youth to self-protect and report personal boundary violations. The policy must include a protocol for addressing incidents of sexual activity, violence, and coercion. (P.R.E.P. program information in the Definitions appendix may be of assistance to providers.)

6.26 CPAs and CCIs must follow the reasonable and prudent parenting standard.

a. CCI must have a staff person identified as the caregiver who will be responsible for such decisions.
b. At least one agency staff (HSP or higher) must attend the OPM RPPS "Train-the-Trainer" course. Providers must ensure that this trained staff member in turn provides RPPS training to all other staff.
c. Providers must have a reasonable and prudent parenting policy; however, this provider policy shall in no way diminish or circumvent DFCS RPPS policy. Caregivers must also be trained in RPPS and the curriculum is available on www.gascore.com.
d. Each youth has regular and on-going opportunities to engage in developmentally appropriate activities.
e. Providers must have a routine process of consulting with children to determine if the children's input regarding having regular opportunities to participate in age appropriate activities.
f. Providers must mark an annual check box in GA+SCORE that indicates that the reasonable and prudent parenting standard policy is operating as intended.

6.27 Providers servicing youth ages 14 years and over must adhere to the Youth Rights and Responsibilities (Child Welfare Policy 13.7). Providers must have a Youth Rights and Responsibilities policy and required to train the agency's employees, volunteers, and caregivers on this policy. Curriculum is available on www.gascore.com.

Standard 7: Least Restrictive and Most Appropriate Placements

Children should be placed in the most appropriate and least restrictive living arrangement.

7.0 Providers must initiate the step-down process for children to less restrictive placements as they meet their service goals and their needs change. Providers must notify the DFCS case manager and OPM at **proteam@dhs.ga.gov** for a review of the child's program designation as indicated. Step-downs may occur within a provider's own service continuum or to other providers who offer the less restrictive and/or less intensive services.

7.1 CCI providers must re-assess the appropriateness of restrictive placements at least every three months but as frequently as assessments warrant and initiate step-downs as indicated.

7.2 Providers must ensure that children in their care are placed appropriately based upon their current needs.

7.3 In partnership with DFCS, providers must make reasonable efforts to place siblings together in the same placement. All siblings in foster care must be placed together, except under specific circumstances when such a joint placement would be contrary to the safety or well-being of any of the siblings. If siblings must be placed separately, efforts must be made to ensure frequent visitation unless visitation is contrary to the safety and well-being of any of the siblings as documented by a licensed professional and approved by the custodial county's director/designee. (See Child Welfare Policy Manual 10.20 and Standards 3.10 and 8.0)

Permanency Support

Standard 8: Achieving Permanency

Providers will assist DFCS in achieving permanency for children.

8.0 Providers must work in partnership with DFCS to facilitate visits between the child and family, and child and siblings. This includes providing transportation (of the child placed with the provider) as practical.

8.1 Provider's role in permanency is to provide supportive services to assist DFCS in achieving permanency for children. Permanency support services include identifying, documenting and partnering with DFCS to address the following:

- Defining and linking interventions to barriers to achieving permanency;
- Teaching the child and family the skills to live successfully in a family setting;
- Assertively reaching out to "hard-to-reach" or "resistant" families;
- Helping siblings maintain or reconstitute their relationship through phone contact and visitation;
- Identifying extended family or other caring adult connection who may be able to provide permanency or support for the child and family;
- Providing the parents and guardians with strategies to manage their own stress, as well as manage their child's challenging behaviors;
- Working with DFCS to arrange for family therapy, family support and skill-building activities for the family;
- Operating on the principle that family contact is a right, not a privilege;

- Supervising family visitation, coordinating unsupervised transitional family visitation, coordinating and monitoring visiting schedule and plan;
- When reunification is not possible, working with DFCS to pursue adoption or transition to another permanency option;
- Helping children who will not be returning home to have the optimal level of involvement with their families; and
- Other strategies as dictated by individual cases.

8.2 When permanency is achieved, the provider must work with DFCS, families, treatment providers and other stakeholders to transition children into the permanent placement.

8.3 Providers must attend/participate when invited to an FTM, Multi-Disciplinary Team (MDT) meetings, Juvenile Court Reviews, Citizen Panel Reviews, and transitional discharge planning meetings as requested by the Department.

8.4 Providers must have contact with the child's birth parents, guardian or other permanency person (EPEM—Every Parent Every Month) in order to support the DFCS case plan unless, in accordance with the DFCS case manager, the provider is not expected to conduct EPEM contacts. The frequency, type, mode and purpose of the contacts must be negotiated with the DFCS case manager. Within the first 30 days of placement, providers must communicate with DFCS to understand each individual child's permanency plan, the DFCS EPEM plan and to establish the provider's EPEM plan. The provider's EPEM plan should be updated when the ISP is updated, when the DFCS case plan or EPEM plan is changed or when events dictate. If in accordance with the DFCS CM, the provider is not required to conduct EPEM contacts, this must be documented in the child's case record.

Standard 9: Planned Discharges and Continuity of Care

Discharges are planned and coordinated with families, DFCS and other stakeholders.

9.0 Discharge planning must begin at the beginning of admission to the provider and is reflected in the initial ISP. Placement disruptions are unplanned changes whereas discharges are planned transitions to less restrictive placements, more appropriate placements or to permanency.

9.1 The DFCS case manager and the provider including any subcontractors must participate in a team meeting prior to discharge for all children placed by Fulton or DeKalb County.

9.2 The Discharge Summary must be provided to the DFCS case manager at the time of notification but no later than 24 hours. The Discharge Summary must include general information covering the child's placement, progress, challenges and recommendations for services and supports the child will need to be successful at home or in the next placement.

9.3 The Department may, in its sole discretion, remove a child from a placement at any time.

Standard 10: Preparation for Independent Living

Adolescents receive independent living skills in preparation for self-sufficiency.

10.0 Providers who care for youth ages 14 years and up will develop Individualized Skill Plans based upon the Casey Life Skills Assessment (CLSA). The individualized skill plan is a supportive component to the DFCS Written Transitional Living Plan (WTLP). The individualized skill plan must be updated every six months.

10.1 Providers must ensure that youth complete the CLSA at ages 14, 16 and 17 ½ years and annually for youth ages 18 to 21 years. An CLSA is required to develop the Individualized Skill Plan. When administering the CLSA, providers must use the appropriate code (which is based on the child's custodial county region). The list of CLSA codes are located in the appendix.

10.2 Providers must provide a monthly Independent Living report on each youth's progress on their Individualized Skill Plan to the DFCS IL Coordinator and DFCS Case Manager by the 10th day of the following month.

10.3 Providers must provide adolescents ages 14 years and older with daily living skills that include such things as menu planning, grocery shopping, meal preparation, dining decorum, kitchen cleanup and food storage, home management, and home safety.

10.4 Providers must provide independent living services to support the youth's Individualized Skills Plan directly and/or ensure that youth participate in county or other independent living services. Independent Living programming includes:

- Housing and community resources to assist youth in making a positive transition to the community. Includes housing, transportation, and community resources.
- Money management to help youth make sound decisions, both now and in the future. Includes exploring beliefs about money and information about savings, income tax, banking and credit, budgeting and spending plans, and consumer skills.
- Self-care to include skills to promote a youngster's physical and emotional development: personal hygiene, health, drugs and tobacco education, and information about human sexuality and making safe choices.
- Social Development focusing on relating to others now and in the future. Includes personal development, cultural awareness, communication and relationships education and training.
- Work and study skills to address the skills needed to help youngsters complete their educational programs and pursue careers of interest. Includes career planning, employment, decision making and study skills.

10.5 Providers must ensure that the daily lives of children provide opportunities, appropriate to the age and needs of the child, for development of knowledge and skills needed for future independent living.

10.6 The provider must develop, amend, or revise with the youth a special Individualized Skill Plan (a supportive component to the DFCS Written Transitional Living Plan (WTLP)) within 90 days of a youth turning 18 years. DFCS is required to facilitate a Transitional Round Table (TRT) within this same timeframe to develop, amend or revise the WTLP. If the provider has not already been invited to the TRT, with 180 days

of the youth turning 18 years the provider should inquiry as to the TRT plan with the DFCS case manager and IL Coordinator. The provider's ISP can be developed with DFCS at the TRT (preferred) or independently if necessary. (See DFCS Child Welfare Manual Policy 13.3)

10.7 Providers serving youth age 14 years and older must be familiar with the policies that govern DFCS Independent Living Services. These policies are covered in DFCS Child Welfare Policy Manual Chapter 13. **Note:** DFCS Independent Living policies refer to services available to all youth ages 14 years and up. Such policies refer to all age eligible youth regardless of whether or not they reside in Specialty RBWO Independent Living or Transitional Living programs. Questions regarding DFCS Independent Living policy and practice should be directed to your IL Coordinator in the provider's region or OPM.

Family Foster Homes

Standard 11: CPA Family Foster Homes Meet DFCS Minimum Standards[2]

All family foster homes must meet safety, well-being and quality of care standards.

11.0 CPA foster homes must meet the minimum approval standards for fostering parenting as outlined in DFCS Child Welfare Policy Manual Chapter 14. Foster homes may not receive placements prior to complete family information being entered into GA SHINES.

11.1 CPAs must approve and re-approve foster homes using the standards and requirements outlined in DFCS Child Welfare Policy Manual Chapter 14. Only foster parents in full approval status, which includes all criminal history and child protective services safety checks, may foster children in DFCS custody.

11.2 CPAs must ensure that prospective caregivers are drug screened per DFCS Child Welfare Policy Manual Chapter 14.11 using a drug testing laboratory. A list of acceptable laboratories may be accessed at http://www.spa.ga.gov/agencyservices/recruitment/collectionSites.asp. This list is not exhaustive but may assist providers who do not already have a laboratory identified.

11.3 CPAs must have a written description of their pre-service and on-going training program for caregivers. The training program should be reviewed and updated periodically to reflect the changing needs of children and families. The pre-service training program must be approved by DFCS.

11.4 Providers must ensure that caregivers participate in relevant annual training that at least meets the requirements of DFCS Child Welfare Policy Manual Chapter 14. CPAs must have a standard format for approving independent study and for measuring and documenting the learning that has taken place.

[2] Providers may use DFCS forms or their own comparable forms to meet requirements.

11.5 Caregivers must complete a pre-service training and a provider orientation to foster parenting as a part of the initial approval process.

11.6 Providers must incorporate the principles of trauma-informed practice into foster parent on-going training (A free trauma curriculum for foster parents can be obtained at The National Child Traumatic Stress Network www.nctsnet.org).

11.7 Foster parent homes must be located close enough to the agency to allow for their involvement in all aspects of the program including pre-service and in-service training, formal and informal support networks, home visits by the case support worker both planned and in emergencies, and participation in all activities related to the development and implementation of the child and family plan.

11.8 Each foster home record must include a copy of the notification to the caregiver (letter, memo, etc.) that indicates the period that the home is approved. Each successive approval period must have such a notification in the record; there should be no gaps in the dates from approval period to approval period. This letter must include the approval period; age range; gender; capacity; agency's case support worker's contact information and include the after-hours contact information.

11.9 Providers must maintain a placement log for each caregiver's home in their respective files. This log must include the child's name, date of birth, date of placement and program designation.

11.10CPAs must ensure that caregivers have a copy of the Foster Parent Bill of Rights and receive an explanation of the grievance process. (Note: This was previously 11.8).

11.11 CPAs must ensure that caregivers are provided with information on their Right To Be Heard during court reviews, hearings and other information in accordance with O.C.G.A. 15-11-58 (p). Such information must be provided during pre-service training and annually during on-going training. It must be documented in the foster parent's training record. (Note: This was previously 11.9).

11.12 CPAs must ensure that their foster parents who provide services to foster children in the custody of DFCS are paid timely (as outlined in the provider's foster parent manual or other agreement with caregivers) and at a minimum the rate equal to the DFCS foster parents. (Note: This was previously 11.10).

11.13CPAs must ensure that children are removed from foster homes and will not be placed in foster homes where there has been a finding by the Department that the foster parent is the perpetrator of substantiated abuse or neglect or whose violation of a DFCS policy has threatened the safety of the child. The only exception is where the home has been determined by the DFCS state office review to be in the best interest of the child/children in the home. A written waiver must be in the case file as well as a plan of correction to alleviate the safety concerns. (Note: This was previously 11.11).

11.14 CPAs must ensure that the number of children placed in their foster homes complies with the following requirements:

a. No child in the custody of DFCS may be placed in a foster home if that placement will result in more than three (3) foster children in that home or, a total of six (6) children in the home, including the foster family's biological and/or adopted, children without the written approval of the DFCS Centralized Services Director.
b. No child in the custody of DFCS may be placed in a foster home if that placement will result in more than three (3) children under the age of three (3) residing in a foster home. (Note: This was previously 11.12).

11.15 CPAs must ensure that the number of children placed or approved to be placed in a foster home will not displace the foster family's children or other members living in the household from reasonable and expected accommodations (i.e., bed, personal space and privacy). CPAs must ensure that placements also comply with the following requirements:

a. Only bedrooms shall be used as sleeping space for children.
b. Each non-related child must have a separate bed.
c. Any collapsible (pack and play), sofas, cots or other such temporary sleeping structures may not be used as the planned bed space for children.
d. A maximum of two (2) children may sleep in a double or larger bed if they are siblings, the same sex and under age 5 years. Preferably all children will have separate beds however. Infants must always be in a separate bed or crib.
e. No child shall sleep in a bed with an adult. Infants may not sleep in a bed with anyone.
f. A child over one (1) year of age cannot sleep in the bedroom of an adult.
g. Preferably, a maximum of three (3) children will share a bedroom. The suitability of children sharing a room must be thoroughly assessed and based on the background/history of the children and the space.
h. Children age five (5) years and older and of different sexes shall not share a bedroom.

In all instances, the suitability of children sharing rooms or beds (as in item C) must be thoroughly assessed and re-assessed as circumstances dictate. (Note: This was previously 11.13).

11.16 Placements should be made after careful consideration of how well the prospective foster family will meet the child and family's needs. CPAs must document the process for making the decisions regarding foster home placements, including discussions with DFCS and the families of children already in the home, in the foster family's file. Proximity to family, including siblings, and home community must be considered in the placement matching decision. Placements must provide nurturing homes, which promote the abilities, contribution and competencies of children and young people in everyday life taking into consideration their age and development. Documentation of the placement decision must be recorded in the case file of the child being placed, as well as that of the child or children already in the home. (Note: This was previously 11.14).

11.17 A caregiver must be provided the right to refuse placement of any child the parent feels is inappropriate for the home or presents a potential safety risk for other children in the home. A record of placement presentations made to caregivers and the result

(accepted, declined) should be maintained for each home. (Note: This was previously 11.15).

11.18 During the first 30 days of placement, providers must assess with the caregivers the necessity of securing sharps, medications, cleaning supplies or other items that may pose a hazard or danger based upon the individual child's needs. Alternatively, providers may have a blanket policy that requires that all sharps, cleaning supplies and other items that may pose hazard or danger to the safety or well-being of children be locked up and inaccessible to children and youth. Providers will also assess household items to ensure that Tip-Over hazards are properly secure to prevent harm or injury to children. (Note: This was previously 11.16).

11.19 The provider, including the caregiver, must be willing to work with the child's family, when applicable**,** and other caring adults in the child's life, e.g. extended family, former foster parents, CASA's, etc. including assisting with, arranging, or providing transportation for visits and helping the child maintain sibling ties. (Note: This was previously 11.17).

11.20 CPAs must conduct an in-home visit within the first week of placement. CPAs must increase visitation during the first thirty days of placement, to ensure the adequacy of the placement match, monitor the in-home implementation of the case plan and to develop strategies to assist the child in being successful in the home, school and community. Some of this time should be spent interacting with the child alone and meeting with the child and the foster parent. (Note: This was previously 11.18).

11.21 During home visits, the case support worker must talk privately with each child placed to ascertain the child's individual perspective, safety, well-being and any concerns. Information gathered must be documented in the case record. (Note: This was previously 11.19).

11.22 Caregivers must have 24 hour access to the provider. Foster parents must know how to contact the provider during nights and weekends. (Note: This was previously 11.20).

11.23 Caregivers must have access to respite care, both planned and crisis. Respite homes must be approved by the agency or another agency as fully approved foster homes. (Note: This was previously 11.21).

11.24 Prior to the child being placed, providers must ensure that their caregivers receive available information concerning children placed including family history, medical, dental, physical, mental health and educational needs prior to the child being placed. Providers must ensure that complete and accurate updated information is provided to the caregivers as information becomes available. (Note: This was previously 11.22).

11.25 Caregivers must be provided with a foster parent manual which outlines standards, policies and expectations of caregivers. The DFCS Foster Parent Manual which is available on the DFCS website (see appendix for link) may be used or the provider may create a comparable version. (Note: This was previously 11.23).

11.26 If a CPA suspects or is notified that a caregiver may have violated a safety, behavior management, quality of care, well-being or other such policy, the suspected violation

must be reported to and screened by the CPS Centralized Intake Call Center. Whether or not the report is investigated by CPS, providers must complete a Policy Violation Assessment (PVA) with related to the issue and develop a Corrective Action Plan (CAP) with the caregiver as appropriate following the policy outlined in DFCS Child Welfare Policy Manual Chapter 14.22. Care should be taken to avoid interfering with any related CPS and/or law enforcement investigations. For violations that the Office of Provider Management becomes aware of, providers will be notified via a GA+SCORE generated e-mail of the need to complete a PVA. Completed PVAs must be uploaded by OPM. OPM will in turn review the PVA and provide feedback to the required of the provider will be outlined in the e-mail. Any required CAPs must be uploaded into the Corrective Action tab in GA+SCORE within 3 days of notification and appeals to OPM's PVA determinations should be directed to the OPM Director by the provider within 3 days of notification. The OPM Director will review the appeal and reply to the provider within 10 days. (Note: This was previously 11.24).

11.27 CPAs must ensure that foster parents who accept placements of infants are informed about the general dangers of infant co-sleeping (with adults or other children) and the DFCS policy which prohibits infants in care from sleeping in the same bed with anyone. CPAs should regularly inquire about infant sleep arrangement including naptimes during home visits and remind caregivers about taking precautions to prevent infant sleep related deaths and injuries. Please refer to the DFCS Infant Safe Sleeping Guidelines and Protocol, Appendix K. (Note: This was previously 11.25).

11.28 Children with a Specialty program designation have intensive needs and require significant levels of care and supervision. Therefore, children who have a Specialty Watchful Oversight program designation --Specialty Base (SBWO), Specialty Maximum (SMWO) and Specialty Medically Fragile (SMFWO)—must be the only placement in the foster home. This includes respite for the Specialty designation child or another child coming into the Specialty home for respite. Any exceptions to this standard (whether for respite or placement) must be approved in advance of the placement by the Placement Resource Operations Unit. Waiver requests should be sent to **proteam@dhs.ga.gov** and include a complete explanation of the supporting circumstances and concurrence from all children's DFCS Case Manager(s). (Note: This was previously 11.26).

11.29 Any previous fostering or adopting experience must be documented in the initial home evaluation and used in making the approval decision. Providers must review any previous home evaluations, training history, policy violations history, corrective action plans history, reasons for closure and any other pertinent information that would assist in making an approval decision. A recommendation must be requested from the previous agency (ies). If a previous agency is closed, no longer has the caregiver's records or for other reasons is unable or refuses to comply with the request, this must be documented in the home evaluation. (Note: This was previously 11.27).

11.30 CPA providers must ensure that all children in care are given all medication as prescribed.

I. Providers must have a medication management policy that includes managing medication refusal and securing of medication.

II. The foster parent will maintain a medication log in the home for all medications taken by children in their care that includes (child's name, foster parent name and signature, name of the medication, medication dosage, administration time and date, log start and end date as well as foster parent initials). Providers may use the DFCS Medication log or create an equivalent document to be used by foster parents.
III. Provider will review and retrieve the original medication log from the foster parent monthly and file in the child's record. (Note: This was previously 11.28).

11.31 CPA providers must keep a log of all Corrective Action Plans (CAP) or policy violations on foster homes. (Note: This was previously 11.29).

11.32 CPA provider should assist the caregiver with integrating new children placed into the foster family and with any children already placed. (Note: This was previously 11.30).

11.33 CPA providers must regularly assess children's clothing needs. Funding for clothing is not included in the CPA per diem. The DFCS case manager should be notified--- when children do not have adequate, season-appropriate clothing suitable for the child's age, gender, size and individual needs -- to determine if the child is eligible for a clothing allowance. CPAs should also consider creating community or other resources to address clothing issues. CPA's requesting reimbursement must submit receipts for clothing within three (3) months of purchase. (Note: This was previously 11.31).

11.34 Foster homes must be placed on hold to additional placements during CPS investigations. The Office of Provider Management must be notified of any CPS investigation as soon as possible. OPM will place the home on hold in GA+SCORE and GA SHINES. At the conclusion of the investigation, the provider must contact OPM so that the foster parent's continued eligibility for placements can be ascertained. (Note: This was previously 11.32).

11.35 CPA Providers must ensure that foster parents maintain a home environment that provides for the safety and well-being of children placed in their care. Foster parents are required to comply with the following safety requirements for children in foster care placement.

a. The foster home and surrounding property must be kept reasonably clean and
b. uncluttered, properly maintained, and free of safety and health hazards, and uncontrolled rodents and insects.
c. All hazardous substances including, but not limited to, flammable and poisonous substances, medications and industrial cleaning supplies are stored out of the reach of children.
d. Ceilings, walls, and floors will be maintained and kept clean and free from graffiti, dirt, or stain buildup.
e. Foster parents must have a plan for regular maintenance and upkeep of the living environment, furniture, and grounds.
f. Each child placed must have a suitable bed, bedding, storage for personal items. Children must be able to personalize their bedrooms to the extent possible.

g. Bath, showers and toilets must be of a number and standard to meet the needs of the children placed and must be free of mold, mildew and debris.
h. Kitchen should be maintained with operable appliances and reasonable clean.

(Note: This was previously 11.33).

Child Caring Institutions

Standard 12: Child Caring Institutions

CCIs provide safe, quality, appropriate and effective programming.

12.0 CCIs must have a procedural manual which contains its statement of purpose, programs, policies, procedures, guidance to staff and other operational information.

12.1 The CCIs location, design and size are in keeping with its purpose and function. The CCI must have sufficient space to meet the needs of children placed.

12.2 CCIs must provide home-like accommodations whenever possible. CCIs must be decorated, furnished and maintained in a home-like manner appropriate for the number, gender mix and abilities of the children placed. Pictures and posters will reflect the cultures of children and families being served and should create a home-like atmosphere. The interior and exterior of the CCI must be safe and in a good state of structural and decorative repair.

12.3 The building and grounds and/or campsites must be designed and maintained to meet the needs of the children and families, and to assist staff in fulfilling their responsibility to provide supervision and oversight of children.

12.4 The building, grounds and/or campsites must be maintained in a condition to ensure the health and safety of the children served. Hazardous items will not be openly accessible to children and youth. The building and grounds will be kept clean and free from trash, debris and pests. Ceilings, walls, and floors will be maintained and kept clean and free from graffiti, dirt, or stain buildup.

12.5 Providers must have a plan for regular maintenance and upkeep of the building, furniture, and grounds. Providers will assess household items to ensure that Tip-Over hazards are properly secure to prevent harm or injury to children. Resources must be available to repair damages and unanticipated repairs to the buildings and furnishings as needed.

12.6 Each child placed must have a suitable bed, bedding, storage for personal items. Children must be able to personalize their bedrooms to the extent possible.

12.7 Each child must have a space to complete homework assignments and study.

12.8 Bath, showers and toilets must be of a number and standard to meet the needs of the children placed.

12.9 Upon admission, children must be provided with an orientation about the CCI, services

they can expect, information on how they will be cared for and who they are likely to share the home with and other information which would orient the child to the placement. The orientation must be documented in the child's records.

12.10 In the initial and subsequent ISP, it should clearly indicate the assessed needs of the child, the objectives of the placement and how these objectives will be addressed on a daily basis which includes efforts to be made by the direct care staff and HSP.

12.11 Providers must actively promote the involvement of all children in the placement's social group, counters isolation of individuals, nurtures friendships between children and supports children who for any reason do not readily "fit in" with the group.

12.12 Providers must have a process for ensuring that the opinions and views of children on the operations of the placement are ascertained on a regular and frequent basis and given due consideration. Children are given the opportunity to meet with staff individually and in groups to discuss the general running of the home, to plan activities and to share their views.

12.13 Providers must ensure that children's privacy is respected and information is handled in a confidential manner. Provider's must ensure that staff know how to deal with and share information which they are given in confidence by the child or others.

12. 14 CCI Providers must have a documented and posted shopping schedule. The shopping schedule interval must be sufficient to ensuring that children are provided with adequate quantities of suitably prepared food and drink having regard to their needs and wishes and as appropriate children have the opportunity to shop for and prepare their own food. Daily menu's should be documented and posted and the food supply should adequately reflect the daily menu.

12.15 Providers shall ensure that nutritional "grab and go" snacks are available and accessible to the children in the program. To the extent possible, providers will ensure that children are able to obtain and or prepare snacks and drinks for themselves at reasonable times during the day.

12.16 The selection, preparation, and serving of food will be guided by the nutritional, social, cultural, religious, and health needs of the children served.

1. Food should be appetizing and attractively served. The dining area should be pleasant.
2. Meals should occur at regularly scheduled times. The atmosphere should be relaxed with opportunities for children to engage in conversation. In small group home settings, there should be enough chairs for all the children to eat together.
3. Meals should include some of the food preferences of the children of different cultural and ethnic groups
4. Children may be encouraged to eat; they may not be forced.
5. Snacks should be offered after school and at other times as appropriate.
6. Children should have a voice in menu planning.
7. Children should be given opportunities to participate, with supervision, in food shopping and preparation.

8. Unless there are dietary or therapeutic restrictions, children should be allowed to have more than one helping.
9. For those children with special dietary needs, a professional nutritionist or a dietitian must be available for consultation on menu planning, portions, and preparation. The dietitian or nutritionist should be aware of the particular needs of children who have experienced neglect and deprivation.
10. For providers who serve more than 12 children and operate a cafeteria, the cafeteria must be inspected by the Department of Public Health annually; results made available when requested and should be free of any concerns.

12.17 Children placed in CCIs may be eligible for an initial (i.e.at entry into foster care) clothing allowance if the initial allowance has not already been expended. Providers should discuss eligibility for initial clothing allowance with the DFCS case manager. CCI providers must continually ensure that children have an adequate amount of clothing to last until the next wash cycle (wash cycle/days should be documented and posted in an area available for the child's viewing). Adequate clothing can be defined as clean and available clothing for each day of the week, season-appropriate clothing suitable for the child's age, gender, size and individual needs. Children should be involved in shopping and selecting their clothing whenever possible. Funding for clothing other than the initial allowance is included in the CCI per diem.

12.18 Providers must ensure that there are ample opportunities for children to participate in a range of appropriate leisure activities.

12.19 Providers will have a program of indoor and outdoor recreational and leisure activities.

12.20 In addition to providing activities on site, the provider shall utilize the community's cultural, social, and recreational resources whenever possible and appropriate. If children are participating in a community program, the provider must ensure that the program has sufficient and appropriate supervision for the children in attendance or provider staff will supplement the supervision as necessary to achieve an adequate level.

12.21 Leisure and recreational activities will be incorporated in each child's service plan. Children's strengths, needs, and interests should be addressed when developing recreational and leisure activities. Recreation and leisure activities must provide opportunities for children to participate in both group and individual events. Providers must ensure that all activities are appropriate for the ages of the children being served.

12.22 Recreational equipment must be in good condition. Games and supplies must be useable and in good condition.

12.23 Providers must have adequate space to allow several different activities to occur simultaneously. Examples of activities that are appropriate for inside are table tennis, reading, art (class and free expression), and board and card games. Sufficient outside space must be provided for more active games such as basketball, volleyball, badminton, and soccer.

12.24 Providers must ensure that children do not spend all (or most) of their leisure time watching television or playing video and computer games.

12.25 Provider will expose youth to various educational and career opportunities through college tours, unique careers and motivational conferences and speakers. This includes the provider developing mentorship and motivational opportunities to cultivate community resources and partnerships providing services for youth.

12.26 CCIs must have a family visiting room or designated areas for visits.

12.27 Providers must have an insured, operable vehicle adequate for the number and needs of children placed.

Note: Appropriate exceptions to the Standards will be made for "Specialty" camp programs. Campsites shall be designed to meet the needs of the children served and shall be maintained in accordance with the RCCL rules and regulations for these programs.

12.28 Daily routines of residents shall provide for appropriate personal care, privacy, hygiene, and grooming commensurate with age, gender, and cultural heritage. All necessary toiletry items and supplies, such as and not limited to, soap, shampoo, hair brushes, toothbrushes and paste, deodorant, lotion, and bath towels, shall be provided.

12.29 CCI staffing standards are based on the assumption that children placed are age 12 years or older. If providers accept children under the age of 12 years of age, an assessment of how staffing will or will not be adjusted must be documented and based on each child's individual needs at admission.

12.30 Providers must have and implement a policy regarding the safe guarding of vehicle keys.

12.31 CCI Providers must follow RCCL rules regarding separate sleeping areas for male and female residents. However, males and females of any age may not share a room.

12.32 For direct care staff new hires, providers must request references regarding previous employment with other CCIs and/or other employers where the applicant had a child caring role.

12.33 New buildings will be accessible to people with disabilities and reasonable accommodations should be made in older buildings. (Note: This was previously 12.25)

12.34 Providers will ensure that fire drills are held and documented at least twice a year.

12.35 If a CCI suspects or is notified that a staff member may have been involved in the maltreatment of a child, the incident must be report to the CPS Centralized Intake Call Center. Whether or not the report is investigated by CPS, providers must complete a Policy Violation Assessment (PVA) related to the issue and develop a Corrective Action Plan (CAP) as appropriate. Care should be taken to avoid interfering with any related CPS and/or law enforcement investigations. For violations that the Office of

Provider Management becomes aware of, providers will be notified via a GA+SCORE generated email of the need to complete a PVA. Completed PVAs must be uploaded into the Policy Violation tab in GA+SCORE within 3 days of notification and appeals to OPM's PVA determinations should be directed to the OPM Director by the provider within 3 days of notification. The OPM Director will review the appeal and reply to the provider within 10 days.

General Administrative Matters

Standard 13 Provider Operations

Provider's administrative structure, programs and policies will provide the framework for delivering quality services to children and families.

13.0 Providers must maintain all license, certifications, or accreditations in effect at the time of the approval of the R.B.W.O. provider contract or as required by federal, state or local law authorities. In addition, regulations and guidelines of the Department of Human Services, professional associations or entities providing accreditation to include business license or occupational tax certification required by certain jurisdictions. Certification or licensing for staff, facilities and programs must maintain compliance with R.B.W.O. Requirements.

13.1 Providers must have computers with internet access to be used by provider staff in performing requirements. Additionally providers must have telecommunications which ensure that the Department is able to reach the provider twenty-four (24) hours per day, seven (7) days per week.

13.2 Providers must maintain sound practice informed by literature, research, legislation, policies and procedures as well as professional ethics and values.

13.3 Providers must notify OPM of any change of address, telephone contacts, administrator/executive director, staff roster (including administrative assistants and part-time staff), admissions contact, GA+SCORE reporting contact and after-hours contact via the GA+SCORE system within 48 hours of the change. There must be at least two (2) distinctly identified staff with different contact information listed in GA+SCORE at all times.

13.4 Providers must notify OPM of change to policies and procedures that significantly impact the delivery of services or programmatic changes (i.e. gender or ages served).

13.5 Providers must use contracted service vendors who possess the appropriate license, certificate, or accreditation, which may be required by the OPM when providing services to children to whom services are provided pursuant to these requirements.

13.6 Providers must comply with all requests for information and records for use in and to participate, as requested, in the annual Time Study and Cost Report, including, but not limited to providing the OPM with a copy of the provider's Annual Independent Audit Report, and to comply with all requests made by the Department to assist it in its efforts to obtain payment or recovery of costs of R.B.W.O services from third parties.

13.7 Providers must provide to OPM such data and reports as it requests for use in developing baselines, baseline data and other reports or review processes to promote improvement in performance under these requirements and in any other area related to the services provided to children placed by DFCS in the following areas: Child health and safety, Family and community involvement, Permanency, Functioning levels, Placement stability, and Reentry to care.

13.8 Providers must fully and accurately submit all required data into the GA+SCORE. Information must be entered timely and kept up to date.

13.9 Providers must employ an adequate number of qualified staff to provide the necessary services (See Staffing Standards).

13.10 At a minimum, RBWO providers must staff the following positions:

CCI's: Director, Human Services Professional (HSP) and the Direct Child Care Worker to meet Staffing Standards.

CPA's: Director, Case Support Supervisor and Case Support Worker (CSW) to meet Staffing Standards.

13.11 Providers must ensure that no staff employed by the facility has an unsatisfactory determination related to his or her criminal record.

13.12 All provider staff must meet the minimum educational and experiential requirements based upon their position as outlined in the Staffing section of the RBWO Minimum Standards.

13.13 Staffing ratios must meet the minimum standards as outlined in the Staffing Section of the RBWO Minimum Standards.

13.14 Providers must designate a staff member to coordinate training.

13.15 An individual staff development plan must be developed for each service staff member and kept on file.

13.16 Case support workers and supervisors, direct care staff and human services professionals must be supported by regular, ongoing supervision.

13.17 Directors must be supported by regular ongoing supervision or consultation.

13.18 Providers must maintain appropriate, clear, relevant, concise, timely and up-to-date records, including electronic and/or hard copy case records. Documentation relevant to children and young people is dated, signed and makes reference to the time of occurrence and is legible. Providers must review the quality of documentation on a regular basis and continuously improve methods. Records must be fully maintained at all times.

13.19 Services must comply with relevant regulations for the protection of the confidentiality and must keep all documentation in a secure environment.

13.20 Providers must comply with all applicable rules and regulations of Residential Child care (RCCL).

13.21 Providers must ensure that DFCS has access to children in its custody 24 hours a day, 7 days a week, regardless of placement in CPA foster homes or CCIs.

13.22 Providers will submit Monthly Summary Reports on each child to DFCS Case Manager by the 10th day of the following month. Monthly summaries should be completed for each child regardless of duration of placement for that month. Providers must maintain proof of submission in the child's case record.

13.23 CCI and CPA staff with direct child care or case support responsibilities including direct care staff, human services professionals and case support workers and supervisors must participate in a minimum of twenty-four (24) clock hours of annual training in issues related to the employee's job assignment and to the types of services provided by the agency . The training requirement applies to part-time or contract employees who work at least 20 hours per week. Participation in training an on confidentiality and Mandated Reporting is required for all staff annually. ESI, First Aid and CPR do not count toward the annual training requirement.

13.24 OPM must be informed in writing if providers offer placements through other agencies (such as DJJ) or via private placements for children/youth who may have greater needs than the DFCS program designations for which the provider is approved for DFCS placements. Notification to OPM may result in a special site review or request for additional information. Providers should also make this information available to county staff seeking placements to assist in making informed placement decisions.

13.25 All foster care records must be maintained until the child has reached age 23 years. If a provider agency closes or ceases to contract for RBWO placements in the meantime and needs assistance with record storage, OPM should be contacted for assistance.

13.26 No child placed in the department’s custody is allowed to go home with any staff or employee member of the agency where that staff person or employee is not a duly approved foster parent. Any special circumstances must be discussed with OPM.

13.27 Providers who utilize volunteers must have a policy that governs such activities. Volunteers used to meet any RBWO staffing requirements must follow all requirements outlined for regular staff. Volunteer policy must include the following:

- A completed application for volunteering;
- A Fitness Determination Letter from DHS, OIG;
- A documented assessment of the volunteer which includes a face to face interview;
- A driving record check on any volunteer expected to transport children
- Review of at least two references; if the volunteer has previous child caring experience or fostering/adopting experience, agency/employer references must be obtained;

- Orientation and training of the volunteer;
- Signing of a confidentiality agreement; and
- Maintenance of a file on the volunteer to include all related volunteer documents, hours worked and duties performed.

13.28 Providers who utilize volunteers must ensure that they are supervised by a qualified RBWO Staff who is responsible for planning and coordinating the volunteer's assigned duties. An appropriate training/orientation program must be conducted by a qualified staff member prior to a volunteer engaging in any activities with youth.

13.29 Providers must have and implement a policy on supporting children and youth's safety on the internet and use of internet social media. The policy must include training of staff and caregiver's on internet safety and providing age-appropriate information to children and youth regarding internet safety.

13.30 Providers must comply with Georgia Department of Labor employment laws and rules.

13.31 RBWO standards and contract deliverables may only be waived by the OPM Director. Waivers from RCCL and/or county or regional DFCS directors are not valid waivers of RBWO standards or deliverables.

13.32 Providers should obtain a reference from an applicant's or volunteer's previous or current employer if the applicant is or has been employed in a job situation that involves children (e.g. school, daycare center, group residential care or intensive residential care facility, etc.) within the past 5 year, prior to hiring the prospective employee. If the applicant or volunteer has served as a previous foster or adoptive parent, obtain references from the former county/agency. Obtain additional references if conflicting, ambivalent or inadequate statements are received from those initially requested.

13.33 Providers (CCI's and CPA foster parents) must have a written Emergency/Disaster Plan to address large scale emergency situations. Emergency situations are defined as anything that will displace children during a statewide or agency disaster. At a minimum the plan should include:
Instructions for how CCI staff as well as CPA foster parents are to proceed during an emergency situation, to include: Transportation, medication and record management, ongoing communication, location for the nearest shelter, hospital, police and fire station. This plan will be reviewed and updated at least annually and uploaded in GA+SCORE.

13.34 CCI and CPA Human Service Professionals, Case Support Workers and Case Support Supervisors must complete RBWO *Foundations* new hire training **within 4 months** from their start date or be waived from training. Staff must enroll in one or both components within 30 days from the date of hire. The complete *Foundations* course consists of three (3) weeks of e-learning / field practice experience and one (1) week of classroom instruction for a total of four (4) weeks of instruction. The classroom component of Foundations culminates with a knowledge-based competency test based on the materials covered during the 5-day classroom experience. The test must be passed with a score of at least 80% in order to earn credit for the classroom

component. The online component of Foundations does not have a knowledge-based test. However, there is module completion verification activities required.

(Please refer to Foundations Training and Standards Guide located on GA+SCORE)

13.35 If existing CSS, CSW and HSP staff members have not completed RBWO Foundations training within the six (6) month deadline, they must be reassigned to roles other than CSS, CSW or HSPs until the training is successfully completed. Agencies identified as systematically failing to ensure that staff meets training requirements are subject to admissions suspension and OPM contract termination.

13.36 Provider will comply with all of the contract deliverables, OPM RBWO Minimum Standards, and DFCS Child Welfare Polices. Failure to comply will result in:

- Intervention from the OPM Risk Management Team (site visit, technical assistance, office conference, etc.),
- Letter of Concern,
- Admission suspensions, and/or
- Termination of contract.

13.37 Providers will implement an internal continuous quality improvement process to at a minimum placement matching, placement disruptions, child protective services investigations, policy violations, services to ILP youth, staff hiring and turnover, caregiver and staff training and performance based placement performance. Continuous quality improvement (CQI) is the complete process of identifying, describing, and analyzing strengths and challenges and then testing, implementing solutions and then learning from the results, and revising solutions in a continuous process that yields optimal programmatic functioning and better outcomes for children and families.

Independent Living and Transitional Living Programs

Transitional and Independent Living Programs provide youth in foster care with opportunities to prepare to live independently, self-sufficiently, and prepare for adulthood. The goal of transitional and independent living programs is to provide older youth in foster care with the support, instruction, and opportunities to practice the necessary independent living skills and acquire the knowledge to become productive adults.

Comprehensive and effective independent living transitional services are key to helping youth function as productive citizens and acquire skills needed for pursuing an education, finding a job, obtaining suitable housing, and protecting their health and well-being when they leave the foster care system.

Transitional and Independent Living Programs serve youth in DFCS custody and those who have agreed to Extended Youth Supportive Services (EYSS). Youth who participate in these programs must be at least age sixteen (16) years through age twenty-one (21) years. Placements may also be provided to youth who were formerly in foster care; and who were discharged from DHS custody on or after their 18th birthday and who have not yet attained their 21st birthday. Transitional and Independent Living Programs must be flexible in order to

meet a wide variety of needs and skill levels while providing youth the opportunity to accept more responsibility with decreasing structure and adult supervision.

Transitional Living Programs (TLP) are specialized RBWO programs for youth at least age 16 years. Youth may be older than 18 years old if they have agreed to EYSS. TLP is designed for youth who are ready to enter a phase of care that will eventually transition them to independent living. Transitional living affords youth an opportunity to practice basic independent living skills in a variety of settings with decreasing degrees of supervision. This specialized RBWO placement provides youth the opportunity to experience increased personal responsibility so youth can become responsible for their own care when they exit foster care. The goal of a transitional living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Independent Living Programs (ILP) are specialized RBWO programs for youth who are at least 18 years of age through 21 years of age. ILP is different from TLP in that youth may live in an alternative living arrangement (i.e., community based housing) rather than a group home, or other residential type facility. ILP placements shall begin no earlier than a youth's 18th birthday. Youth in ILP will experience "graduated independence" regarding program expectations, skill development and levels or types of supervision provided. The goal of an independent living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Hybrid Program Models

RBWO providers who have applied for and been approved to provide Teen Development services may exclusively provide ILP, TLP or both programs under the same program/site/name. Programs who operate a combined program or hybrid model must assign youth to their ILP or TLP programs based upon age, ability and overall assessment. Youth under the age of 18 may only participate in TLP programs whereas youth over the age of 18 years may participate in either program. Provider performance will be assessed based upon each youth's program.

TLP and ILP Program Outcomes

Overall outcomes expected from transitional and independent living programs are as follows:

- youth have an affordable and permanent place to live upon their discharge from foster care;
- youth have a permanent connection with at least one safe, stable, nurturing adult outside of the social services system;
- youth have obtained a high school diploma or GED and are pursuing secondary or technical education;
- youth are employed or have gained significant employment experience or vocational training;
- youth can demonstrate self-sufficiency and independence from social services;
- youth can demonstrate personal responsibility;
- youth are free from illegal entanglements and risky behaviors;

- youth have secure, positive peer relationships; and
- youth understand their rights and responsibilities as a citizen.

II. RBWO Providers

OPM has developed Minimum Standards for TLP and ILP placements to help provide consistency in the development and delivery of services. All agencies desiring to provide transitional and/or independent living programs through an RBWO contract must be able to meet Standards.

Providers of Transitional Living Programs, which are for youth who are at least 16 years of age must be licensed through the RCCL. Providers of Independent Living Programs who only accept youth who have already turned 18 years and who are not and cannot be licensed through RCCL, must go through a pre-approval process with OPM before submitting a request to be a contracted provider.

Difference between Provision of Independent Living Skills and Specialized RBWO Programs for Independent and Transitional Living

All RBWO providers who serve youth ages 14 years and up must incorporate independent living skills into their services. These "soft skills" may be achieved through regular and natural opportunities in family foster care or congregate care (helping with chores, cooking meals…), through classes or workshops and / or participation in a county or regional Independent Living program through an Independent Living Specialist (ILS). Regardless of the administering entity (child-placing agency, residential facility or DFCS foster home), youth must be provided opportunities to learn the skills they need to live independently. These skills, at a minimum, may include: preparing meals; doing laundry; cleaning the home; living cooperatively with other housemates or neighbors; maintaining employment; paying bills; handling finances in general; washing and ironing; using public transportation; handling basic maintenance, simple repairs; creating and maintaining order in a living space; and training in basic first aid, for example. Regardless of the skills being taught, the skills must be tailored to a youth's current level of functioning. Additional skills may be introduced as a youth progresses, achieves success in the minimum skills, and desires to learn more advanced skills.

RBWO providers who are designated as ILP or TLP providers have programs which specialize in preparing youth for independence or supporting emancipated youth who have chosen to remain in foster care. These programs have specific goals and requirements which differentiate them from other RBWO programs. Youth in RBWO TLP and ILP programs are being further prepared for adulthood by being provided a realistic living experience, through transitional or independent living placements where they can take full responsibility for themselves. Elements of living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions;
- Youth being involved in their skill development planning;
- Life skills practice while having access to staff for support and advice;
- Ability to determine needed areas of support before emancipation or transfer to a less supervised living arrangement;
- Daily social contacts;

- Emotional adjustment to the difference between present living situation and previous ones, and to the loneliness that may occur due to a change in living situations;
- Practice in living alone;
- Use of emergency medical procedures;
- Obtaining and using transportation to access needed resources;
- Safe use of household appliances;
- Practice in basic housekeeping;
- Negotiating a rental agreement;
- Use of leisure time;
- Practice in money management and budgeting;
- Experience in shopping, food preparation, food storage; and
- Consumer skills.

These experiences must also be tailored to a youth's current level of functioning. Additional experiences and opportunities may be introduced as a youth's skill level increases and more complex opportunities are desired.

Transitional Living Minimum Standards

RBWO providers are responsible for assuring that their transitional living programs meet the following requirements as well as applicable *RCCL rules and regulations.* TLP youth who are under the age of 18 years are still in DFCS custody and thus TLP providers of these youth must follow the RBWO Minimum Standards for all providers *and* the Standards for this specialized program. Providers with youth who are over the age of 18 years and in a TLP will be assessed using general RBWO Standards and TLP standards with exceptions made where general Standards are not applicable to youth over the age of 18 years.

Standard 14: TLP Admissions

Providers must only admit youth to a TLP for whom the admissions assessment indicates that the youth is appropriate for the program.

14.0 Admitted youth must be at least 16 years of age, with any permanency plan and have been assessed by the provider to be invested in and able to benefit from the TLP.

14.1 Providers must have defined admittance criteria, which include a youth-completed application and interview.

14.2 Providers must maintain an up to date roster on GA Score.

14.3 Providers must determine whether youth will be accepted or denied admission within three business days of a completed application.

14.4 Youth admitted into a TLP must have an orientation to the program. Youth must be provided with a handbook or other literature describing the program. Youth must sign an acknowledgement of having participated in the orientation and having received an explanation of their rights and responsibilities as a program participant.

14.5 All youth entering TLP must have a staffing within the first 30 days of placement, which must include the youth DFCS Case Manager, and other supports. The ILS should be invited. The purpose of the staffing is to review expectations, the WTLP and TLP ISP.

Standard 15: TLP Supervision and Independence

Youth should receive levels of supervision that fit their needs and be provided with appropriate independence to practice skills needed for independent living.

15.0 TLP youth must have a documented assessment which supports their Supervision and Independence plan.

15.1 The Supervision and Independence Plan must be signed by the youth, DFCS Case Manager and Life Coach.

15.2 The Supervision and Independence Plan must be re-assessed at least every three months or as often as circumstances or changes dictate by the DFCS Case Manager or Life Coach.

15.3 Youth in TLPs must be supervised under the same standards as general RBWO programs. However, TLP youth may be appropriate for "Graduated Independence" which outlines decreasing levels of supervision based upon the program objectives, the youth's maturity and other factors.

Standard 16: Independent Living Skill Building

TLP programs must assist youth in making progress toward achieving the goals of the TLP ISP.

16.0 Providers must utilize the DFCS Written Transitional Living Plan (WTLP) in the development of the youth's TLP Individual Skills Plan (TLP ISP). The TLP ISP must support the WTLP and be based upon the youth's needs, desires, Casey Life Skills Assessment (CLSA) and permanency plan. (The TLP ISP is the ISP for the TLP programs. All other standards for the ISP apply.)

16.1 The TLP ISP must have defined goals and objectives with timeframes established. Case documentation should reflect progress and/or efforts toward meeting goals.

16.2 The TLP ISP incremental steps or goals must include the following:

- Development of Permanency Pacts or other agreements with caring adult connections;
- Living arrangements upon discharge from Extended Youth Supportive Services;
- Educational and/or vocational planning; and
- Any other goals or objectives which will assist the youth in being successful post discharge.

16.3 Providers must submit a monthly summary of each youth's progress to the regional Independent Living Specialist (ILS) and the DFCS case manager by the 10th of the following month. The list of ILSs is located in Appendix G.

16.4 TLP youth must be engaged in learning and developing "soft" and "hard" independent living skills, daily living and self-care skills. Hard skills include the teaching of areas including, but limited to banking, apartment hunting, job search, budgeting and educational planning. Soft skills include the teaching of areas including, but not limited to anger management, goal-oriented behaviors, parenting skills, problem solving skills and interpersonal communication. Daily living skills should include instruction in nutrition, menu planning, grocery shopping, meal preparation, dining decorum, kitchen cleanup, food storage, home management, and home safety. Opportunities for youth to apply these skills would include developing menus, shopping for ingredients, preparing meals, cleaning the kitchen and dishes at the conclusion of the meals, and appropriately storing leftover food. Self-care skills should include instruction about topics such as hygiene, health, alcohol, drugs, tobacco, parenting skills, responsible sexuality and sexual practices. Opportunities for youth to apply these skills would include discussions as well as role playing and rehearsal of parenting and hygiene skills.

16.5 At a minimum, providers should document at least two efforts weekly that record the youth's engagement in independent living skills development.

16.6 Youth should attend county/regional IL meetings unless there is a reason why it is not possible or practicable. Provider must document the reason in the monthly summary report to the ILS and DFCS Case Manager.

16.7 Providers must coordinate educational services, facilitate career plan development, provide tutors, and help youth attain educational goals.

16.8 Providers must assist youth in developing a career plan. The plan should include the youth's interests, strengths in school, visions for career and personal life, and opportunities for career and work experience.

16.9 Providers must connect youth with local industries and employment programs so that youth have the opportunity to explore career opportunities and develop a plan to achieve their career aspirations.

16.10 Providers must offer job search training in areas such as resume writing and interviewing.

Standard 17: Permanency Planning

Providers must provide support of the youth's permanency plan.

17.0 Providers must document supportive activities which assist youth with achieving DFCS permanency goal.

17.1 For youth with Another Planned Living Arrangement (APPLA) goals which includes emancipation, providers must include in the TLP ISP incremental steps or goals which include the following:

- Development of Permanency Pacts or other agreements with caring adult connections;
- Living arrangements upon discharge from foster care;
- Consideration of extending foster care services;

- Educational and/or vocational planning; and
- Any other goals or objectives which will assist the youth in being successful post discharge from foster care.

17.2 Youth between the ages of 17 to 17 ½ must be provided with an orientation to benefits provided by the state Independent Living program, community resources as well as any other public assistance benefits such as food stamps, housing, or TANF.

17.3 Within three months prior to a youth's exit plan from foster care, in collaboration with DFCS, provider and youth should jointly develop and sign a formal transition plan describing how the youth will successfully move from state custody to independence. A staffing must occur to discuss the transitional process. At a minimum, a plan should be discussed at this meeting to indicate what steps the youth will take to meet his or her education and vocational goals, identify community services the youth can turn to if he or she needs assistance, and outline individualized tasks the youth will undertake to meet specific challenges identified on his or her TLP ISP or WTLP.

Standard 18: Life Coaching

Youth are supported in achieving personal goals through a Life Coach.

18.0 Youth in TLP programs must have a life coach. Life Coaches must meet the same educational and experiential requirements of a Human Services Professional (HSP). Life coaching is a practice that helps people identify and achieve personal goals. Life Coaches help clients set and reach goals using a variety of tools and techniques. Life Coaches model life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making) and provide activities for youth to practice life skills and provide appropriate feedback to the youth.

Note: Life Coaches serve as the HSP for TLP programs.

18.1 TLP Life Coaches must participate in a basic certification training provided by the state IL Program Manager. Training covers Independent Living policies, Casey Life Skills Assessment (CLSA) and other requirements of the program.

18.2 TLP Life Coaches must attend at least one county/regional/ state IL training, meeting or workshop quarterly. This requirement may also be met by meeting individually with the Regional ILS or DFCS Case Manager to staff the youth.

18.3 Life Coaches must have a written plan for each youth includes at least bi-monthly face-to-face sessions with youth. The Life Coach plan may be a separate document or incorporated into the TLP ISP. Life Coaches must utilize the results of the youth's ACLSA in the development of the TLP ISP and Life Coaching plan.

18.4 Life Coaches must participate in at least twenty-four (24) hours of annual training. At least twelve (12) hours should be directly related to work with teens including understanding developmental needs of adolescents and strength-based assessments.

Standard 19: TLP Outcome Measures

Providers must track outcomes of youth and overall program performance.

19.0 TLP providers must track outcomes for youth. Minimally, programs should compile, on an annual basis, results on the following:

- Demographics on youth served;
- Life skills programming;
- Educational outcomes;
- Vocational outcomes;
- Youth involvement with DJJ or DOC; and
- Housing, adult connection, employment, educational status of youth emancipating from the program.

19.1 Providers must distribute reports for the contract year by July 30th annually (reports cover July 1- June 30). Reports should be provided to the OPM, regional ILS and the state IL Program Manager.

Standard 20: TLP Housing Options

20.0 Transitional living placements may be offered through a variety of residential on-campus living arrangements where youth have the opportunity to practice independent living skills with decreasing degrees of care and supervision. Apartment living may also be considered when the apartments are grouped together in what is known as a "pod," and only individuals participating in the program are allowed to live within the pod. A pod must be in a specific location with a supervisor living on-site twenty four (24) hours a day, seven days a week (i.e., 24/7). Other supervisory regulations will be determined on a program by program basis.

20.1 Providers are prohibited from using mobile homes as the housing unit for transitional living placements.

20.2 Transitional living facilities must be in locations that are designated for the unique purpose of transitional living (e.g., a separate wing in a building; a freestanding building) and must allow the residents free access to the exterior (e.g. no lock-down units).

Independent Living Program Minimum Standards

RBWO providers are responsible for assuring that their independent living programs meet the following requirements as well as any applicable *RCCL rules and regulations.* The Office of Provider Management is responsible for monitoring RBWO providers to assure that Standards are met.

Independent Living Programs (ILP) are different from TLP in that youth may live in an alternative living arrangement (i.e., community based housing) rather than a group home, or other residential type facility. All ILP youth must eventually transition into independent housing. This placement provides the opportunity for youth to experience decreased care and supervision as they become responsible for their own care. The goal of an independent living placement is to prepare youth to become socially and financially independent from the foster

care system. Independent living placements shall begin no earlier than a youth's 18th birthday.

Standard 21: ILP Admissions

Providers must only admit youth to ILPs for whom the admissions assessment indicates that the youth is appropriate for the program.

21.0 Admitted youth must be at least 18 years of age and have elected to participate in Extended Youth Support Services. Youth must be assessed by the provider to be invested in and able to benefit from ILP. Admissions criteria must include that youth must be employed at least part time (15-20 hrs. /week) or attending school full-time.

21.1 Providers must have defined admittance criteria, which includes a youth-completed application and interview.

21.2 Providers must maintain an up to date roster on GA+SCORE.

21.3 Providers must determine whether youth will be accepted or denied admission within three business days of a completed application.

21.4 Youth admitted into an ILP must have an orientation to the program. Youth should be provided with a handbook or other literature describing the program.

21.5 Youth admitted into an ILP must sign an acknowledgement of having participated in an orientation to the program and having received an explanation of their rights and responsibilities as a participant in the program.

21.6 ILP Youth must sign an acknowledgement that they may be discharged from the ILP if they willingly and knowingly participate in illegal or disruptive behavior or it is determined that they are unable or unwilling to benefit from the program. All youth discharged for violating ILP rules must be given a 60 day notice and assistance with transition. Providers must create a written transition plan.

21.7 All youth entering the ILP must have a staffing within the first 30 days of placement, which must include the youth DFCS Case Manager, ILS and other supports. The purpose of the staffing is to review expectations, the WTLP and ILP ISP and to discuss the youth's eligibility for services and funding.

Standard 22: ILP Supervision and Independence

Youth should receive levels of supervision that fit their needs and be provided with appropriate independence to practice skills needed for successful independent living.

22.0 ILP youth must have a documented assessment which supports a Supervision and Independence plan regarding levels of supervision and independence.

22.1 ILP youth must have twenty-four (24) hour telephone access to the provider. The provider must have a key to youth's housing so as to have twenty-four (24) hour access.

22.2 Providers must develop a schedule for providing supervision based on a specific youth's maturity, acquired skills, and abilities. The supervisory schedule will be developed in

collaboration with the youth and DFCS Case Manager. Supervision must be designed so that the provider may observe that the youth is practicing healthy life skills and decision-making.

22.3 Supervision of ILP youth includes at a minimum the following:

- safety, health, and overall well-being;
- ability to manage school and work responsibilities without daily supervision;
- ability to follow program and landlord rules;
- ability to use good judgment in daily activities; and
- overall progress toward established goals and desired outcomes.

22.4 The frequency of in-person supervision may vary due to many factors (e.g., readiness for independence; living arrangements chosen; presence or availability of other adults; other factors unforeseen until after placement). The following in person supervisory schedule, at a minimum, shall be utilized during the first four (4) weeks in Single Occupancy Housing:

- 1st Week: Daily face-to-face supervision.
- 2nd through 4th Weeks: Twice a week face-to-face supervision and daily phone calls.

After the fourth (4th) week, face-to-face supervision must occur no less than once a week based upon a documented assessment by the provider. The full supervision plan should include telephone contacts and / or other forms of check-ins or contacts. In a one month time period, at least 50% of the face-to-face visits should be unannounced.

22.5 The Supervision and Independence Plan must be signed by the youth, DFCS Case Manager and Life Coach.

22.6 The Supervision and Independence Plan should be re-assessed at least every three months or as often as circumstances or changes dictated by the DFCS Case Manager and Life Coach.

Standard 23: Independent Living Skill Building

ILPs must assist youth in making progress toward achieving the goals of the ILP ISP.

23.0 Providers must develop an ILP Individual Service Plan (ILP-ISP). The ILP-ISP must be based upon the youth's needs, desires, Casey Life Skills Assessment (CLSA) and future goals and objectives. All other standards for the ISP apply.

23.1 The ILP ISP must have defined goals and objectives with timeframes established. Case documentation should reflect progress and/or efforts toward meeting goals.

23.2 The ILP ISP incremental steps or goals must include the following:

- Development of Permanency Pacts or other agreements with caring adult connections;
- Living arrangements upon discharge from Extended Youth Supportive Services;

- Educational and/or vocational planning; and
- Any other goals or objectives which will assist the youth in being successful post discharge.

23.3 If the ILP is housed in a group home or other congregate care type facility, the ILP ISP must include a goal directed at the youth obtaining and maintaining single occupancy housing.

23.4 Providers must submit a monthly summary of each youth's progress to the assigned Independent Living Specialist (ILS) and the DFCS Case Manager by the 10th of the following month. The list of ILSs is located in Appendix G.

23.5 ILP youth must be engaged in learning and developing "soft" and "hard" independent living skills, daily living and self-care skills. Hard skills include the teaching of areas development including, but limited to banking, apartment hunting, job search, budgeting and educational planning. Soft skills include the teaching of areas including, but not limited to anger management, goal-oriented behaviors, parenting skills, problem solving skills and interpersonal communication. Daily living skills should include instruction in nutrition, menu planning, grocery shopping, meal preparation, dining decorum, kitchen cleanup, food storage, home management, and home safety. Opportunities for youth to apply these skills would include developing menus, shopping for ingredients, preparing meals, cleaning the kitchen and dishes at the conclusion of the meals, and appropriately storing leftover food. Self-care skills should include instruction about topics such as hygiene, health, alcohol, drugs, tobacco, parenting skills, and responsible sexuality. Opportunities for youth to apply these skills would include discussions as well as role playing and rehearsal of parenting and hygiene skills.

23.6 At a minimum providers should document at least two efforts weekly that record the youth's engagement in independent living skills development.

23.7 Providers must coordinate educational services, facilitate career plan development, provide tutors, and help youth attain educational goals.

23.8 Providers must assist youth in developing a career plan. The plan should include the youth's interests, strengths in school, visions for career and personal life, and opportunities for career and work experience.

23.9 Providers must connect youth with local industries and employment programs so that youth have the opportunity to explore career opportunities and develop a plan to achieve their career aspirations.

23.10 Providers must offer job search training in areas such as resume writing and interviewing.

Standard 24: Single Occupancy Housing

Providers must assist youth with securing and maintaining stable, affordable housing.

24.0 Providers must assist the youth in securing appropriate, single occupant housing by the 13th month of participation in the program.

24.1 Independent living placements may be offered through a variety of residential on-campus living arrangements where youth have the opportunity to practice independent living skills with decreasing degrees of care and supervision. Youth must be in single occupancy housing by the 13th month of participation in the program.

24.2 Providers may not use mobile homes as the housing unit for independent living placements.

24.3 Once youth are in Single Occupancy Housing, during the first and second year, the lease must be in the provider's name, unless approval is granted by OPM for the lease to be in youth's name. In the third year, the lease should be in the youth's name whenever possible. Utilities should be billed in the youth's name as soon as practicable.

Note: A youth that is a parent of a child in the custody of DFCS must be approved by the Senior Manager-Placement Services prior to being placed in a single occupancy setting with their child(ren).

Standard 25: Life Coaching

Youth are supported in achieving personal goals through a Life Coach.

25.0 Youth in ILP programs must have a life coach. Life coaches must meet the same educational and experiential requirements of a Human Services Professional (HSP). Life coaching is a practice that helps people identify and achieve personal goals. Life coaches help clients set and reach goals using a variety of tools and techniques. Life Coaches model life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making) and provide activities for youth to practice life skills and provide appropriate feedback to the youth.

Life Coaches are minimally responsible for the following activities:

- Assisting the youth in obtaining educational, vocational and employment opportunities;
- Providing transportation when necessary to achieve the goals of the ILP ISP;
- Assisting the youth in establishing and maintaining involvement in community/recreational activities;
- Assisting the youth in securing mental and medical health assistance when necessary; and
- Monitoring youth savings and expenditures to ensure proper budgeting of income.

Note: Life Coaches serve as the HSP for ILP programs.

25.1 ILP Life Coaches must participate in a basic certification provided by the state IL Program Manager. ILP Life Coaches must participate in a basic certification training provided by the state IL Program Manager. Training covers independent living policies, ACLSA and other requirements of the program.

25.2 ILP Life Coaches must attend at least one county/regional/ state IL training, meeting or workshop quarterly. This requirement may also be met by meeting individually with the regional ILS (or DFCS Case Manager) to staff the youth.

25.3 Life coaches must have a written plan for each youth and have at least weekly face-to-face sessions. The Life Coach plan may be a separate document or incorporated into the ILP ISP.

25.4 At a minimum Life Coaches should document at least two efforts weekly that record the youth's engagement in independent living skills development.

25.5 Provider will assign a Life Coach to each youth in the program. The ratio of Life Coaches to youth is no more than 1:15.

Standard 26: Financial Independence

Youth are supported in developing financial independence skills.

26.0 Youth in Single Occupancy Housing must be provided with a monthly food allowance. The food allowance amount must be based on documented assessment of the youth's needs. Provider must assist youth with creating a shopping plan/schedule for the purchase of food. All youth are eligible to apply for food stamps.

26.1 Providers must assist youth with maintaining their employment in order to remain in the ILP (if they are not attending school full-time). If youth is dismissed from employment or out of work for any reason, they will be given 60 days to find another job. The Life Coach must develop a plan to assist the youth with finding employment. Contacts during this time the plan must include at least two phone calls a week and two face-to-face visits weekly to support the youth's job search. If another job is not identified within the established time frame, a staffing must be held with ILS, DFCS Case Manager and other supports to determine next steps.

26.2 Providers must document youth's earnings (copies of pay stubs & bank statements).

26.3 Providers must support youth's development and maintenance of a savings account (Individual Development Accounts (IDA) are preferred.). Youth must save a percentage of their income as follows:

A. 1st year participants or youth 18-19 years of age are required to save 50% of their income.

B. 2nd year participants or youth 19-20 years of age are required to save 25% of their income.

26.4 Providers must develop a financial plan to help youth gradually take financial responsibility of their housing and other expenses. All contributions put into savings with the provider must be signed and acknowledge by the youth each month. The outlined plan below can be modified based on the youth's needs/ability.

A. 1st year participants or youth 18 – 19 years of age will have all housing related expenses (rent, utilities, food allowance) paid for whether or not youth has already obtained single occupancy housing.

B. By the 2nd year all youth must be in single, occupancy housing. Youth in the 2nd year of an ILP must contribute in the following manner:
   1. 1st–3rd month: 100% of housing expenses will be paid by the provider.
   2. 4th–6th months: 70% of rent and all other expenses will be paid by provider. Youth must pay 30% of rent to provider with appropriate late fees assessed as applicable.
   3. 7th–9th month: 50% of rent and 70% of utilities will be paid by provider. Youth must pay 50% of rent and 30% of the utilities to provider with appropriate late fees assessed as applicable.
   4. Starting the 10th month and ongoing: 25% of rent and 50% of utilities will be paid by ILP provider. Youth must pay 75% of rent and 50% of the utilities to provider with appropriate late fees assessed as applicable.

Note: Providers have the flexibility of creating individualized financial contributions plan for youth who are not working but attending school full-time. The plan must be documented in the case record.

26.5 Providers must hold the youth's contributions toward their expenses in a bank savings account and reimburse the full amount saved to the youth upon case closure. Providers must maintain documentation of the contributions and disbursements. Providers must have a separate account for youth contributions, which are not a part of the agency's account. All banking fees must be incurred by the provider and any interest drawn from the account must be given to youth upon account closure.

26.6 Start-up cost for youth's Single Occupancy housing will be provided in accordance with DFCS Child Welfare Policy 13.11. All start-up cost must be pre-approved by the Regional ILS. Start-up costs are limited to the following:
   a. First month's rent, security deposits, renter's insurance, startup utility and telephone connection fees (NO cable or satellite television installation fees are allowable.
   b. Basic furniture items (bed, chest of drawers, table and chairs)
   c. Cooking and cleaning supplies

Standard 27: Outcome Measures

Providers track outcomes of youth and overall program performance.

27.0 ILP providers must track outcomes for youth. Minimally, programs should compile on an annual basis the following:
- Demographics on youth served;
- Life skills programming and service delivery;
- Educational outcomes;
- Vocational outcomes;
- Youth involvement with DJJ or DOC; and
- Housing, adult connection, employment, educational status of youth discharged and continuing in the program.
-

27.1 Providers must distribute reports for the contract year by July 30th annually (reports cover July 1- June 30). Reports should be provided to the OPM, regional ILS and the state IL Program Manager.

Standard 28: General Administrative

28.0 Providers must contact the DFCS Case Manager immediately when significant issues or incidents occur and the issue/incident is severe enough to risk a youth's loss of the independent living placement (e.g., apartment) or the issue/incident creates a danger to the youth.

28.1 Providers must notify the Office of Provider Management whenever significant events occur relating to the safety or well-being of IL youth or relating to the IL program.

28.2 Providers must adhere to applicable general RBWO.

28.3 Providers must adhere to the CCI staffing standards with the exception of having Child Care Workers. The HSP may serve as the ILP Life Coach.

Maternity and Parenting Support Programs

Maternity and Parenting Support (also referred to as Second Chance Home) Programs address the needs of adolescents in foster care during and after pregnancy, and those who are parenting. A provider will supply full-time residential care, support and supervision to pregnant and parenting youth through 21 years of age and their child(ren) as applicable. Program services include parenting skills, job training, transitioning to independent living, family budgeting, health and nutrition, and other skills to promote residents' long-term independence and the well-being of youth and their child(ren).

Maternity Programs (MP) are specialized, RBWO programs established for the purpose of caring for young adolescents during pregnancy. These services can be provided in a Child Caring Institute (CCI) or Child Placement Agency (CPA). Providers of Maternity Programs who offer services for youth who are 21 years of age and younger, in a residential setting, must be licensed through the RCCL as a Maternity Home. A Maternity Home may only provide such services to pregnant youth, before, during or within two (2) weeks after childbirth through a maximum period of eight (8) weeks following delivery unless also providing Parenting Support Program (Second Chance Home) services.

Parenting Support Programs (PSP) (also called Second Chance Homes) are specialized, adult supervised RBWO programs established for young mothers and their children who cannot live at home because of abuse, neglect or other extenuating circumstances. These services can also be provided in a residential setting, supportive foster home, transitional or independent living environment. Providers of Parenting Support Programs who offer services for youth who are 21 years of age and younger, in a residential setting, must be licensed through the RCCL as a Maternity Home. A Parenting Support Program may serve no more than a total of 16 residents. Residents refer to parenting youth and their children.

Child Placing Agencies (CPA) may offer Maternity and Parenting Support Program services through their caregivers. Additional caregiver and staff training and oversight is expected to serve this unique population.

Hybrid Program Models
RBWO providers who have applied for and been approved to provide either Maternity or Parenting Support Program services exclusively may seek approval to provide both programs under the same program/site/name. Due to the unique circumstances of the population being served, and dependent on the requested age range and housing framework, the approval process could include a Transitional or Independent Living Program component. Additions of programs may impact the overall capacity limits of the total service continuum.

Note: Currently there are no programs with the Hybrid Model. If you are interested, please contact the Provider Relations Manager within OPM.

General RBWO Standards and MP/PSP Standards

OPM has developed Minimum Standards for MP and PSP placements to help provide consistency in the development and delivery of services. All agencies desiring to provide Maternity and Parenting Support Programs must meet these special Standards as well as all other general RBWO standards as applicable.

Child Placing Agency foster homes that have placement of pregnant and/or parenting youth are also addressed in these standards.

Maternity Program Minimum Standards

RBWO providers are responsible for assuring that their Maternity Program (MP) meets the following requirements as well as all other general applicable RBWO standards and RCCL Rules and Regulations.

Standard 29: MP Admissions

Providers admit youth to a MP for whom the admissions assessment indicates that the youth is appropriate for the program.

29.0 Admitted youth must be at least 12 years of age with any permanency plan and have been assessed by a physician as being pregnant.

29.1 Providers must have defined admittance criteria, which include a youth-completed application and interview.

29.2 Providers must document all referrals including the reasons for admittance or denial into the MP. Providers must determine whether youth will be accepted or denied admission within three (3) business days of a completed application.

29.3 Youth admitted into a MP must have an orientation to the program. Youth should be

provided with a handbook or other literature describing the program. The handbook must include, at a minimum, the homes rules and regulations, grievance policy, expectations of the parenting teen and the program, phase system, and services offered.

29.4 Youth admitted into a MP must sign an acknowledgement of having participated in an orientation to the program and an understanding of their rights and responsibilities as a participant in the program.

Standard 30: MP Supervision and Oversight

Pregnant youth receive levels of supervision that are age appropriate and a fit for their needs.

30.0 Watchful oversight is the responsibility of the mother for her child (ren). The provider must take reasonable action to provide for the health, safety, and well-being of a resident and the resident's child (ren) who may or may not be in the resident's legal custody, however, under the watchful oversight of the provider. The provider is responsible for ensuring the protection from physical, emotional, social, moral, financial harm and personal exploitation of the resident and her child (ren) while in care. The provider is responsible for providing the amount of supervision and care indicated by a resident's age, developmental level, physical, emotional, and social needs and her ability to meet the fundamental needs of her child (ren).

30.1 Providers should ascertain the youth's current program designation level in order to determine the minimum staffing ratios required. See CCI staffing ratio standards.

30.2 Youth in MPs must be supervised under the same standards as general RBWO programs. Youth may be assessed for "Graduated Independence" which outlines decreasing levels of supervision based upon the program objectives, the youth's maturity and other factors.

30.3 Providers will assist the Department with providing transportation when necessary to achieve youths' goals and providing opportunities for community connections.

30.4 Providers must ensure that all meals follow the USDA guidelines for babies, children, adolescents and adults. The guidelines must be posted where they are easily accessible for reference.

30.6 The provider will utilize non-violent intervention techniques to diffuse crisis situations and provide conflict resolution training to parenting teens, particularly during resident meetings.

30.7 The following safety features must be in place and functioning:

- Smoke detectors,
- Posted evacuation plan,
- No exposed wires,
- Electrical outlet covers, and
- Child-safe environment: safety gates, safety locks, outlet guards, dangerous materials/ cleaning supplies out of reach of children.

Standard 31: MP Staff and Caregiver Requirements

MP programs have dedicated staff, advocates and mentors with targeted skills in working with pregnant and parenting youth in foster care. Staff is qualified to carry out the agency's program of services.

In addition to the CCI staffing standards, the following standards apply to MP programs:

31.0 The provider of a Maternity Program shall provide and adhere to a written plan for securing qualified professional consultation and/or referral services for health care, nutrition, and health education services as outlined by Residential Child Care Rules for Maternity Homes.

31.1 All staff and volunteers must be supervised to ensure that assigned duties are performed adequately and to protect the health, safety and well-being of the residents in care. There shall be sufficient relief staff to ensure adequate coverage of all functions.

31.2 A provider offering a Maternity Program must designate a Director who is authorized and qualified to manage the program. When the Director is temporarily absent from the facility and resident(s) are present, the Director must designate a staff person, with equivalent qualifications, as responsible for supervising the operation of the program.

31.3 The provider shall have a designated Life Coach/Human Services Professional (HSP) to provide oversight of services to residents. There must be at least one (1) Life Coach/HSP employed for every 16 residents in care. Note: Life Coaches serve as the HSP for MP programs.

31.4 When volunteers are utilized, a qualified staff member must be designated to plan, supervise, and coordinate the volunteer's duties. An appropriate training/orientation program must be conducted by a qualified staff member prior to a volunteer engaging in any activities with youth. (See Standard 13:27)

Standard 32: MP Staff Training

MP staff are qualified, well-trained and supported in carrying out the goals of the MP program.

32.0 Prior to working with residents, all staff must receive an orientation outlining the program's purpose, a description of all policies and procedures, a review of individual assigned duties and responsibilities.

32.1 At a minimum, the orientation session should also review the following policies and procedures: grievance policies and procedures, child abuse and exploitation policies and procedures, reporting requirements for suspected cases of child abuse and sexual exploitation, diseases and serious injuries, procedures for handling medical emergencies, and managing use of medications by residents in care, infection control policies and procedures, appropriate behavior management and emergency safety interventions, and privacy and confidentiality of residents.

32.2 All employees who provide direct care to residents should receive a minimum of twenty-four (24) hours of annual training that is targeted toward enhancing the outcomes and success of the constituent population served.

32.3 Direct Care Staff and Life Coach/HSP must be trained by the provider in the following content areas within sixty (60) days of hire:

- appropriate relationships with youth
- staff boundaries
- knowledge of adolescents and adolescent development
- development of engagement skills
- sexuality and pregnancy of adolescent females
- accessing community resources
- infant safe sleeping guidelines
- competency with culturally diverse populations
- conflict resolution and de-escalation

Note: Life Coaches serve as the HSP for MP programs.

32.4 Staff who serve in the caregiving or Life Coach role must maintain up to date certification in CPR training for infants, adolescents, and adults.

Standard 33: MP Parenting Preparation & Life Skills Plan

As a part of the Individual Service Plan, providers ensure that youth have a Parenting Preparation and Life Skills Plan which focuses on the unique needs of pregnant youth.

33.0 Providers must ensure that youth are provided with Parenting Preparation & Life Skills Plan as a part of their ISP. The Parenting Preparation & Life Skills Plan is a plan for ensuring services and supports for the youth are designed to ensure healthy adolescent development, support overall family functioning, positive peer relationships and assist in maximizing overall healthy development and eventual independence of a young person and their child(ren). Such skills include the following:

- Child-focused Nutrition and Wellness
- Father Engagement
- Information on community resources including Women, Infants & Children Supplemental Nutrition Program (WIC)
- Life Skills Preparation
- Coaching & Mentoring
- Parenting Development & Support
- Understanding & Managing "Purple Crying"
  - Purple Crying is the phrase used to describe the point in a baby's life when they cry more than any other time. This period of increased crying is often described as colic, but there have been many misunderstandings about what "colic" really is.
- Transportation Services
- Car Seat Safety
- Access to Day Care Services
- Transition Planning
- Community Connections
- Discouragement of Co-sleeping (also known as bed sharing; see Appendix K: Infant Safe Sleeping Guidelines and Protocol)

The Parenting Preparation & Life Skills Plan component must assess the needs of the resident in the areas of health care, oversight, education, family relationships, personal, social and vocational development (where appropriate), and any behavioral areas that require close

monitoring not already covered in the ISP. Assessments, service plans, and service delivery must reflect and be tailored to the needs, strengths and resources of the youth.

33.1 The Parenting Preparation & Life Skills Plan must be updated at a minimum of every trimester and immediately following any significant change in circumstances including childbirth. Pertinent progress notes and data shall be incorporated in the plan to measure attainment of stated goals and objectives.

33.2 The Parenting Preparation & Life Skills Plan should outline supportive services required during a youth's pregnancy that assist her in meeting the needs arising from the pregnancy and in developing a plan that assures both the infant's and the young parent's maximum development.

33.3 The Parenting Preparation & Life Skills Plan should outline securing the necessary supportive services that optimize any medical, nutritional, emotional, behavioral, educational and mental health needs.

33.4 The Parenting Preparation & Life Skills Plan for the youth should include counseling that covers all pregnancy options, prenatal and postpartum health care services.

33.5 The Parenting Preparation & Life Skills Plan must include postpartum transition/discharge plan to a Parenting Support Program (Second Chance Home), foster family, or an independent living parenting program.

33.6 The Parenting Preparation & Life Skills Plan must include father engagement as appropriate.

33.7 The Parenting Preparation & Life Skills Plan must include a comprehensive post-partum plan.

33.8 The provider will administer AAPI-II, Adult & Adolescent Parenting I-II assessment tool, for teens within 30 days of admission. AAPI-II results must be incorporated into teens' Individual Service Plan (ISP). DFCS will provide access and training on the AAPI-II.

33.9 The provider will use Ages and Stages Questionnaire (ASQ & ASQ SE) assessment tool to screen all children three months and older. Within 30 days of entry into the home complete assessments as appropriate based on child's age. The provider will complete assessment and arrange additional screening for children showing development delays. The results from these assessments should be utilized in development of the child's Individual Service Plan (ISP). DFCS will provide access and training on the ASQ & ASQ SE.

33.10 The provider must conduct weekly resident meetings to foster community living and discuss life or parenting skills. The provider will document and file all weekly meetings either in each resident's file or in a weekly meeting folder. Documentation should include case notes, meeting minutes, parenting curriculum forms, etc. It should also note the explanation for any lapse in scheduled meetings.

33.11 Youth must have an individual weekly meeting to address the youth's progress and Individualized Service Plan goals and discussions regarding positive parenting.

Standard 34: MP Medical Services

Youth receive quality medical care in relation to their pregnancy as well as other medical needs, supported in achieving personal goals through a Life Coach/HSP and other coordinated community services.

34.0 Providers must ensure that youth have access to a broad range of health care services tailored to their special circumstances. A community system of health should include:

- Maternity counseling
- Primary, prenatal, and postnatal health care
- Comprehensive reproductive health care services
- Sexual education, family planning and referral services
- Nutritional information and counseling
- Screening for venereal diseases
- Provisioning of pediatric care
- Mental/Behavioral health care and relationship counseling services.

34.1 In the event of a medical or mental health emergency, medical attention should be sought immediately. The provider should encourage the youth to comply with medical advice. Regardless of age, the county of custody should be notified immediately of any occurrence of treatment and/or refusal of treatment.

34.2 At admission, the provider shall secure a signed consent for medical treatment authorization form. The form shall be signed by the youth's guardian. The consent form should be filed in the youth's case file at the program site.

34.3 The provider shall have a written plan naming a general hospital, clinic, or physician, and dentist, to provide the youth with routine or emergency services on a 24-hour-a-day basis.

34.4 The provider shall ensure that all residents receive timely, qualified medical or psychological care in cases of medical emergencies (life-threatening, limb-threatening, or function-threatening conditions). Policies shall be in place for the emergency medical care of residents with a local hospital or other health care facility that provides emergency services or with a local physician.

34.5 The provider and youth (teen-parent) are responsible for keeping all immunizations up to date. The provider and youth will arrange for early and periodic screening (EPSDT) for babies through public health departments or other approved providers.

34.6 The provider will offer access to health education for pregnant and parenting teens and their children. Health education enhances parenting skills and child development by assisting pregnant and parenting teens with developing the knowledge to access and improve their overall health and well-being. All pregnant and parenting teens should have a thorough knowledge of their own personal health and the health of their children.

34.7 The provider will offer access to sex education which emphasizes abstinence but includes contraceptive use to prevent repeat teen pregnancy, HIV, and sexually

transmitted infections (STIs). Allowances shall be made to accommodate spiritual, religious, and/or cultural values.

Standard 35: MP Life Coaching

Youth are supported in achieving personal goals through a Life Coach.

35.0 Youth in MP programs must have a life coach. Life Coaches must meet the same educational and experiential requirements of a Human Services Professional (HSP). Life Coaching is a practice that helps people identify and achieve personal goals. Life Coaches help clients set and reach goals using a variety of tools and techniques. Life Coaches model life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making) and provide activities for youth to practice life skills and provide appropriate feedback to the youth.

Life Coaches are minimally be responsible for the following activities:

- Post-partum planning
- Father Engagement
- Maternal and paternal family engagement
- Health pregnancy
- Future family planning
- Assisting the youth in obtaining educational, vocational and employment opportunities;
- Assisting the youth in establishing and maintaining involvement in community/recreational activities;
- Assisting the youth in securing mental and medical health assistance when necessary; and
- Other activities and supports as defined by the ISP or Parenting Preparation & Life Skills Plan.

Note: Life Coaches serve as the HSP for MP programs.

35.1 MP Life Coaches must participate in a basic certification provided by the state IL Program Manager. Training covers independent living policies, ACLSA and other requirements of the program.

35.2 MP Life Coaches must attend at least one county/regional/ state IL training, meeting or workshop quarterly. This requirement may also be met by meeting individually with the regional ILS (or DFCS Case Manager) to staff the youth in the ILP.

35.3 Life coaches must have a written plan for each youth and have at least weekly face-to-face sessions. The Life Coach plan may be a separate document or incorporated into the MP ISP/ Parenting Preparation & Life Skills Plan.

35.4 At a minimum, Life Coaches should document at least two efforts weekly that record the youth's engagement in Parenting Preparation & Life Skills Plan goals.

35.5 Provider will assign a Life Coach to each youth in the program. The ratio of Life Coaches to youth is no more than 1:16.

35.6 Provider and youth must develop and implement a parenting contract within 48 hours from the date of admission. Parenting contract must establish clear roles and responsibilities for caring for the youth's child.

35.7 Parenting teens should be given a choice regarding child care provided around the area. The provider will offer information regarding Georgia Child Care and Parent Services (GACAPS) and ensure that the youth has a clear understanding of the program.

Standard 36: Maternity Program Outcome Measures

Providers track outcomes of youth and overall program performance.

36.0 Providers must track outcomes of youth and overall program performance against mission, goals, and day-to-day operations to determine effectiveness. Minimally, programs should compile, on an annual basis, results on the areas identified below:

- Demographics on youth served
- Parenting Preparation & Life Skills Plan Outcomes
- Outreach to Fathers/Child Support
- Adult Connections
- Healthy Delivery

Parenting Support Program Minimum Standards

Standard 37: PSP Admissions

Providers must only admit youth to a PSP for whom the admissions assessment indicates that the youth and their child(ren) are appropriate for the program.

37.0 Admitted youth must be at least 12 years of age with any permanency plan and have at least one biological child with whom they provide care for. The provider should ascertain from DFCS whether the youth or DFCS has legal custody.

37.1 Providers must have defined admittance criteria, which include a youth-completed application and interview.

37.2 Providers must document all referrals including the reasons for admittance or denial into the PSP. Providers must determine whether youth will be accepted or denied admission within three (3) business days of a completed application.

37.3 Youth admitted into a PSP must have an orientation to the program. Youth should be provided with a handbook or other literature describing the program. The handbook must include, at a minimum, the homes rules and regulations, grievance policy, expectations of the parenting teen and, phase system, and services offered.

37.4 Youth admitted into a PSP must sign an acknowledgement of having participated in an orientation to the program and an understanding of their rights and responsibilities as a participant in the program.

Standard 38: PSP Supervision and Oversight

Parenting youth should receive levels of supervision that are age appropriate and a fit for their needs, as well as those of their child(ren).

38.0 Supervision is the continued responsibility of the provider. The provider must take reasonable action to provide for the health, safety, and well-being of a resident, including protection from physical, emotional, social, moral, and personal exploitation while in care. The provider is responsible for providing the amount of supervision indicated by a resident's age, developmental level, physical, emotional, and social needs.

38.1 Providers should ascertain the youth's current program designation level in order to determine the minimum staffing ratios required. See CCI staffing ratio standards.

38.2 Youth in PSPs must be supervised under the same standards as general RBWO programs. Youth may be assessed for "Graduated Independence" which outlines decreasing levels of supervision based upon the program objectives, the youth's maturity and other factors.

38.3 The youth's supervision plan must include how the youth will be supported in supervising their child. Youth should do the best of their ability be in partnership with their adult caretaker in the care of the baby. This should be negotiated, discussed and be a part of the assessment process.

38.4 Providers will assist the Department with providing transportation when necessary to achieve the youth's goals and providing opportunities for community connections.

38.5 Provider must ensure that all meals follow the USDA guidelines for babies, children, adolescents and adults. The guidelines must be posted where they are easily accessible for reference.

38.6 The provider will utilize appropriate intervention techniques to diffuse crisis situations and provide conflict resolution training to parenting teens, particularly during resident meetings.

38.7 The provider will comply with all RCCL, O.C.G.A and RBWO requirements for Childcare Licensing Institutions in the State of Georgia.

Standard 39: PSP Staff and Caregiver Requirements

PSP programs have dedicated staff, advocates and mentors with targeted skills in working with pregnant and parenting youth in foster care. Staff is qualified to carry out the agency's program of services.

In addition to the CCI staffing standards, the following standards apply to MP programs:

39.0 The provider of a PSP shall provide and adhere to a written plan for securing qualified professional consultation and/or referral services for health care, nutrition, and health education services as outlined by the Residential Child Care Rules for Maternity Homes.

39.1 All staff and volunteers must be supervised to ensure that assigned duties are performed adequately and to protect the health, safety and well-being of the residents in care. There

shall be sufficient relief staff to ensure adequate coverage of all functions.

39.2 A provider offering a PSP must designate a Director who is authorized and qualified to manage the program. When the Director is temporarily absent from the facility and resident(s) are present, the Director must designate a staff person as responsible for supervising the operation of the program with equivalent qualifications.

39.3 The provider shall have a designated Life Coach/Human Services Professional (HSP) to provide oversight of services to residents. There must be at least one (1) Life Coach/HSP employed for every 16 residents in care. The Director, if qualified by education, may perform the duties of a Life Coach/HSP.

39.4 When volunteers are utilized, a qualified staff member must be designated to plan, supervise, and coordinate the volunteer's duties. An appropriate training/orientation program must be conducted by a qualified staff member prior to a volunteer engaging in any activities with youth. See Standard 13.27

Standard 40: PSP Staff Training

PSP staff are qualified, well-trained and supported in carrying out the goals of the PSP program.

40.0 Prior to working with residents, all staff must receive an orientation outlining the program's purpose, a description of all policies and procedures, a review of individual assigned duties and responsibilities.

40.1 At a minimum, the orientation session should also review the following policies and procedures: grievance policies and procedures, child abuse and exploitation policies and procedures, reporting requirements for suspected cases of child abuse and sexual exploitation, diseases and serious injuries, procedures for handling medical emergencies, and managing use of medications by residents in care, infection control policies and procedures, appropriate behavior management and emergency safety interventions, and privacy and confidentiality of residents.

40.2 All employees who provide direct care to residents should receive a minimum of twenty-four (24) hours of annual training that is targeted toward enhancing the outcomes and success of the constituent population served.

40.3 Direct Care Staff and HSP/Life Coaches must be trained by the provider in the following content areas within sixty (60) days of hire:

- appropriate relationships with youth
- staff boundaries
- Post-partum depression and related topics
- Parenting young children
- Infant and child development
- knowledge of adolescents and adolescent development
- development of engagement skills
- Infant safe sleeping guidelines
- sexuality and pregnancy of adolescent females
- accessing community resources
- competency with culturally diverse populations
- conflict resolution and de-escalation

Note: Life Coaches serve as the HSP for PSP programs.

40.4 All staff who serve in a care giving or Life Coach role must maintain up to date certification in CPR training for infants, adolescents, and adults.

Standard 41: PSP Parenting Preparation & Life Skills Plan

As a part of the Individual Service Plan, providers ensure that youth have a Parenting Preparation and Life Skills Plan which focuses on the unique needs of parenting youth.

41.0 Providers must ensure that youth are provided with Parenting Preparation & Life Skills Plan as a part of their ISP. The Parenting Preparation & Life Skills Plan is a plan for ensuring services and supports for the youth are designed to ensure healthy adolescent development, support overall family functioning, positive peer relationships and assist in maximizing overall healthy development and eventual independence of a young person and their child(ren). Such skills include the following:

- Child-focused Nutrition and Wellness
- Father Engagement
- Information on community resources including Women, Infants & Children Supplemental Nutrition Program (WIC)
- Life Skills Preparation
- Coaching & Mentoring
- Parenting Development & Support
- Understanding & Managing "Purple Crying"
    - Purple Crying is the phrase used to describe the point in a baby's life when they cry more than any other time. This period of increased crying is often described as colic, but there have been many misunderstandings about what "colic" really is.
- Transportation Services
- Car Seat Safety
- Access to Day Care Services
- Transition Planning
- Community Connections
- Discouragement of Co-sleeping (also known as *bed sharing*; see Appendix K: Infant Safe Sleeping Guidelines and Protocol)

The Parenting Preparation & Life Skills Plan component must assess the needs of the resident in the areas of health care, oversight, education, family relationships, personal, social and vocational development (where appropriate), and any behavioral areas that require close monitoring not already covered in the ISP. Assessments, service plans, and service delivery must reflect and be tailored to the needs, strengths and resources of the youth.

41.1 The Parenting Preparation & Life Skills Plan must be updated at a minimum of every quarter and immediately following any significant change in circumstances including childbirth. Pertinent progress notes and data shall be incorporated in the plan to measure attainment of stated goals and objectives.

41.2 The Parenting Preparation & Life Skills Plan should outline supportive services required to support the parenting youth.

41.3 The Parenting Preparation & Life Skills Plan should outline securing the necessary

supportive services that optimize any medical, nutritional, emotional, behavioral, educational and mental health needs for the youth and child(ren).

41.4 The Parenting Preparation & Life Skills Plan for the youth should include counseling that covers all postpartum options and health care services.

41.5 The Parenting Preparation & Life Skills Plan must include father engagement as appropriate.

41.6 The provider will administer AAPI-II, Adult & Adolescent Parenting I-II assessment tool, for parenting teens within 30 days of admission. AAPI-II results must be incorporated findings into teens Individual Service Plan (ISP). DFCS will provide access and training for the AAPI-II.

41.7 The providers will use Ages and Stages Questionnaire (ASQ & ASQ SE) assessment tool for youth to screen all children three months and older. Within 30 days of entry into the home complete assessments as appropriate based on child's age. The provider will complete assessments and arrange additional screening for children showing development delays. The results from these assessments should be utilized in development of the child's Individual Service Plan (ISP). DFCS will provide access and training to the ASQ & ASQ SE.

41.8 Providers must conduct weekly resident meetings to foster community living and discuss life or parenting skills. The provider will document and file all weekly meetings either in each resident's file or in a weekly meeting folder. Documentation should include case notes, meeting minutes, parenting curriculum forms, etc. It should also note the explanation for any lapse in meetings.

41.9 Youth must have an individual weekly meeting to address the youth's progress and Individualized Service Plan goals and discussions regarding positive parenting. At weekly meetings, the provider is responsible for reviewing progress and providing assistance or counseling on ISP goals.

Standard 42: PSP Medical Services

Youth receive quality medical care in relation to their post-partum status as well as other medical needs.

42.0 Providers must ensure that youth have access to a broad range of health care services tailored to their special circumstances. A community system of health should include:

- Pregnancy testing and maternity counseling
- Primary, prenatal, and postnatal health care
- Comprehensive reproductive health care services
- Sexual education, family planning and referral services
- Nutritional information and counseling
- Screening for venereal diseases
- Provisioning of pediatric care
- Mental/Behavioral health care and relationship counseling services.

42.1 In the event of a medical or mental health emergency, medical attention should be

sought immediately. The provider should encourage the youth to comply with medical advice. Regardless of age, the county of custody should be notified immediately of any occurrence of treatment and/or refusal of treatment.

42.2 At admission, the provider shall secure a signed consent for medical treatment authorization form. The form shall be signed by the youth's guardian. The consent form should be filed in the youth's case file at the program site.

42.3 The provider shall have a written plan naming a general hospital, clinic, or physician, and dentist, to provide the youth with routine or emergency services on a 24-hour-a-day basis.

42.4 The provider shall ensure that all residents receive timely, qualified medical or psychological care in cases of medical emergencies (life-threatening, limb-threatening, or function-threatening conditions). Policies shall be in place for the emergency medical care of residents with a local hospital or other health care facility that provides emergency services or with a local physician.

42.5 The provider must ensure that each youth is informed of the need for a postpartum examination, unless the examination is provided before her discharge from the home or facility. Provisions shall be made for all post-pregnancy residents to receive a postpartum examination within 8 weeks after confinement if she remains in residence. Provisions shall be made to ensure the resident's return to a public health clinic or physician, physician's assistant, advanced practice registered nurse, or midwife for necessary checkups and medical instruction on postpartum care that may be indicated.

42.6 The provider must ensure that each resident is informed of the need for postnatal examination for her infant, unless the examination is provided before the infant's discharge from the home or facility. Provisions shall be made for a complete physical examination by a physician, physician's assistant, advanced practice registered nurse, midwife, or public health clinic within the first 24 hours or sooner if indicated. A repeat examination shall be completed within the first 10 days. The repeat physical examination shall be completed by a physician, physician's assistant, advanced practice registered nurse, registered nurse, midwife, or public health clinic.

42.7 The provider and youth (teen–parent) are responsible for keeping all immunizations up to date. The provider and youth will arrange for early and periodic screening (EPSDT) for babies through public health departments or other approved providers.

42.8 The provider will offer access to health education for pregnant and parenting teens and their children. Health education enhances parenting skills and child development by assisting pregnant and parenting teens develop the knowledge to access and improve their overall health and wellbeing. All pregnant and parenting teens should have a thorough knowledge of their own personal health and the health of their children.

42.9 The provider will provide access to sex education which emphasizes abstinence but also contraceptive use to prevent repeat pregnancy, HIV, and sexually transmitted infections (STIs). Allowances shall be made to accommodate spiritual, religious, and/or cultural values.

Standard 43: PSP Life Coaching

Youth are supported in achieving personal goals through a Life Coach.

43.0 Youth in PSP programs must have a life coach. Life Coaches must meet the same educational and experiential requirements of a Human Services Professional (HSP). Life Coaching is a practice that helps people identify and achieve personal goals. Life Coaches help clients set and reach goals using a variety of tools and techniques. Life Coaches model life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making) and provide activities for youth to practice life skills and provide appropriate feedback to the youth.

Life Coaches are minimally be responsible for the following activities:

- Post-partum planning
- Father engagement
- Maternal and paternal family engagement
- Health pregnancy
- Future family planning
- Assisting the youth in obtaining educational, vocational and employment opportunities;
- Ensuring safe sleeping of infants;
- Assisting the youth in establishing and maintaining involvement in community/recreational activities;
- Teach youth to plan and prepare balanced meals for themselves and their children.
- Assisting the youth in securing mental and medical health assistance when necessary; and
- Other activities and supports as defined by the ISP or Parenting Preparation & Life Skills Plan.

Note: Life Coaches serve as the HSP for PSP programs.

43.1 PSP Life Coaches must participate in a basic certification provided by the state IL Program Manager. Training covers independent living policies, ACLSA and other requirements of the program.

43.2 PSP Life Coaches must attend at least one county/regional/state IL training, meeting or workshop quarterly. This requirement may also be met by meeting individually with the regional ILS (or DFCS Case Manager) to staff the youth.

43.3 Life coaches must have a written plan for each youth and have at least weekly face-to-face sessions. The Life Coach plan may be a separate document or incorporated into the PSP ISP/ Parenting Preparation & Life Skills Plan. Every youth's file should have case notes that accurately portray the services, treatment, parenting and life skills received in the home.

43.4 At a minimum, Life Coaches should document at least two efforts weekly that record the youth's engagement in Parenting Preparation & Life Skills Plan goals.

43.5 Provider will assign a Life Coach to each youth in the program. The ratio of Life Coaches to youth is no more than 1:16.

43.6 Based on assessments, individual sessions, and contacts with educational and other relevant providers, Life Coaches should link the residents with services in the community to enable them to meet Individual Service Plan (ISP) goals. All linkages to services should be documented in the resident's file.

43.7 Provider and youth must develop and implement a parenting contract within 48 hours from the date of admission. Parenting contract must establish clear roles and responsibilities related to caring for the youth's child.

43.8 Parenting youth should be given a choice regarding child care located around the area. The provider will provide information regarding Georgia Child Care and Parent Services (GACAPS) and ensure that the youth have a clear understanding of the program.

Standard 44: Parenting Support Program Outcome Measures

Providers track outcomes of youth and overall program performance.

44.0 Providers must track outcomes of youth and overall program performance against mission, goals, and day-to-day operations to determine effectiveness. Minimally, programs should compile, on an annual basis, results on the areas identified below:

- Demographics on youth served
- Parenting Preparation & Life Skills Plan Outcomes
- Outreach to Fathers/Child support
- Adult Connections
- Healthy Delivery

CPA: Pregnant and/or Parenting Youth Placement

Standard 45: Child Placing Agency Foster Homes

Foster parents are trained and supported in their care of pregnant and/or parenting youth.

45.0 Family foster care homes should be selected with great care and with a focus upon the pregnant or parenting adolescent's plan regarding pregnancy, parenting and permanency. The caregiver(s) should demonstrate an ability to model a healthy family lifestyle and be willing to participate as a member of the service delivery team, which includes facilitating access to prenatal care, counseling appointments, family planning and post-partum care (at a minimum).

45.1 The CPA must provide specialized training to foster parents who are interested in placement of pregnant or parenting youth. Suggested content areas include:

- Healthy pregnancy—nutrition, emotional and medical support.
- Adolescent development
- Teaching youth parenting skills
- Post-partum depression and related topics

- Father engagement
- Safe sleeping guidelines for infants
- Conflict resolution
- Sexuality and pregnancy of adolescent females
- Accessing community resources
- Competency with culturally diverse populations.

45.2 The CPA must ensure that case support services address the needs of the pregnant or parenting youth. Providers must develop a Parenting Preparation and Life Skills Plan which focuses on the unique needs of pregnant or parenting youth. (See Standard 32).

45.3 At a minimum, the CPA must document at least two efforts monthly that record the youth's engagement in Parenting Preparation & Life Skills Plan goals.

45.4 The CPA should provide additional support and supervision to caregivers with placement of pregnant youth especially during latter stages of pregnancy. The provider, youth and caregiver should have an emergency plan for addressing crisis issues as well as a birthing plan.

45.5 Parenting or pregnant youth must be supervised under the same standards as general RBWO programs. Youth may be assessed for "Graduated Independence" which outlines decreasing levels of supervision based upon the program objectives, the youth's maturity and other factors.

45.6 For pregnant youth, the CPA should staff the case with DFCS following birth of the infant to ascertain and document the custody status of the youth and initiate post-partum planning.

45.7 For parenting youth, the youth's supervision plan must include how the youth will be supported in supervising their child. Youth should do the best of their ability be in partnership with their adult caretaker in the care of the baby. This should be negotiated, discussed and be a part of the assessment process.

Medically Fragile Placements

Medically Fragile placements are designed to care for children who require complex health procedures, special therapy or specialized equipment/supplies to enhance/sustain their lives. Medically Fragile placements provide a temporary, home-like environment for medically fragile children, technology dependent children and children with special health care needs who are deemed clinically stable by a physician. These children require assistance with activities of daily living to facilitate transitions from a hospital or other facility. Note: Placements may occur in CCIs or CPA foster homes.

Medically Fragile placements care for children with **serious to severe** medical conditions with a Specialty Medically-Fragile Watchful Oversight (SMFWO) program designation. Non-compliance with any prescriptive regimen of care will endanger the life or health of the child. These children require time-intensive treatments/procedures to be performed on a frequent and reoccurring basis and by a trained caregiver. Due to the severity of issues and

attentiveness required in caring for a child with a specialty program designation, other children are not permitted to be placed in the foster home without the written approval from a DHS/DFCS Designee.

These are some of the characteristics which would qualify a child for Medically Fragile Programs. This list is not intended to be all inclusive:

- Has a medical condition which requires management with medications
- Has a tracheotomy
- Is oxygen dependent
- Has persistent reflux causing frequent vomiting
- Requires oral feedings that takes at least 30 minutes or requires tube feedings
- Requires nebulizer treatments on a daily basis
- Requires medications by feeding tube, injection or suppository
- Requires ostomy care
- Has any type of body cast
- Is blind or has severe visual impairment
- Is deaf or has severe hearing impairment
- Has complete or partial paralysis (child weighing 20 pounds or more)
- Has self-harming behaviors such as cutting, ingesting poisonous substances, etc.
- Depends upon medication to keep a life threatening condition under control – including, but not limited to asthma, chronic lung disease, diabetes, heart disease, HIV infection or chronic kidney disease being maintained by dialysis
- Has limited mobility
- Bedwetting and urination in places other than the toilet
- Is several years behind in the development of age-appropriate knowledge of self-care or life skills
- May require medical interventions while in school

RBWO Providers

RBWO providers are responsible for assuring that their Medically Fragile placements meet the following requirements as well as any applicable general RBWO standards and *RCCL rules and regulations.* The goal of these special standards is to ensure that children with severe or serious medical conditions receive the services needed to reach their full potential.

Medically Fragile (MF) placements may occur in Child Placing Agency foster homes or Child Caring Institutions.

Standard 46: MF Admissions

Providers admit children into a MF placement for whom the admissions assessment indicates that the child's needs can be met.

46.0 The provider's staff and/or caregiver will attend a pre-placement meeting to receive appropriate training for managing the care of the child. If a pre-placement meeting is not possible, training is provided as soon as possible so as to ensure that the caregiver is always equipped to provide adequate care to the child.

46.1 Providers will have a defined admittance criteria and caregivers who are skilled and

prepared to take on the care of admitted children.

Standard 47: Safety and Supervision

Medically fragile children are appropriately supervised and their safety and well-being needs met.

47.0 Provider will complete an initial home visit within two business days of a MF placement.

47.1 Providers will meet with caregivers weekly for at least the first thirty (30) days of placement to ensure that the caregiver receives all needed supports and to ensure the child's safety and well-being.

47.2 Providers will have a process and policy for assessing the needs of a medically fragile child and identify supports to meet the needs.

47.3 Providers will ensure that during each home visit that the home has the child's required equipment and that there are no unaddressed issues as to maintenance and use.

47.4 Caregivers who are caring for a medically fragile child that requires life sustaining equipment (i.e. ventilator, tracheotomy, etc.) requiring electricity will have an emergency plan to address power outages such as having access to a generator.

47.5 Providers will have a grief response plan to enact in the event of a significant lost (death of a child) or crisis. Caregivers will be assessed for temporary placement holds.

Standard 48: Education

Children's educational needs are met.

48.0 Providers will work in conjunction with the DFCS Case Manager and school officials to develop an Individualized Education Plan (IEP) once the youth is declared eligible.

The Individuals with Disabilities Education Act (IDEA) provides children the right to a "free appropriate public education" in the "least restrictive environment" appropriate to their needs. "Least restrictive environment" is defined as when: "to the maximum extent appropriate, children with disabilities are educated with children who are not disabled and special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."

To be considered IDEA-eligible, a student must be diagnosed with one or more of the disabilities listed in the federal statute and must require special education instruction and/or related services as a result of that disability. This list is not intended to be all inclusive:

- Autism
- Deaf-Blindness
- Deafness
- Emotional Disturbance
- Hearing Impairment

• Mental Retardation
• Multiple Disabilities
• Orthopedic Impairment
• Other Health Impairment
• Specific Learning Disability
• Speech or Language Impairment
• Traumatic Brain Injury
• Visual Impairment Including Blindness

48.1 Foster parents who care for school-aged medically fragile children will be trained/certified as educational surrogates by the local school system. Note: If the school system does not require training or certification, that should be noted in the caregiver's record.

Standard 49: Training

Caregivers and staff have the skills to meet children's needs.

49.0 Providers will ensure that all staff and Foster Parents have documented training by the appropriate personnel on new equipment and assistive devices.

49.1 Foster Parents and staff working with medically fragile children should receive training on specific issues related to MF placements including but are not limited to:

- Universal precautions, preventing exposure and transmission to communicable diseases
- Appropriate Hand Washing
- Basic first aid
- IEPs
- Cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED)
- Proper techniques for lifting and moving medically fragile children
- Emergency safety interventions specific to the needs of the child placed
- Sudden Infant Death Syndrome (SIDS)
- Developmental Delays
- Crib and car seat safety
- Childhood Disorders/Issues, i.e. Asthma, Seizures, Diabetes, Sickle Cell Anemia, Injections, Feeding tubes etc.
- DFCS Discipline Standards

49.2 Caregivers will have 1st Aid and CPR training prior to any MF placements and maintain their certifications.

Program Designations

There are twelve types of R.B.W.O. care for all children whether they are served in residential care with Child Caring Institutions or Child Placing Agencies. The types of care and the children served are described as follows:

CPA	**CCI**
Traditional Care	BASE Care-BWO
BASE Care-BWO	Additional Watchful Oversight- AWO
Maximum Watchful Oversight- MWO	Maximum Watchful Oversight- MWO
Specialty Base Watchful Oversight- SBWO	
Specialty Maximum Watchful Oversight- SMWO	
Specialty Medically Fragile Watchful Oversight- SMFWO	
	Maternity Home
	Parenting Support Program (Second Chance Homes)
	Teen Development
	Independent Living Program
	Specialty Camp

Traditional (CPA) or BASE-BWO (CCI) Care:

A child served in Traditional Care or Base Care will have **mild to occasionally moderate** emotional and/or behavioral management problems that interferes with the child's ability to function in the family, school and/or community without guidance and supervision. The behaviors identified for Traditional Care children placed in a CPA are identified as **mild**. The behaviors identified for BWO children placed in a CCI are identified as **mild to moderate**.

The following are the child characteristics and operational impact on children in Traditional Care or BWO according to the Difficulty of Care Factors:

- May be learning disabled requiring supports such as Student Support Team and tutoring services
- May have poor concentration at school and home

- May have occasional disruptive or disobedient behaviors resulting in In-School Suspension
- May have behaviors that are managed by medications
- Disregard for others property – minor property damage
- Non-compliance with curfew and/or limits set by adults
- Difficulty in adjusting to new environments
- May lack age-appropriate knowledge of self care or life skills
- May have behavioral outbursts inclusive of profane and/or provocative language
- May exhibit "annoying" behaviors to include excessive teasing, horseplay, and language taunting
- May exhibit shyness, fear, anxiety, and nervousness in group/community settings
- May exhibit irritability and/or hostility toward peers
- May exhibit impulsive behaviors that create mild risk – inappropriate verbal outbursts, wanders away from the group
- May be easily frustrated; temper tantrums
- May have difficulty making friends

A child served in Base or Traditional programs will have **minimal to mild** medical needs and can have a mild developmental delay that does not coexist with any medical condition.

BASE-BWO (CPA) or Additional Watchful Oversight- AWO (CCI):

A child served in the Base with Watchful Oversight or Additional Watchful Oversight will have **moderate** to **occasionally serious** emotional and/or behavioral management problems. In the CCI program, the behaviors exhibited by a child interfere with his or her ability to function in the family, school, and/or community outside of a supervised and structured setting. The behaviors identified for BWO children placed in a CPA are identified as **moderate**. The behaviors identified for AWO children placed in a CCI are identified as more frequent and **serious**.

The following are the child characteristics and operational impact on children in BWO or AWO according to the Difficulty of Care Factors:

- Performance is not in accordance with ability
- Learning disability requiring IEP services
- Disruptive and/or disobedient to school rules, could result in suspension
- Frequent attendance and truancy problems
- Oppositional and defiance in the home and school setting
- Use of vulgar and/or provocative language
- Annoying behaviors – picks on peers, repetitive actions or language, and taunting
- Demanding and threatening
- Lacks age-appropriate knowledge of self care or life skills
- Occasionally assaultive without causing major injuries
- Disregard for the property of others; intentional property damage
- Occasionally runs away and/or refuses to abide by curfews
- Self harming behaviors, eraser burns, repeatedly picking at sores, biting fingernails until they bleed, and head banging

- Does not engage in typical peer interactions or recreational activities because of tendency to be picked on or bullied by others
- Often fearful, anxious, or sad
- Difficulty identifying and/or expressing emotions, emotionally blunted
- Easily annoyed, frequent and intense irritability
- Possible delinquent behaviors and Department of Juvenile Justice (DJJ) involvement
- Child has engaged in substance use, but use does not interfere with daily activities
- Impulsive actions that create risk (inappropriate outbursts, plays with fire and/or wanders away)

A child served in Base or Additional programs will have **minimal to mild** medical needs and can have a mild developmental delay that does not coexist with any medical condition.

Maximum Watchful Oversight- MWO (CPA & CCI)

A child served in the Maximum Watchful Oversight Program will have **serious** to **severe** emotional and/or behavioral management problems. In the CCI program, the behaviors exhibited by a child interfere with his or her ability to function in the family, school, and/or community outside of a supervised and structured setting. The behaviors identified for MWO children placed in a CPA are identified as **serious**. The behaviors identified for MWO children placed in a CCI are identified as more frequent and **severe**.

The following are the child characteristics and operational impact on children in MWO according to the Difficulty of Care Factors:

- School attendance is poor, grades are poor, concentration is poor when in school; requires oversight from teachers, family and/or caregiver
- Multiple school suspensions and disciplinary actions
- History of explosive outburst in schools
- Failure and/or inability to learn
- IEP with placement in specialized classes for behavioral or learning disabilities
- May require adaptive learning tools
- Refuses help with school work or tutoring
- Several years behind in the development of age-appropriate knowledge of self-care or life skills
- Verbal aggression (Use of vulgar and/or provocative language)
- Oppositional and defiant in the home and school setting
- Demanding and/or threatening
- Smearing and/or throwing of feces
- Bedwetting – graduating to intentional urination in places other than the toilet
- Hiding soiled clothing/bed linens
- Limited ability to perform routine tasks of daily living such as chores and laundry
- Deliberately or impulsively destroying property while in a structured setting breaking windows, pictures, mirrors, damage to furniture, appliances, clothing, electronics, and vehicles
- Preoccupation with fire

- History of cruelty to animals
- Sexual acting out with or without aggression that may be opportunistic, situational or planned
- Highly sexualized behaviors, promiscuity, seeking inappropriate relationships with older persons, poor physical boundaries, often with history of sexual abuse and poor self esteem
- Recurrent and/or severe self-injurious behaviors and/or suicidal behaviors that are under control
- Homicidal and/or suicidal threats
- Physical aggression and/or assault (hitting, kicking, spitting, attacking may with or without a weapon, throwing objects) toward adults and/or other children with and/or without injuries
- Withdrawn behavior, attention seeking behaviors that are excessive, constant complaining about physical ailments, nightmares, difficulty going to bed and/or refusal to stay in bedroom
- Fears, worries, and anxieties that affect daily activities; frequent and severe headaches, stomach aches and/or refusal to get out of bed
- Serious problems with personal hygiene
- Impulsive behaviors that present barrier to maintaining physical safety
- Chaotic and poor control of anger toward self and others with frequency and intensity that needs attention
- Inflexibly adheres to routines or rituals and has difficulty with transitions, which may lead to serious harm to self or others or extremely aggressive behaviors
- Difficulties with social interactions and/or communication (failure to speak, make eye contact, shake hands, hiding, standing too close, revealing personal information inappropriately to strangers, etc.)
- Odd, bizarre or explosive actions, which pose a significant risk of harm to self or others
- Hearing voices and/or seeing things that are not there
- Frequent and/or uncontrollable behavioral outbursts and mood swings
- Seems unable to form any meaningful friendships, is socially isolated and unable to enjoy activities with peers
- Delinquent behaviors – stealing, burglary, assault and/or battery
- Recurring involvement with Department of Juvenile Justice (DJJ)
- Fire setting with intent to destroy property or injure others and/or preoccupation with fire
- Intentionally and/or maliciously cruel to animals
- Runs away with involvement in situations where high risk activities are likely to occur
- Drinking and/or drug use which may have resulted in disciplinary actions and/or affect daily function
- Involvement with gangs and/or gang-like activities
- Poorly prepared for and lacking skills necessary for independent living

A child served in this group may have **moderate** medical needs requiring specialized services. Child generally sees 2 or more physicians at least on a quarterly basis for medical needs, requires routine lab work to assess the effectiveness of medications. Medical needs in this group could include two-three of the following:

- Global developmental delay as the primary diagnosis
- Mild Cerebral Palsy
- Fetal Alcohol Syndrome
- Recovering from head injury
- Cancer in remission
- Diabetes – managed with insulin and follow up with Endocrinologist
- Ordered to have physical, occupational, and/or speech therapy 1-2 times weekly
- Infant with sucking difficulty and/or on a monitor
- Reflux that is controlled with 1-2 medications
- HIV exposure with medications
- Severe visual impairment to include a diagnosis of legal blindness
- Seizure disorder requiring medication
- Episodes of enuresis or encopresis or a history of one or both
- Autism (high functioning)
- Deafness or severe hearing impairment
- May have self-harming behaviors such as cutting or ingesting harmful substances.
- Children with mental retardation may not be able to follow simple one and/or two-step directions and frequently have difficulty with three step directives.

Children with the identified medical needs can either be served in a MWO CPA or CCI program. However, there are children in the MWO category through selected CCI or Children's Transition Care Center (CTCC) programs whose medical needs are **serious to severe**. These children are deemed clinically stable by a physician but are dependent on life-sustaining medications, treatment/procedures and equipment. Children ages 0-12 are not permitted to be place in group setting without approval of a DFCS Director. However, under special circumstances with an exclusive contract a provider may be approved to place medically fragile children ages 0 –18 in a group setting.

Some of the characteristics in which a child would qualify for a medically fragile approved MWO CCI/ CTCC provider are as followed but not limited to:

- A medical condition which requires management with medications
- Child has a tracheotomy
- Child is oxygen and feeding tube dependent
- Complete or partial paralysis (child weighing 20 pounds or more)
- Depends upon medication to keep a life threatening condition under control including, but not limited to asthma, chronic lung disease, diabetes, heart disease, HIV infection, or chronic kidney disease being maintained by dialysis
- Limited mobility

Specialty Base Watchful Oversight- SBWO (CPA)

A child served in this specialty program will have **serious** emotional and/or behavioral management problems that interfere with the child's ability to function normally with in the family, school, and community. Due to the severity and required attentiveness in caring for a child approved with a specialty program designation, other children are not permitted to be placed in the home without the written approval from a DHS/DFCS Designee. The child

characteristics on children in SBWO are the same as MWO; however the severity and frequency are increased.

Specialty Maximum Watchful Oversight- SMWO (CPA)

A child served in the Specialty with Maximum Oversight Program will have **severe** emotional and/or behavioral management problems that interfere with the child's ability to function in the family, school, and/or community. Due to the severity and required attentiveness in caring for a child approved with a specialty program designation, other children are not permitted to be placed in the home without the written approval from a DHS/DFCS Designee. The child characteristics on children in SMWO are the same as SBWO; however the severity and frequency are increased.

Specialty Medically Fragile Watchful Oversight- SMFWO (CPA)

A child served in the Specialty Medically Fragile program has **serious to severe** medical conditions. Non-compliance with any prescriptive regimen of care will endanger the life or health of the child. These children require time-intensive treatments/procedures to be performed daily by a trained caregiver. Due to the severity and required attentiveness in caring for a child approval with a specialty program designation, other children are not permitted to be placed in the home without the written approved from a DHS/DFCS Designee.

These are some of the characteristics in which a child would qualify for SMFWO but not limited to:

- A medical condition which requires management with medications
- Child has a tracheotomy
- Child is oxygen dependent
- Persistent reflux causing frequent vomiting
- Requires oral feedings that take at least 30 minutes or requires tub feedings
- Requires nebulizer treatments on a daily basis
- Requires medications by feeding tube, injection or suppository
- Requires ostomy care
- Has any type body cast
- Blindness
- Deafness or severe hearing impairment
- Complete or partial paralysis (child weighing 20 pounds or more)
- Has self-harming behaviors such as cutting, ingesting poisonous substances, etc.
- Depends upon medication to keep a life threatening condition under control – including, but not limited to asthma, chronic lung disease, diabetes, heart disease, HIV infection, or chronic kidney disease being maintained by dialysis
- Limited mobility
- Bedwetting and urination in places other than the toilet
- Several years behind in the development of age-appropriate knowledge of self-care or life skills
- Medical interventions may be required while in school

Maternity Homes & Parent Support Programs (Second Chance Homes):

A child served in the Maternity Homes and Parenting Support Programs (Second Chance Homes) is preparing for motherhood or receiving hands on parenting training. The premise of these program designations are to support an adolescent who is either pregnant or have a child/children with the skills and knowledge to care for their child(ren). Their emotional and/or behavioral management problems are **mild**.

The following are the child characteristics and operational impact on children according to the Difficulty of Care Factors:

- May be learning disabled requiring supports such as Student Support Team and tutoring services
- May have poor concentration at school and home
- May have occasional disruptive or disobedient behaviors resulting in In-School Suspension
- May have behaviors that are managed by medications
- Non-compliance with curfew and/or limits set by adults
- Difficulty in adjusting to new environments
- May have behavioral outbursts inclusive of profane and/or provocative language
- May exhibit "annoying" behaviors to include excessive teasing, horseplay, and language taunting
- May exhibit impulsive behaviors that create mild risk – inappropriate verbal outbursts and wanders away from the group
- May be easily frustrated; temper tantrums
- May have difficulty making friends

A child under Maternity and Parenting Support (Second Chance Homes) have minimal to mild medical needs and can have a mild developmental delay that does not coexist with any medical condition.

The Parenting Support (Second Chance Homes) not only serves the mother but also the mother's child(ren). The following are the program designations codes for Second Chance Homes in GA SCORE:

- 2CMB1- Second Chance Mother with one (1) child
- 2CB1- Second Chance one (1) child
- 2CMB2- Second Chance Mother with two (2) children
- 2CB2- Second Chance two (2) children

Camp:

A child served in the Camp will have **moderate to severe** emotional and/or behavioral management problems that interfere with the child's ability to function in the family, school, and/or community outside of a supervised and structured setting. The child characteristics on children approved for the Camp are the same as AWO and MWO.

A child under, Camp has minimal to mild medical needs and can have a mild developmental delay that does not coexist with any medical condition.

Teen Development:

A child served in the Transitional Living/ Independent Living Program greatly benefits from life skill training to be more self-sufficient and preparing them for adulthood. The premise of this program designation assignment is not behavioral based as the BWO, AWO and MWO are. Behaviors may be considered in the placement of a child, based on each approved provider admission criteria. This program designation can serve adolescent as young as 16 years.

DESCRIPTION OF PROGRAM TYPES

Child Caring Institution (CCI)

- Any child-welfare facility that provides full-time room, board and watchful oversight to six or more children through 18 years of age (the exception would be if an emancipated child signed himself/herself back into the care of the Division of Family and Children Services, then 21 years of age or under). The children in CCI's are residing outside of their own home environment. These facilities provide care, supervision, and oversight in a residential setting, including neighborhood - based group homes, campus - based arrangements, and self-contained facilities. The facility Director, Human Service Professional, and Direct Care Staff work as a team to provide a stabilizing and nurturing environment that promotes, safety, well-being and permanency, and it allows the children to be stepped down to the less restrictive environment.

Parenting Support Program (Second Chance Home) PSP

- The PSP is a Child Caring Institution by definition; however, this type of CCI serves between four and eight adolescents and their child or children. PSPs help adolescent mothers to become self-sufficient by providing them with a safe living environment, support for long-term economic independence, child development, parenting and life skills.

Maternity Home (MH)

- **Maternity Programs (MP)** are specialized, RBWO programs established for the purpose of caring for young adolescents during pregnancy. These services can be provided in a Child Caring Institute (CCI) or Child Placement Agency (CPA). Providers of Maternity Programs who offer services for youth who are 21 years of age and younger, in a residential setting, must be licensed through the RCCL as a Maternity Home. A Maternity Home may only provide such services to pregnant youth, before, during or within two (2) weeks after childbirth through a maximum period of eight (8) weeks following delivery unless also providing Parenting Support Program (Second Chance Home) services.

  This facility offers a group living experience to pregnant adolescents or young mothers. Professional staff assists the young women before and after giving birth to address individual problems and help them plan for living arrangements, employment and/or school, and caring for their new infants. The Director, Human Service Professional, Resident Staff, and Medical Staff

work together as a team to promote the safety, permanency and well-being of the children that they serve.

Children's Transition Care Center (CTCC)

- CTCC is a Child Caring Institution by definition, but this type of CCI provides a temporary, home-like environment for medically fragile children, technology dependent children, and children with special health care needs, who are deemed clinically stable by a physician but are dependent on life-sustaining medications, treatments, and equipment. These children require assistance with activities of daily living to facilitate transitions from a hospital or other facility. The Director, Human Service Professional, Registered Nurse Staff, and the Direct Care Staff work together as a team to promote the safety, permanency and well-being of the children that they serve.

Outdoor Child Caring Program -"Specialty" Camp (OCCP)

- OCCP is a Child Caring Institution by definition, however this type of CCI provides room, board and watchful oversight in a wilderness or camp environment that is designed to improve the emotional and behavioral adjustment of the children in care. The use of physical, environmental, athletic and other challenging activities are designed to improve the functioning of the children and to teach them pro-social and adaptive skills.

Independent Living Program:

- Specialized RBWO program for youth who are at least 18 years of age through 21 years. ILP is different from transitional living in that youth may live in an alternative living arrangement (i.e., community based housing) rather than a group home, or other residential type facility. Independent living placements shall begin no earlier than a youth's 18th birthday. Youth in ILP will experience "graduated independence" regarding program expectations, skill development and levels or types of supervision provided. The goal of an independent living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Transitional Living Program:

- Specialized RBWO program for youth at least age 16 years. Youth may be older than 18 years old if they have agreed to Extended Youth Support Services. Transitional living is designed for youth who are ready to enter a phase of care that will eventually transition them to independent living. Transitional living affords youth an opportunity to practice basic independent living skills in a variety of settings with decreasing degrees of supervision. This specialized RBWO placement provides youth the opportunity to experience increased personal responsibility so youth can become responsible for their own care when they exit foster care. The goal of an transitional living placement is to prepare youth to become socially, emotionally and personally independent of social services while connecting them to life-long permanency connections and laying the foundation for the pursuit of educational and career opportunities.

Child Placing Agency (CPA)

Any child welfare agency which places children in foster homes for temporary individualized care, supervision and oversight, and are provided in a resource family setting. These agencies that arrange for children to receive care in foster homes must make arrangements to assess the placement regarding the appropriateness of the room, board and watchful oversight that the prospective foster family will provide. The agency's Director, Case Support Staff, and the foster parents work as a team to provide a stabilizing and nurturing environment that promotes, safety, well-being and permanency.

CPA Staffing Standards

These requirements build on CPA rules and regulations and reflect the increasing needs and service requirements.

The R.B.W.O. CPA provider shall have the administrative and professional staff necessary to oversee and provide R.B.W.O. services to children and families. No person having an unsatisfactory determination based on his/her criminal record shall be employed by the agency.

Director

- Director must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, or childhood education, business or public administration or related field and two (2) years of paid work experience in the field of social services or human service delivery and at least one of which has been in an administrative or supervisory capacity; or a bachelor's degree from an accredited college or university in the same areas of study and four (4) years of paid work experience in a human services delivery capacity or a related field and at least two of which have been in an administrative or supervisory capacity.

- The Director may serve as the Case Support Worker (C.S.W.) if the Director meets the educational qualifications of the Case Support Worker no longer than 90 days to cover a vacancy. OPM must be notified in writing when the position is vacated and the plan to replace the C.S.W.

Note: Some directors were grandfathered in and may not meet the current qualifications for case support supervisor or case support worker. *Those who were not grandfathered in may be required to attend RBWO Foundations Classroom Components to gain basic knowledge of RBWO programming.*

Case Support Supervisor

The role of the Case Support Supervisor is to plan, provide, arrange, coordinate and document services to children and families. Case Support Supervisor must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, psychology, childhood education, special education, guidance counseling, or related field with one (1) year experience in the field of childcare or a bachelor's degree from

an accredited college or university in the same areas of study with two (2) years of paid work experience in a human services delivery capacity or a related field.

Role of Case Support Supervisor (CSS)

- Responsible for ensuring that the case support worker is meeting the needs of the child and foster parent

Case Support Worker

The Case Support Workers (CSW) maximum allowed caseload is determined by children's program designations.

Maximum caseload numbers follow:

• Traditional Care Only---20 children per CSW
• Base Care Only--- 18 children per CSW
• MWO Only --- 15 children per CSW
• Specialty Designations Only-- (SBWO, SMWO and SMFWO) – 12 children per CSW
• For combined caseloads of Traditional, Base and Maximum Watchful Oversight, the following criteria must be followed:
    - Base and Traditional Only: The CSW caseload number must not exceed 18 children.
    - Base, Traditional and MWO in any combination: The CSW caseload number must not exceed 15 children.
    - Specialty plus Base, Traditional and MWO in any combination: The CSW caseload number must not exceed 12 children.

Providers should give consideration to the level of experience of the Case Support Worker in determining actual caseload size and type.

Case Support Worker must have a bachelor's degree from an accredited college or university in the area of behavioral or social sciences, social work, psychology, childhood education, special education, guidance counseling, or related field with two (2) years direct service experience with children and families or a master's degree from an accredited college or university in the same areas of study with one (1) year of paid work experience with children and families.

Role of Case Support Worker (CSW)

- Responsible for ensuring that the educational, medical, emotional and social needs of the child are met.
- Responsible for ensuring that the foster parent's needs are met to enable them to care for the child.

DFCS will not place children with CPA foster parents who are also employees of the CPA agency.
*Any existing foster homes where foster parents are also CPA staff must be reported to the Director of the Office of Provider Management within 14 days from July 1, 2014.

CCI Staffing Standards

The following Requirements are for Child Caring Institutions, "Specialty" Camps, and Maternity Homes providing Room, Board, and Watchful Oversight (R.B.W.O.) services to children. The Staffing Requirements for R.B.W.O. described below build on the RCCL rules and regulations, and reflect the increasing needs and service requirements of the children.

ADMINISTRATION AND ORGANIZATON

Each provider of R.B.W.O. shall employ or contract with an adequate number of qualified staff to provide the necessary services. Staff shall not be assigned more than one position except in rare situations based on the work assignment and responsibilities at the discretion of the agency's director.

- A Director shall not serve in the capacity of director for more than one agency that is under contract with the Department of Human Services as an R.B.W.O. provider. In addition, the Director may serve as the Human Services Professional (H.S.P.), when it is vacated, if the Director meets the educational qualifications of the H. S. P. The Director may act in the capacity of the H.S.P. for no longer than 90 days, and must notify the Department in writing when the position is vacated and of its plan to replace the H.S.P.

No person having an unsatisfactory determination as to his or her criminal record shall be employed by the facility.

The director may not rely on out of state staff to meet any of the staffing needs.

Director

When providing services for the following R.B.W.O. programs and designations, Base Watchful Oversight (BWO), Additional Watchful Oversight (AWO), 2nd Chance, Maternity, Teen Development, Camp and Maximum Watchful Oversight (MWO), the provider must designate an individual responsible for its administrative services. Based on the qualifications outlined below, this individual assumes final responsibility for the provision and oversight of all essential tasks and services described in these standards.

- A Director must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, childhood education, business or public administration or related field and two (2) years of paid work experience in the field of social services or human service delivery and at least one of which has been in an administrative or supervisory capacity; or a bachelor's degree from an accredited college or university in the same areas of study and four (4) years of paid work experience in a human services delivery capacity or a related field and at least two of which have been in an administrative or supervisory capacity.

- Ideally, the Director should not serve in any other capacity unless it is in an emergency situation (loss of an HSP or child care worker). If this occurs, the director may act in the capacity of the HSP or child care worker, for no longer than 90 days

and must notify the Department of the situation and its plan to replace the staff. The director must meet the qualifications of an HSP in order to temporarily serve in this capacity.

Note: Some directors were grandfathered in and may not meet the current qualifications for serving as an HSP. *Those who were not grandfathered in may be required to attend RBWO Foundations Classroom Components to gain basic knowledge of RBWO programming.*

Human Services Professional

When providing services for the following programs and designations: Basic Watchful Oversight (BWO), Additional Watchful Oversight (AWO) and Maximum Watchful Oversight (MWO), Specialty Camps and Maternity Homes the provider must designate staff to assume the responsibilities of a Human Services Professional (HSP) to plan, provide, arrange, coordinate and document services to children and their families.

- An HSP is responsible for providing and/or coordinating services for no more than 16 children.
  The HSP must have a master's degree from an accredited college or university in the area of behavioral or social sciences, social work, or psychology, childhood education and (1) year of paid work experience in the field of social services or human service delivery or a bachelor's degree from an accredited college or university in the same areas of study with (2) year of paid work experience in social service, child care or a related field.

Role of Human Services Professional (HSP)

Responsible for ensuring that the educational, medical, emotional and social needs of the child are met. Responsible for providing and/ or coordinating ancillary and social services for the child.

Child Care Workers

The provider shall have designated Child Care Workers responsible for the daily care and supervision of children in the living unit. The Child Care Worker must be at least 21 years of age and possess at least a high school diploma or GED and two (2) years of direct service experience with children and families or an Associate's degree or higher in a behavioral or social science field. New Child Care Workers must log at least 40 hours of work with the provider before working unsupervised with children.

Child-Staff Ratios

- When providing services for children with a program designation of Base Watchful Oversight (BWO), Child Care Workers shall be available to provide a staff to child ratio of 1:10 (staff to child ratio is subject to change when the safety is in question). Programs that offer Base Watchful Oversight services only, are not required to have awake staff, unless the agency has residents who require constant supervision, e.g. children with histories of sexual offending or chronic runaway behavior.

- If only one Child Care worker is required to be on duty, day or night, there must be a designated, proximate back-up person on-call at all times in case of an emergency. The back-up person must be listed on the daily schedule. When a Child Care Worker is required to be on duty, the Child Care Worker shall monitor sleeping children every 15 minutes and document in writing.
- When providing services for children with a program designation of Additional Watchful Oversight (AWO), Child Care Workers shall be available to provide a staff to child ratio of 1:8 (staff to child ratio is subject to change when the safety is in question) during the day and night. The Child Care Worker shall monitor sleeping children every 15 minutes and document in writing.
- When providing services for children with a program designation of Maximum Watchful Oversight (MWO), Child Care Workers shall be available to provide a staff to child ratio of 1:5 (staff to child ratio is subject to change when the safety is in question) during the day and night. The Child Care Worker shall monitor sleeping children every 15 minutes and document in writing.
- When providing services for children with mixed program designations (AWO and MWO) and the number of MWO children is higher than 25% of the population in the facility, the MWO staff ratio standards apply.

Note: Providers may request in writing a review of their child-staff ratio needs. The request to OPM should include a detailed explanation with supporting facts as to why an exception to the expected staffing standards should be granted. OPM will review the request and make an appropriate determination in writing. Until the written determination is made, providers must maintain expected staffing standards.

House Parent Model

- This model may be utilized for programs that accept Base Watchful Oversight designations only. The programs must have a process in place to ensure that children are asleep before the house parent goes to sleep and can be reasonably assured that children will be safe and secure overnight. Agencies must utilize awake staff if serving children who require constant supervision, e.g. children with histories of sexual offending or chronic runaway behavior. CCI Programs serving Additional Watchful Oversight (AWO) and Maximum Watchful Oversight designations shall not use the House Parent Model.

- Relief staff must have the same qualifications and training as regular child care staff.

Note: Independent Living Programs are required to have a Director, Life Coach, and Community Support Liaison.

Role of Life Coach (LC)

Responsible for ensuring that the educational, medical, emotional and social needs of the child are met through day to day operations. Responsible for documenting/maintain youth's file. Responsible for providing and/ or coordinating ancillary and social services for the child.

Role of Community Support Liaison (CSL)

Responsible for developing partnerships within the community (i.e. internships, jobs, scholarships, and identifying mentorship opportunities etc.) Responsible for coordinating educational services for youth (i.e. tutoring, attending school meetings/functions and assisting with completing application for schooling).

CSL must have a bachelor's degree from an accredited college or university in the area of behavioral or social sciences, social work, psychology, childhood education, special education, guidance counseling, or related field with two (2) years direct service experience with children and families or a master's degree from and accredited college or university in the same areas of study with one (1) year of paid work experiences with children and families.

Note: The HSP nor Director can serve in the role of CSL.

Appendix

Definitions

Individual Service Plan Checklist

Internet Resources

Waivers and Program Designation Request Information

Grievances and Appeals

OPM Staff Contact List and Placement Resource Operations Specialist List

Independent Living Coordinators and CLSA Codes

Regional Directors

Forms

Infant Safe Sleeping Guidelines and Protocol (pending release)

Appendix A-DEFINITIONS

Academic Support- an educational activity, service, or resource that assists the child with meeting learning standards, accelerates their learning process, and/or encourages and promotes the child's overall academic success. Some examples include, but are not limited to;

- Tutoring
- Attendance at school meetings (IEP, PTA, conference, etc)
- Digital and online learning applications
- Community/volunteer based learning programs
- Summer bridge programs

Bullying - Deliberately hurtful behavior, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are physical (e.g. hitting, kicking, theft), verbal (e.g. racist or homophobic remarks, threats, name calling) and emotional (e.g. isolating an individual from the activities and social acceptance of their peer group). The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self-harm). All settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies.

Casey Life Skills Assessment (CLSA) - A free assessment that the Georgia's Independent Living Program has adopted as a standard part of case planning. Youth will have their Independent Living Strengths and Needs assessed through the appropriate Ansell-Casey Life Skills Assessment (ACLSA).

Chemical Restraints - Drugs that that are administered to manage a youth's behavior in a way that reduces the safety risk to the youth or others; that have the temporary effect of restricting the youth's freedom of movement; and that are not being used as part of a standard regimen, as specified in the youth's treatment plan, to treat current symptoms of a medical or psychiatric condition.

Child Abuse - (O.C.G.A.19-7-5):

- Physical injury or death inflicted upon a child by a parent or caretaker by other than accidental means; provided however, physical forms of discipline may be used as long as there is no physical injury to the child;
- Neglect or exploitation of a child by a parent or caretaker;
- Sexual abuse of a child; or
- Sexual exploitation of a child.

Child/Youth - A person less than 18 years of age or considered to be a minor under State law.

Corporal Punishment - This is any physical punishment of a child to inflict pain as a deterrent to wrong doing. It may produce transitory pain and potential bruising. If pain and

bruising are not excessive or unduly severe and result only in short-term discomfort, this is not considered maltreatment.

Criminal Records Check - Statement regarding results of criminal records check by way of GCIC and NCIC fingerprint screenings for all adult household members eighteen (18) years and older residing temporarily or permanently in the home and having access to the children. If an adult residing in the home has a criminal record history and the home is being recommended for approval, discussion of the offense and justification for approval are required (Refer to Child Welfare Policy Manual Chapter 14.2). Live Scan results of GBI and NCIC reports must be kept in a locked file.

Emergency Safety Intervention (E.S.I.) - Those behavior management techniques that are authorized by an approved individualized emergency safety intervention plan; emergency safety interventions are only utilized by properly trained staff in an urgent situation to prevent a consumer from doing immediate harm to self or others.

Every Child Every Month (ECEM) - Purposeful contacts with the child monthly.

Every Parent Every Month (EPEM) – Purposeful contacts with child's parents or other permanency person monthly.

Family Team Meeting – Is a task oriented, facilitated, structured meeting which exist to craft, implement or change the individualized child and family plan; or to make critical case decisions regarding child safety, permanency and well-being.

Foster Care - A Federal-State program that provides financial support to a person, family, or institution that is raising a child or children that are not their own.

GaDOE – Georgia Department of Education www.doe.k12.ga.us

Individualized Service Plan – Provider's service plan for the child.

Individual Skills Plan – Provider's service plan for youth age 14 years and up focusing on independent living skills.

LEA – Language Assistance Program

Maltreatment - This refers to one or more forms of neglect, abuse or exploitation. It may be used as a general term or in reference to a specific category such as neglect, physical abuse, emotional neglect, medical neglect, emotional abuse, sexual abuse, exploitation or exposure to family violence.

Mandated Reporter - This is a person required to report known or suspected child abuse, neglect or exploitation under penalty of law for failure to report. Mandated reporters include physicians, osteopathic physicians, interns, residents and other hospital personnel, dentists, psychologists, podiatrists, nursing personnel, social work personnel (including all DFCS professional staff), school teachers and administrators, school guidance counselors, child care personnel, day care personnel, law enforcement personnel, child counseling and child service organization personnel.

Medical Neglect - This is a form of neglect involving the absence or omission of essential medical care or services, causing harm or seriously threatening harm to the physical or

emotional health of a child younger than eighteen years. It includes the withholding of medically indicated treatment for disabled infants with life-threatening conditions.

Multi-Disciplinary Team (MDT) Meeting - Multiple disciplines meets to review all relevant aspects of the child's case information. It is the team's responsibility to make the best and most appropriate recommendations for services and placement (if appropriate) that meets the needs of the child and family. The team will select reasonable, achievable goals/objectives that are positively stated, measurable, clear, concise, and address the specific behaviors or conditions that must be corrected for the child to be safely returned to the parent and incorporated into the initial case plan.

Neglect - Failure of a parent/caretaker to provide adequate food, clothing, shelter, medical care, supervision or emotional care for child to whom they are responsible. Physical injury to a child may occur when appropriate actions by a parent/caretaker are not taken.

Permanency - Is assessed on a case-by-case basis and takes into consideration the safety and best interests of the child. In the order of preference, the permanent outcomes for children in care are: (1) reunification; (2) adoption; (3) guardianship; (4) permanent placement with a fit and willing relative; or (5) another planned permanent living arrangement; e.g., long-term foster care or emancipation.

Physical Abuse - This is physical injury or death inflicted or permitted to be inflicted, upon a child, by a parent/caretaker by other than accidental means (O.C.G.A. 19-7-5). It is the willful infliction of physical injury or suffering which often occurs in the name of discipline or punishment and may range from the use of the hand to the use of objects.

Physical Injury - This is bodily harm or hurt such as bruises, welts, fractures, burns, cuts or internal injuries but excluding mental distress, fright or emotional disturbance. When corporal punishment is involved, the severity of injuries will determine whether the situation is deemed physical abuse.

Placement Disruption – Unplanned placement changes not resulting in permanency or step-down.

Protective Capacities - Family strengths or resources that reduce control and/or prevent threats of serious harm from arising or having an unsafe impact on a child and enable a caregiver to meet the child's basic needs.

PREP: Georgia's Personal Responsibility Education Program (GA-PREP) is administered by the Georgia Division of Family and Children Services (DFCS). Through community engagement and training, Georgia PREP provides funding to public agencies and non-profit organizations to provide training and education to youth in the areas of healthy relationships, abstinence and contraception for the prevention of unintended pregnancy and sexually transmitted infections (STI's), including HIV and AIDS. The program targets youth, ages 10-19, who are in foster care, live in rural areas or in geographic areas with high teen birth rates, or who represent diverse racial or ethnic minority groups. The program also supports pregnant and parenting teens under the age of 21.
In addition to reducing and preventing teen pregnancy and STI infection, GA-PREP provides the opportunity for youth to learn the skills and tools necessary to become healthy, responsible and self-sufficient adults by educating them on healthy relationships, adolescent

development, financial literacy, parent-child communication, educational and career preparation, and healthy life skills. For more information about GA-PREP, please contact:

Patrice Moss, MPH
Interim PREP Director
Georgia Division of Family and Children Services Community Programs Unit
2 Peachtree Street, 26-296
Atlanta, GA 30303
(404) 656-2918 Office
(470) 217-2368 BB
(770) 344-5524 Fax
Patrice.Moss@dhs.ga.gov

PRTF – Psychiatric Residential Treatment Facility (PRTF) services provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in a psychiatric residential treatment facility and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the child or adolescent to the community. The PRTF is not a placement, but a temporary hospitalization.

Psychotropic medications – Are drugs that affect the mind / perception, behavior and mood. Common types of psychotropic medications include:

- Antidepressants
- Anti-anxiety agents
- Antipsychotics
- Mood stabilizers

Respite - A support service to allow foster parents "time away" from their parenting responsibilities, and the foster children are pre-approved to stay with another approved foster family.

Safe - There are no imminent threats of serious harm stemming from caretakers' actions or inactions or the accessible protective capacities of the family are able to prevent these actions or inactions.

Safety - This is the absence of immediate risk of harm to a child, based on current conditions.

Safety Assessment - A decision-making and documentation process conducted in response to a child abuse and/or neglect report or any other instances in which safety needs to be assessed throughout the life of the case to help evaluate safety threats, present danger, child vulnerability, family protective capacities, and to determine the safety response.

Safety Threat - Acts of conditions that have the capacity to seriously harm any child.

Serious Injury - This is an injury such as bodily injury that involves substantial risk of death, extreme physical pain, disfigurement or protracted loss or impairment of the function of a

body part, organ or mental capability. Examples include head trauma, blunt trauma, internal bleeding, multiple bruising and contusions, laceration of organs and amputation.

Sexual Abuse - This is a form of child abuse in which any of nine specific behaviors occur between a child under the age of eighteen years and the parent or caretaker and during which the child is being used for the sexual stimulation of that adult or another person. Sexual abuse shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than three years older than the minor. However, sexual abuse may be committed by a person under the age of eighteen years when that person is either significantly older than the victim or when the abuser is in a position of power or control over another child. Alleged sexual abuse by an extra-familial perpetrator must be evaluated on the basis of parental approval or the lack of parental

Significant Events - Serious events relating to the care or protection of children. Including but not limited to:

- Media Coverage
- Injuries requiring more than First Aid
- Death
- Suicide / Homicidal Attempt
- Police Involvement
- Impact from Natural Disaster or Fire, Flood.
- Emergency Safety Intervention

  3 or more times in one month with the same child and/or more than 10 emergency safety interventions for all children in care within a 30-day period.

Transition Services Plan - The purpose of a Transition Service Plan is to assist children with their IEP team and natural supports, build the skills and support they need to reach their post-school goals. The successful transition of children with disabilities from school to post school environments should be a priority of every IEP team. The purpose of the Individuals with Disabilities Act (1997) was "to ensure that all children with disabilities have available to them a free appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living," (20 U.S.C. ~ 140 (d) (1) (A).

Transitional Round Table-- Transition Roundtable (TRT) is a youth-centered, teaming process that generates an action plan for expediting permanency and permanent connections for youth while also addressing their well-being needs. The target population is adolescents in custody between the ages of 14 and 18. The meeting is mandatory for all youth in care who reached age 17. Partners in the process include youth-selected allies, Independent Living Specialist (ILS), Regional Adoption Coordinators (RAC), Education Support Monitors (ESM), Caregivers and Court Appointed Special Advocates (CASA).

Trauma-Informed Knowledge - A "trauma-informed" system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services. This model accommodates the vulnerabilities of trauma

survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment.

Vulnerable child - Is defenseless, exposed to behavior, conditions or circumstances that he or she is powerless to manage, and is susceptible and accessible to a threatening parent or caregiver. Vulnerability is judged according to the child's physical and emotional development, ability to communicate needs, mobility, size and dependence.

Written Transitional Living Plan (WTLP) - A DFCS plan that is developed by and for youth in foster care upon turning 14 years old (and every six months thereafter). The WTLP has individualized goals that are specific to youth's strengths and needs as growth & development occur.

Appendix B- Individual Service Plan (ISP) Checklist

Safety

- ☐ Behavior support and intervention plan (Reference 2.1).
- ☐ Identification of child's triggers, coping behaviors, and calming measures and have a crisis plan in place (Reference 2.2).
- ☐ Behavior management strategies to avoid (Reference 2.8).
- ☐ Emergency safety interventions must be limited to least restrictive appropriate method (Reference 2.18).

Quality of Care

- ☐ Must be strength based and reflective of assessment findings (Reference 3.0).
- ☐ ISP must addresses permanency (Reference 3.0)
- ☐ Address emotional and psychological needs (Reference 3.0).
- ☐ Assessments, service plans, and service delivery must be tailored to the needs, strengths, and resources of the child and family (Reference 3.0).
- ☐ Must promote the welfare, education, interest, and health needs of child (Reference 3.0)
- ☐ Take cultural, ethnic, or religious identity into account (Reference 3.3).
- ☐ Goals and outcomes, with input from the custody holder (Reference 3.3).
- ☐ Steps and measures to meet the needs of child (Reference 3.3)
- ☐ Plan must be tailored towards the needs of child (Reference 3.3).
- ☐ Must include DFCS or courts recommendations (Reference 3.3).
- ☐ Family members are included in review of ISP (Reference 3.3).
- ☐ Copy of ISP given to child (if age appropriate) and family members (Reference 3.5).
- ☐ Must ensure that all services to child and family are identified (Reference 3.7).

- ☐ Managed by a case support worker or HSP to ensure requirements of ISP are met (Reference 3.9).
- ☐ Health plan component, which covers health history and needs (Reference 6.1).
- ☐ Must include provisions for routine medical and dental services according to Medicaid's Early Prevention and Screening Diagnostic Test (EPSDT). standards (Reference 6.2).

Permanency Support

- ☐ Every Parent Every Month (EPEM) must be updated when ISP is updated (Reference 8.4).
- ☐ EPEM must be updated whenever assessments needs warrant a change (Reference 8.4).
- ☐ Discharge plan begins at admissions and should be reflective in ISP (Reference 9.0). Child Care Institutions (CCI's)
- ☐ Initial ISP must clearly indicate the assessed needs of the child (Reference 12.10).

Timelines

- ☐ ISP must be developed within 7 days of admissions (Reference 3.1)
- ☐ Submit ISP to DFCS by the 30th day of child's placement (Reference 3.2)
- ☐ ISP must be updated every 6 months (Reference 3.2)

Appendix C- Internet Resources

DFCS Child Welfare Policy Manual

http://odis.dhs.ga.gov/ChooseCategory.aspx?cid=1029

Department of Education

The following links are provided by The State of Georgia Department of Education Title I, Part D – Neglected and Delinquent Children, to offer additional information regarding services designed to improve educational services for children in institutions for neglected or delinquent children so that children have the opportunity to meet the same challenging State academic content standards and challenging State student academic achievement standards that all children in the State are expected to meet.

http://www.doe.k12.ga.us/tss_title_grant.aspx?PageReq=TSSTitleID

http://www2.ed.gov/programs/titleipartd/applicant.html

Kenny A Consent Decree

http://childwelfare.net/activities/kennya/

United States Department of Agriculture (USDA) Guidelines

http://www.fns.usda.gov/fns/regulations.htm

Residential Child Care Licensing (RCCL) Food Consumption Policy

http://rules.sos.state.ga.us/docs/290/2/6/21.pdf

Appendix D--RBWO Program Designation and Waiver Applications

The process below describes the process for applying for child program designations and/or CPA foster parent waivers. Applications are posted on www.gascore.com .

1.) DFCS Case Managers or providers may initiate the applications to assign assess children for program designations. The application form (revised June 2011) along with supporting documentation must be sent to OPM via fax or email using the contact information below:
   - Email address: **proteam@dhs.ga.gov**
   - Fax #: (770) 359-5335

2.) A complete packet should not exceed 25 pages and include the following components:
   - Application Form (revised June 2011);
   - Current Psychological Evaluation;
   - Other Supporting Documentation; and
   - If a provider initiated application---a statement, email or other documentation indicating that the DFCS case manager concurs with the application must be included.

3.) Failure to submit a complete packet will result in an automatic denial.

4.) A decision on the application will be provided to the DFCS case manager and the provider (if the application was initiated by a provider) within five (5) business unless the application involves a pending adoption.

5.) In the case of an emergency, (child is in need of permanent placement within 24 hours from the day of the request, not to include respite) waivers will be processed **on the same business day or within one (1) business day** in writing. When needed, verbal approval can be obtained from the OPM Director, PRO Director and/or designee. Failure to obtain approval for the placement of a child when a waiver is required may result in agency office conference, a letter of concern, a temporary hold on agency admissions and/or termination of provider contract

Appendix-E-- Grievance and Appeals Process

Provider Grievance, Appeal & Dispute Process

The DFCS Office of Provider Management (OPM) is committed to an effective partnership with Providers. Providers are encouraged to contact the OPM when they experience a concern with the monitoring results, program designation decisions or performance based scoring. The OPM will work with the Provider to resolve any concerns as expeditiously as possible.

Provider Performance Based Placement (PBP) Disputes

Providers will receive quarterly PBP score results.

Note: Please keep in mind that unless there is a noted exception, Providers must enter all data reported to GA+SCORE by the 10th of the following month to receive credit for PBP compliance. Accuracy and timeliness in monthly reporting are major contributors to the overall accuracy of the quarterly PBC report.

Providers have ten (10) business days from the date of receipt of the PBP report to respond in writing to the Director of OPM with any dispute related to the quarterly score report. Providers should submit relevant, mitigating information related to the disputed score including any official documentation such as case records, submitted monthly reports (eg. ECEM reports, monthly summary reports), treatment records, clinical assessment results, physician statements, and financial invoices.

A decision regarding the dispute will be provided in 15 business days of receipt, via email, to the Provider.

OPM's response will outline any changes, if applicable, to the PBP score as a result of this reconciliation. If there are no changes to the scoring in dispute, OPM's response will outline the rationale for its denial of the change to the disputed scoring.

If the Provider is still in disagreement with OPM's decision to the PBP Scoring dispute, the Provider has ten (10) business days to notify OPM of the 2nd appeal and request a formal reconciliation meeting.

The 2nd Appeal includes an office conference facilitated by the Senior Manager of Placement Services. A final decision will be rendered within 10 business days after the meeting. The decision reached after this meeting is final.

Once the PBP Score dispute has been finalized, a newly revised scoring report will be issued within ten (10) business days (if applicable). Any revisions to the scoring will be incorporated into the overall results for the Provider's performance results.

Provider Monitoring Disputes

The OPM will notify the Provider in writing of its monitoring results (either comprehensive or safety reviews). The Provider will then have ten (10) business days from the date of receipt to respond in writing to the Director of OPM with any dispute related to the monitoring report and it's summarized scoring results. The Provider may provide only relevant, mitigating information related to each specific category under dispute; "mitigating information" includes any official documentation such as case records, submitted monthly reports (eg. ECEM

reports, monthly summary reports), treatment records, clinical assessment results, physician statements, and financial invoices.

OPM will consider the dispute, within the required timeframe, and provide a response of receipt of the dispute within 10 business days of actual receipt. A decision regarding the dispute will be provided in 10 business days of receipt via email to the Provider.

OPM's response will outline any changes, if applicable, to the monitoring score as a result of this reconciliation. If there are no changes to the scoring in dispute, OPM's response will outline the rationale for its denial of the change to the disputed scoring.

If the Provider is still in disagreement with OPM's decision to the PBP Scoring dispute, the Provider has ten (10) business days to notify OPM of the 2nd appeal and request a formal reconciliation meeting.

The 2nd Appeal includes an office conference facilitated by the Senior Manager Director of Centralized Social Services. A final decision will be rendered within 10 business days after the meeting. The decision reached after this meeting is final.

Once the monitoring score dispute has been finalized, a newly revised monitoring report will be issued within ten (10) business days (if applicable). Any revisions to the scoring will be incorporated into the overall results for the Provider's performance results.

General Grievances/Constituent Complaints

A grievance is any area of complaint that is outside the scope of specific provider scoring results but related to administrative operations and the Provider's interface with the Department of Family and Children Services. All grievances should be documented on the Provider Dispute Form and submitted to OPM.

If the grievance is related to the interpretation of minimum standards, policy or contract deliverables, please be specific about the area in question.

OPM will acknowledge receipt of the grievance within ten (10) business days of its receipt and respond within 30 days.

OPM Dispute Packet Delivery Options

Acceptable methods of submitting a dispute, appeal or grievance to OPM include email, hand delivery, fax, or mail. The packet must include a completed OPM Provider Dispute Form (Forms are available on the GA+SCORE Website) and include any supporting documentation. The Provider must ensure a copy of all submitted documentation is maintained by the sender; no packets will be returned. Limit the number of pages submitted to 10 pages.

Hand delivery **DFCS Office of Provider Management**
Floor 18 Front Reception Desk

Postal address	**DFCS Office of Provider Management** **Attn:_____, Director** **Floor 18, 2 Peachtree St. NW,** **Atlanta, GA 30303**
Facsimile Delivery	(770) 359 - 5335
Electronic lodgment	**opmreports@dhs.ga.gov**

Alternatively, grievances can always be submitted to DFCS Constituent Services within 30 days of the event, if event specific. The DFCS - Constituent Services Unit contact information is:

Attn: Yvonne Davenport, Unit Manager
Floor 18, 2 Peachtree St. NW
Atlanta, GA 30303
yvonne.davenport@dhs.ga.gov

Appendix F -OPM Staff Contact List

Division of Family and Children Services - Office of Provider Management					
2 Peachtree Street, Suite 18-436, Atlanta GA 30303					
Name	**Title**	**Office Number**	**Mobile Number**	**Fax Number**	**Email**
	Office of Provider Management Director				
Shaun Johnson	Provider Relations Manager	(404) 657-3762	(678) 727-3112	(770) 359-5335	shaun.johnson@dhs.ga.gov
Brenda Jones	Operations Analyst	(404) 232-7860	(404) 859-6147	(770) 359-5335	brenda.jones@dhs.ga.gov
Andria Bolton	Resource Maintainer	(404) 657-8961	(404) 895-7135	(770) 359-5335	andria.bolton@dhs.ga.gov
Stephanie Jackson	Resource Maintainer	(404) 895-7135	(404) 821-8774	(770) 359-5335	stefanie.jackson@dhs.ga.gov
Claudine Smith	Resource Maintainer	(404) 463-7021	(404) 632-8569	(770) 359-5335	claudine.smith@dhs.ga.gov
Monitoring Teams					
Name	**Title**	**Office Number**	**Mobile Number**	**Fax Number**	**Email**

Karsten Hartman	Monitoring Team Manager (Red)	(404) 463-0911	(404) 520-0529	(770) 359-5335	karsten.hartman@dhs.ga.gov
Tiffany Cutliff	Monitoring Team Manager (Green)	(404) 463 - 2216	(229) 733-1110	(770) 359-5335	tiffany.cutliff@dhs.ga.gov
Shakaria Glass	Monitoring Supervisor	(404) 657-0673	(404) 450-5417	(770) 359-5335	shakaria.glass@dhs.ga.gov
Michelle Williams	Monitoring Supervisor	(404) 657 - 3553	(404) 987-5001	(770) 359-5335	michelle.williams3@dhs.ga.gov
Juanita Evans	Monitoring Specialist	N/A	(678) 733-2175	N/A	juanita.evans@dhs.ga.gov
Sara Beth Brown	Monitoring Specialist	N/A	(404) 673-9213	N/A	sara.brown@dhs.ga.gov
Sharon Greene	Monitoring Specialist	N/A	(678) 733-2059	N/A	sharon.greene@dhs.ga.gov
Tyrone Edwards	Monitoring Specialist	N/A	(706) 594-2297	N/A	tyroned.edwards@dhs.ga.gov
Derek Mouzon	Monitoring Specialist	N/A	(404) 387-0896	N/A	derek.mouzon@dhs.ga.gov
Chandler Scott	Monitoring Specialist	N/A	(470) 426-4746	N/A	chandler.scott@dhs.ga.gov
Samuel Pittman	Monitoring Specialist	N/A	(404) 354-2518	N/A	samuel.pitman@dhs.ga.gov
Azure McCullough	Monitoring Specialist	N/A	(404) 357-3569	N/A	azure.mccollough@dhs.ga.gov
Shemkia Harris	Monitoring Specialist	N/A	(404) 416-8655	N/A	shemkia.reid-harris@dhs.ga.gov
OPM Risk Management/Training Team					
Name	**Title**	**Office Number**	**Mobile Number**	**Fax Number**	**Email**
	Risk Manager				
Deborah Spaulding	Risk Management Specialist	(404) 463-7256	(404) 803-7489	(912) 717-6819	deborah.spaulding@dhs.ga.gov
Gail Cohn	Risk Management Specialist	(404) 656-0583	(470) 755-4233	(770) 344-5010	gail.cohn@dhs.ga.gov
LaShaunda Daniel	Training and Curriculum Specialist	(404) 657-0919	(404) 909-4259	(770) 359-5335	lashaunda.daniel@dhs.ga.gov

Placement Resource Operations (PRO) Specialist Contact List

In addition to consulting with the DFCS case manager, Providers should contact the PRO Specialist regarding the placement needs for MWO youth and/ placement specific waiver request.

James Kizer
PRO Director
James.kizer@dhs.ga.gov
(404) 657-2329 (office)
(404) 387-1304 (mobile)

Becky Kane
Interim PRO Team Supervisor
Becky.kane@dhs.ga.gov
(912) 432-8782

PRO Specialist	Phone Number	E-mail Address
Bridgette Miller	(404) 821-9061	bridgette.miller@dhs.ga.gov
Matashia Collier	(404) 276-6870	matahshia.collier@dhs.ga.gov
Gabrielle Starr	(678) 613-9723	gabrielle.starr@dhs.ga.gov
Sandra Wimbush	(404) 987-4910	sandra.wimbush@dhs.ga.gov
William Wynn	(678) 733-2089	william.wynn@dhs.ga.gov
Donna Wall	(404)801-9961	donna.wall@dhs.ga.gov

Appendix G –Independent Living Program (ILP) Directory

Dr. Nia Cantey, ILP Director
nia.cantey@dhs.ga.gov
(404) 463-2215 (Office)

Department of Family & Children Services
2 Peachtree Street NW
Suite18-422
Atlanta, GA 30303

Frances Atwater, ILP Supervisor
frances.atwater@dhs.ga.gov
(404) 657-1741 (Office)
(770) 342-7809 (Fax)

Department of Family & Children Services
2 Peachtree Street NW
Suite 18-215
Atlanta, GA 30303

Tacia Bazile, ILP Program Associate tacia.bazile@dhs.ga.gov 404-657-0037 (Office) 404-210-6136 (Mobile) 770-342-7809 (Fax)	Department of Family & Children Services 2 Peachtree Street NW Suite 18-224 Atlanta, GA 30303

VACANT-BUSINESS OPERATIONS SPECIALIST	Department of Family & Children Services 2 Peachtree Street NW Suite 18- Atlanta, GA 30303
Devin Martin, ILP Credit Report Specialist devin.martin@dhs.ga.gov 404-657-1396 (Office) 770-342-7132 (Fax)	Department of Family & Children Services 2 Peachtree Street NW Suite 18-217 Atlanta, GA 30303

ILP SPECIALIST	**ADDRESS**	**PHONE/FAX #**	**SERVICE AREA(S)**
Region 1 **Lisa Boatman** **lisa.boatman@dhs.ga.gov**	990 E Main Street, Suite 10 Blue Ridge, GA 30513	O (706) 272-2841 F (866) 808-9809	Catoosa, Chattooga, Dade, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield
Region 2 **VACANT** **Wynecoka Thompson in Region 9**	Region 2 DFCS Office Union County DFCS 163 Blue Ridge HWY Blairsville, GA 30512	C (229) 357-0861 F (478) 783-6195	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephen, Towns, Union, White
Region 3 **Meghan Bennett** **meghan.park@dhs.ga.gov**	Douglas County DFCS 8473 Duralee Lane Suite 100 Douglasville, GA 30134	O: (770) 947-7556 C (706) 594-8154 F (770) 489-9057	Cherokee, Douglas, Paulding
James Maddox **james.maddox@dhs.ga.gov**	Bartow County DFCS 47 Brook Drive Cartersville, Ga. 30120	O (770) 387-4863 C (678) 739-9134 F (770) 357-8925	Bartow, Floyd, Haralson, Polk
Region 4 **Gerrica Morton** **Gerrica.morton@dhs.ga.gov**	Coweta County DFCS 533 Hwy. 29 North Newnan, GA 30263	O (770) 254-7545 C (404) 354-0281 F (770) 357-8828	Butts, Carroll, Coweta, Fayette, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson
Region 5 **Jo R. Thomas**	Region 5 Clarke DFCS 284 North Ave PO Box 1887 Athens, GA 306031887		Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
Region 6 **C. Latrice Bakon** **chandralatrice.bakon@dhs.ga.gov**	Bibb County DFCS office Bibb County DFCS 456 Oglethorpe St. Macon, GA 31201	O (478) 752-1570 C (478) 319-7330 F (478) 314-9729	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson

Region 7 **Kevin Wright** **kevin.wright@dhs.ga.gov**	Richmond County DFCS 520 Fenwick Street Office Box 2277 Augusta, GA 30903	O (706) 721-5738 C (706) 871-6405 F (706) 434-5595	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes
Region 8 **Angela Payne Davis** **angela.davis2@dhs.ga.gov**	Muscogee County DFCS 2100 Comer Ave DFCS 2 Columbus, Georgia 31902	O (706) 649-1327 C (229) 314-9728 F (706) 256-7951	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
Region 9 **Wynecoka Thompson** **wynecoka.thompson@dhs.ga.gov**	Bleckley County DFCS Post Box 499 Cochran, GA 31014	O (478) 934-3193 C (229) 357-0861 F (478) 934-3332	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox
Region 10 **Recarlo Williams** **recarlo.williams@dhs.ga.gov**	Miller County DFCS 69 Thompson Town Road Colquitt, GA 39837	O (229) 758-3530 C (229) 309-1889	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
Region 11 **Teresa Reese** **teresa.reese@dhs.ga.gov**	Ben Hill County DFCS - 3rd Floor 124 S Grant Street Fitzgerald, GA 31750	O (229) 426-5369 C (229) 445-1484 F 1-800- 871-5691	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
Region 12 **Estelline Beamon** **estelline.beamon@dhs.ga.gov**	Chatham County DFCS Post Office Box 2566 761 Wheaton Street Savannah, GA 31401	O (912) 651-2684 C (912) 275-2226 F (912) 544-7717	Bryan, Bullock, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
Region 13 **Shante Campbell** **shante.campbell@dhs.ga.gov**	Clayton County DFCS 877 Battlecreek Road Jonesboro, GA 30236	O (770) 288-8959 C (404) 293-3577 F (770) 603-4673	Clayton, Henry, Rockdale

Region 14 **Kathleen Edwards** **kathleen.edwards@dhs.ga.gov** **Tracy Johnson** **tracy.johnson@dhs.ga.gov** **Heather Coggins** **heather.coggins@dhs.ga.gov**	DeKalb County DFCS 178 Sams Street Decatur, GA 30030 Fulton County DFCS 5710 Stonewall Tell Road College Park, GA 30349	O (404) 370-5557 F (404) 370-5078 O (770) 774-7592 C (404) 308-9981 O (770) 774-7605 C (404) 416-0202 F (770) 357-9002	DeKalb Fulton
Region 15 **Gary Frazier** **gary.frazier@dhs.ga.gov**	Gwinnett County DFCS 33 S. Clayton St. Suite 100 Lawrenceville, GA 30046	O (770) 774-7592	Gwinnett, Cobb

CLSA Codes

https://view.officeapps.live.com/op/view.aspx?src=http%3A%2F%2F.georgia.gov%2Fsites%2Fdfcs.dhs.georgia.gov%2Ffiles%2Fimported%2FDHR-DFCS%2FDHR-DFCS_CommonFiles%2FRT_173.doc

Appendix H- Regional Directors

Region	Regional Director	Administrative Assistant	Mailing Address	Contact Information
1	Ashley Parham Interim Ashley.Parham@dhs.ga.gov	Teresa Renz	P.O. Box 1044 Dalton, GA 30722 (Location: Whitfield DFCS 1142 N. Thornton Avenue)	706-272-2709 O 888-419-3451 F 706-581-6333 BB
2	Kenny Jarvis Kenny.Jarvis@dhs.ga.gov	Merissa Mashburn	970 McEver Road Ext. Gainesville, GA 30504	770-531-6006 O 770-359-1022 F 706-599-9570 BB
3	Ross Collins Ross.Collins@dhs.ga.gov	Renee Bruce Shanita Wells (Back-up)	450 Riverside Parkway, Suite 220 Rome, GA 30162	706-295-6193 O 706-802-5378 F 706-512-2464 BB
4	Tammy Reed Interim Tammy.Reed@dhs.ga.gov	Ja'Melle Smith	533 Highway 29 North Newnan, GA 30263	770-254-7502 O 770-357-9205 F 404-217-5064 BB
5	Mary Havick	Kim Dixon	c/o Oconee County DFCS	706-310-2275 O

	Mary.Havick@dhs.ga.gov		1400 Greensboro Hwy. Watkinsville, GA 30677	706-552-2339 F 706-248-9777 BB
6	Sekema Harmon Sekema.Harmon@dhs.ga.gov	Bradley Jackson	456 Oglethorpe Street Macon, GA 31210	478-751-3556 O 478-314-9866 F 706-573-0022 BB
7	Lynn Barmore Lynn.Barmore@dhs.ga.gov	Samantha Riles	P.O. Box 808 Millen, GA 30442 (618 South Gray Street)	478-982-2430 O (478) 982.1279 F 706-871-6403 BB
8	Marva Reed Marva.Reed@dhs.ga.gov (Interim effective 04.01.2015)	Albena Moore	1601 N. MLK Jr. Blvd Suite 120 Americus, GA 31719	229-931-2512 O 229-931-2428 F 404-291-3341 BB
9	Stacey Barfield Stacey.Barfield@dhs.ga.gov	Tina Moore	106 7th Street N, Suite A Cordele, GA 31010	229-271-4977 O 229-271-4999 F 229-322-0094 BB
10	Deborah Smith Deborah.Smith@dhs.ga.gov	Cindy Wortham	460 Smith Avenue Thomasville, GA 31792	229-227-2530 O 229-584-1547 F 229-584-0515 BB
11	Vicki Townsend Vicki.Townsend@dhs.ga.gov	Pearl Fore	410 West 2nd Street Tifton, GA 31794	229-386-3089 O 229-386-7035 F 229-977-1746 BB
12	Richard (Rick) Chamberlin RichardT.ChamberlinJr@dhs.ga.gov	Kay Brantley	P.O. Box 1535 Brunswick, GA 31521 (Location: Glynn DFCS) 823 Scranton Road	912-280-6856 O 912-280-6857 F 912-213-2952 BB
13	Andrea Tulloch Andrea.Tulloch@dhs.ga.gov	Carol Hagan	277 S. Fairground St, SE Marietta, GA 30060	770-528-3404 O 770-528-3429 F 404-615-5132 BB
14	Andrea Tulloch Andrea.Tulloch@dhs.ga.gov	Cheryl Charleston	1249 D. L. Hollowell Pkwy. Atlanta, GA 30318	770-528-3404 O 770-528-3429 F 404-615-5132 BB

Permanency Unit

Name	Address	Phone	Counties Served
Christie Sterl [RAC **Reg 1**]	P.O. Box 1203 Dalton, GA 30722-1203	C: 706-410-6677	Reg. 1: Catoosa, Chattooga, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield
Stephanie Boylan [RAC **Reg 2**]	970 McEver Road Ext. Gainesville, Georgia 30504-3938	O: 770-532-5328 C: 770-316-5468	Reg. 2: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White
Erica Slocum [RAC **Reg 3**]	47 Brook Drive Cartersville, GA 30120/PO Box 818 Cartersville, GA 30120	C: 404-432-468**8**	Reg. 3: Bartow, Floyd
Julie Evans [RAC **Reg 3**]	P.O. Box 826 Canton, GA 30169 105 Lamar Haley Pwy Canton, GA 30114	O: 770-720-3674 C: 678-209-6229	Reg. 1: Cherokee Reg. 3: Douglas, Haralson, Paulding, Polk
Marion Pitts-Benson [RAC **Reg 4]**	Two Peachtree Street NW Suite 8-417 Atlanta, GA 30303	C: 404-576-5128	Reg. 4: Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spaulding, Troup, Upson

Kristen Parker [RAC **Reg 5**]	16 Lee Street Winder, GA 30680	C: 404-387-1084	Reg. 5: Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton
Alissa Kautz [RAC **Reg 6**]	P.O. Box 97 Roberta, GA 31078	O:478-836-6034 C: 478-319-7331	Reg 6: Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson, Jasper
Michael Simmons [RAC **Reg 7 and 9**]	520 Fenwick Street Augusta, GA 30903	C: 706 401-2463	Reg 7: Burke, Columbia, Glascock, Hancock Jefferson, Jenkins Lincoln, McDuffie, Richmond, Screven Taliaferro, Warren, Washington, Wilkes Reg 9: Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler and Wilcox.
Cheryl Cameron [RAC **Reg 8 and 10**]	505 S. Wheat Avenue Bainbridge, GA 39819	O:229-248-3943 C: 229-254-2026	Reg 8: Chattahoochee, Clay, Crisp, Dooley, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Tayor, Webster Reg 10:Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
Barbara Williams [RAC **Reg 11**]	206 South Patterson Street 2nd floor Valdosta, GA 31601	O:229.245.2426 C: 229-225-6284	Reg. 11:Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
Somiki Reddick **[RAC Reg 12]**	PO Box 68 Kingsland, GA 31548	O: **C: 912-717-3192**	Reg. 12:Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long and McIntosh
Andrew Willis [RAC **Reg 13/14 A**]	Two Peachtree Street NW Suite 8-202 Atlanta, GA 30303	O: 404.657-3550 C: 404.275.8451	Reg 14: Dekalb Reg 13: Gwinnett
Chalilah Ford [RAC **Reg 13/14 B]**	2221 Austell Rd. Building 1, Suite 110 Marietta, GA 30008	C: 404-229-8955	Reg: 14: Fulton Reg 13: Cobb Reg. 13: Clayton
Karla Wells [Program Manager]	Two Peachtree Street NW Suite 8-417 Atlanta, GA 30303	C:770-296-3180	Statewide
Deborah Burrus [Director]	Two Peachtree Street NW Suite 18-460 Atlanta, GA 30303	O: 404-463-7347 C: 404-276-6331	Statewide
Demetris Mason [Adoption Program Consultant]	Two Peachtree Street NW Suite 18-456 Atlanta, GA 30303	O: 404-463-5427	Regions:4, 11 – 14
Evangel Wicks [Adoption Program Consultant]	Two Peachtree Street NW Suite 18-433 Atlanta, GA 30303	O: 404-657-3589	Private CPSs
Chanda Floyd-Bryant [Wednesday's Child Coordinator]	Two Peachtree Street NW Suite 18-436 Atlanta, GA 30303	O: 404-657-4451 C: 404-579-4500	Statewide
Telisa Hansford [Adoption Program Consultant	Two Peachtree Street NW Suite 18-435, Atlanta, GA 30303	O:404-651-5731	Regions: 1 - 3
Nortecia Morrow [Adoption Program Consultant]	Two Peachtree Street NW Suite 18-430 Atlanta, GA 30303	O: 404-232-1072	Regions: 5 - 10
Steven Turner [Project Manager]	Two Peachtree Street NW Suite 18-457 Atlanta, GA 30303	O: 404-232-1282	Statewide
Fran Marie George [Program Manager]	Two Peachtree Street NW Suite 18-454 Atlanta, GA 30303	O: 404-657-0022 C: 404-276-9539	Statewide
Laura Stokes [Program Assistant]	Two Peachtree Street NW Suite 18-455	O: 404-657-6901	Statewide

	Atlanta, GA 30303		

Caregivers Recruitment and Retention Unit

Candis L. Jones, LAPC
Division of Family and Children Services
Caregiver Recruitment & Retention Unit Manager (CRRU)
2 Peachtree Street
18th Floor 18-233
Atlanta, GA 30303
(404) 640-2611 – Cell
(404) 463-0941 – Office
(770) 342-7233

Kemberly Watkins
Caregiver Recruitment & Retention Ombudsman (CRRU)
2 Peachtree Street
18th Floor 18-242
Atlanta, GA 30303
Kemberly.Watkins@dhs.ga.gov
(404) 463-0998 - Office
(404) 780-5110 – Cell
(770) 344-3082 – Fax

REGION	LNAME	FNAME	WORK EMAIL	EMAIL (OTHER)	WORK CELL PHONE
1,2,11	**ALEXANDER**	Mindy	mindy.alexander@dhs.ga.gov	zmalexander95@yahoo.com	(404)656-7197
6,9,12	**BARNES**	Sarah	sarah.barnes@dhs.ga.gov	sarah.barnes1114@gmail.com	(404)654-7199
3,5,7	**BOWSER**	Sherry	sherry.bowser@dhs.ga.gov	sherrytbowser@yahoo.com	(404)655-6312
4,8,10	**DAVIS**	Billy	billy.davis@dhs.ga.gov	dbillyyo@gmail.com	(404)558-0645
13-14	**HECTOR**	Ieshia	Ieshia.Hector@dhs.ga.gov	eshhector@gmail.com	(470)725-5342
5-8	**OLIVER**	Seth	seth.oliver@dhs.ga.gov	setholiver7@aol.com	(404)276-9660

13,14	**PARKER**	Gloria	gloria.parker@dhs.ga.gov	grcp12@att.net	(404)655-5465
9-12	**RUTHERFORD**	Samantha	Samantha.Rutherford@dhs.ga.gov		(470)553-5556
1-4	**SIMMONS**	Ilean B.	Ilean.Simmons@dhs.ga.gov	ileanbs@yahoo.com	(404)985-5767
	WILLIAMS	Chelsey	Chelsey.Williams@dhs.ga.gov	Willcb10@gmail.com	(404)656-0784

Appendix I: FY 2017 RBWO Minimum Standards Change Guide

The following list indicates standards that are new or revised in the FY 2017 Minimum Standards. Every effort has been made to ensure that all changes have been included in this list; however this list should only be considered as a helpful guide. Providers should review the entire document for changes.

1. Standard 1.3
2. Standard 1.7
3. Standard 1.11
4. Standard 1.16
5. Standard 4.8
6. Standard 6.2
7. Standard 6.23
8. Standard 6.26
9. Standard 6.27
10. Standard 9.2
11. Standard 9.3
12. Standard 11.8
13. Standard 11.9
14. Standard 11.10
15. Standard 11.11
16. Standard 11.12
17. Standard 11.13
18. Standard 11.14
19. Standard 11.15

20. Standard 11.16
21. Standard 11.17
22. Standard 11.18
23. Standard 11.19
24. Standard 11.20
25. Standard 11.21
26. Standard 11.22
27. Standard 11.23
28. Standard 11.24
29. Standard 11.25
30. Standard 11.26
31. Standard 11.27
32. Standard 11.28
33. Standard 11.29
34. Standard 11.30
35. Standard 11.31
36. Standard 11.32
37. Standard 11.33
38. Standard 11.34
39. Standard 11.35
40. Standard 12.35
41. Standard 13.22
42. Standard 13.34
43. Standard 24.3

Appendix J - Forms

Forms are posted at www.gascore.com.

Appendix K – Infant Safe Sleeping Guidelines and Protocol

Georgia Division of Family and Children Services

Infant Safe to Sleep Guidelines and Protocol

Table of Contents

Definitions

AAP - American Academy of Pediatrics

Caregiver - This term is used to refer any person providing care, watchful oversight and supervision of a child (e.g., parent, guardian, relative, foster parent, child care provider, baby-sitter, etc.).

DFCS - Georgia Division of Family and Children Services

Infant - This term is used to refer to any child under the age of 12 months.

Sudden Infant Death Syndrome (SIDS) [1] is a cause assigned to infant deaths that cannot be explained after a thorough investigation, including a scene investigation, autopsy and review of the clinical history.

Sudden Unexpected Infant Death (SUID)[2], also known as sudden unexpected death in infancy, is a term used to describe any sudden and unexpected death, whether explained or unexplained (including SIDS), that occurs in infancy.

Swaddling - This term refers to the practice of wrapping an infant firmly in clothing, a blanket, etc. in such a manner that the infant is bound and unable to room-share and co-sleep.

Co-Sleeping - There are two main types of co-sleeping - room-sharing and bed-sharing:

> **Bed-sharing or surface-sharing -** where the child shares the same sleep surface (adult bed, couch, chair, etc.) with another child or an adult. It is associated with a higher risk of suffocation, entrapment, other sleep-related injuries and death. It is not recommended.
>
> **Room-sharing -** where a child is provided his or her own separate sleep space within the same room as the caregivers, within sensory distance of each other, but not on the same sleep surface. Room-sharing is useful for promoting breastfeeding and is associated with a reduced risk of sleep-related death.

Positional Plagiocephaly (also known as “flat head syndrome”) - The most common cause of a flattened head is a baby's sleep position. Because infants sleep for so many hours on their backs, the head sometimes flattens in one spot. Placing babies in devices where they lie down often during the day (e.g., infant car seats, carriers, strollers, swings, bouncy seats, etc.) also adds to this condition.

Purpose

The purpose of this protocol is to increase the awareness of infants sleeping safely according to the recommendations provide by the American Academy of Pediatrics. Training and use of the recommendations will assist with preventing the occurrence of sleep-related infant deaths, provide written practice guidance on caregiver education and infant sleep related death prevention efforts to DFCS staff including both direct and non-direct services staff and contractors and providers.

Introduction

According to the Georgia Child Fatality Review Panel, sleep-related deaths have been the leading cause of preventable infant deaths for the past four years within the state of Georgia. From 2009 to 2013, there were **929** infant sleep-related deaths reported to Georgia the Child Fatality Review Panel. The average is **154** infant deaths each year, an average of **3** infant deaths per week due to sleep-related causes alone.

There are many conditions and practices related to sleeping that are dangerous and have been associated with fatalities of infants, either from SIDS (Sudden Infant Death Syndrome) or SUID (Sudden Unexplained Infant Death). Unsafe sleeping practices may include:

- **Wedging –** Where an infant's face when sleeping is wedged between two adjacent surfaces, such as on a couch, chair, or bed with a headboard or in a crib in which there are spaces between the mattress and frame.
- **Soft Surfaces** - Placing the infant to sleep on a soft surface or with soft bedding (such as pillows, blankets and crib bumpers) or soft objects (such as stuffed animals), or using an infant positioner. This includes placing an infant on a bed or crib with a soft mattress and, especially, on a couch, armchair, cushion, waterbed, etc.
- **Sleep Position** - Placing an infant to sleep in any position other than on the back.
- **Overheating** - Allowing an infant to get too hot because of high room temperature (the temperature should be comfortable for a lightly clothed adult) or overdressing.
- S**moking** - Smoking in a room where an infant sleeps, or maternal smoking during or after pregnancy.
- **Bed-sharing** - An infant and one or more adults or children sleeping together on any surface, not necessarily a bed; bed-sharing also refers to an infant and another person sharing a surface such as a couch, chair or futon while sleeping.

Distinguishing between the types of sleep-related deaths (SIDS and SUID) can be somewhat challenging. Since the risk factors for both are very similar, it is imperative that caregivers learn and apply safe infant sleeping practices that may reduce the risk of both SIDS and

SUID. To promote safe sleeping practices for infants, the Division of Family and Children Services (DFCS) has collaborated with the Division of Public Health and the Georgia Child Fatality Review Panel to actively engage in efforts to reduce sleep-related deaths to infants. DFCS will utilize the recommendations as provided by the American Academy of Pediatrics (October 2011).

The DFCS Infant Safe to Sleep Guidelines and Protocol will focus on the issue of prevention, with recognition that unsafe sleeping conditions may occur anywhere in the range of child welfare cases: child protective services, preventive services, foster care, financial independence or adoptive placements; therefore, this protocol applies to all categories of child welfare work. By providing parents and caregivers with information on infant safe to sleep environments, DFCS staff members can enable them to make informed choices concerning their children's sleep environments.

Infant Safe to Sleep Practices

The American Academy of Pediatrics (AAP) Task Force on Sudden Infant Death expanded its recommendations on the promotion of safe sleep environments in October of 2011. The three primary safe sleep recommendations are as follows:

Alone - Room-sharing without bed-sharing is recommended

Back - Back to sleep for every sleep

Crib - In a sleep setting such as a crib, to include a firm sleep surface, without soft objects, toys or stuffed animals and loose bedding.

For purposes of this protocol, details regarding the AAP recommendations and guidance when discussing infant safe to sleep practices with caregivers are as follows:

1. **Back to sleep** for every sleep. Place infants on their backs for **every** nap or sleep time, unless the infant's primary care physician provides a written statement indicating that the infant requires an alternate sleeping position. The written statement must include instructions for how the infant shall be placed to sleep and the timeframe for which the instructions are to be followed.

2. Use a **firm sleep surface**. Examples include a firm crib mattress covered by a tightly fitted sheet or a safety approved bassinet with a tightly fitted sheet.

    a. Use only a crib, bassinette or portable crib/play yard that conforms to the safety standards of the Consumer Product Safety Commission (CPSC) and ASTM International (formerly the American Society for Testing and Materials) safety standards. Ensure the product is maintained in good repair and is free from hazards or recalls.

    b. Move infants who fall asleep on the floor or elsewhere (e.g., carrier, car seat, swing, stroller, chair, highchair, etc.) to a safety- approved sleep surface for sleep as soon as possible.

    c. Allow only one infant at a time to sleep in a crib.

3. **Room-sharing without bed-sharing** is recommended. Sharing the same room with an infant provides the opportunity for a caregiver to remain in close proximity of the infant while also providing a firm, safe sleep environment for the child. Bed-sharing and other same surface-sharing of any kind **is not** recommended, especially during the first four to six months. Infants should **not** sleep in an adult bed, on a couch, in a chair or in any other adult sleep place alone or with another person including another child.

4. **Keep soft objects and loose bedding out of the crib**. Place no objects in or on a crib with a sleeping infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys (or other soft items), crib gyms, mirrors or mobiles. Make sure nothing covers the infant's head. Ensure all bibs, necklaces and garments with ties or hoods are removed from a sleeping infant. Dress the baby in sleep attire not requiring blankets or covers such as using a sleep sack (see additional information below).

5. **Pregnant women should receive regular prenatal care**.

6. **Avoid smoke exposure during pregnancy and after birth**. Always place the crib in an area that is smoke-free.

7. **Avoid alcohol and illicit drug use** during pregnancy and after birth.

8. **Breastfeeding is recommended**. Breastfeeding is considered a protective factor against SIDS and is recommended for at least the first six months of infant life.

9. **Consider offering a pacifier at nap time and bedtime** (after breastfeeding is established). At sleep time, only offer an infant a clean, dry pacifier that does not attach to the infant's clothing. Attaching mechanisms such as cords and strings pose a strangulation risk. The pacifier does not need to be reinserted once the infant falls asleep. If an infant refuses the pacifier, do not force him or her to take it. If you are breastfeeding, wait until your baby is used to breastfeeding before trying a pacifier.

10. **Avoid overheating the infant.** For an infant's warmth and comfort, use only sleepers, sleep sacks and wearable blankets that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face. Avoid overheating and overdressing the infant throughout the day as well as the night. Infants typically only need one more layer of clothing than an adult would need in order to be comfortable. There is not enough conclusive evidence to recommend for or against swaddling; however, if parents swaddle their infant, they should be advised of the proper method, continue to avoid overheating and should typically discontinue the practice no later than 3 to 4 months of age.

Case study demonstration: "In the case of a 3-month-old boy found dead while sleeping alone in an adult bed, despite a bassinet noted in the same room, his father had surrounded him with pillows to prevent him from rolling. Moreover, he was placed in prone position, and it was noted that the father had "placed baby on stomach because he had just fed him and 'he did not want the baby to spit up and choke' if he placed him face up."

(Hackett et al., 2014)

11. **Do not use home cardiorespiratory monitors as a strategy for reducing the risk of SIDS.** Do not use home heart or breathing monitors or infant positioning devices (i.e., wedges) unless the infant's primary care physician provides a written statement authorizing such use. The written statement must include instructions on how to use the device and a timeframe for use.

<u>Practice Guidance for Direct Services Staff and Non-Direct Services Staff</u>

Direct services and non-direct services staff within the Division of Family and Children's Services have significant opportunities to interact and provide education and awareness with current and prospective parents and caregivers on infant safe to sleep practices. It should be noted that parents are not the only people to receive guidance on safe to sleep practices because infants are often cared for by other caregivers such as family members and friends as well. Therefore, it is necessary that **all infant caregivers** are aware of the safe

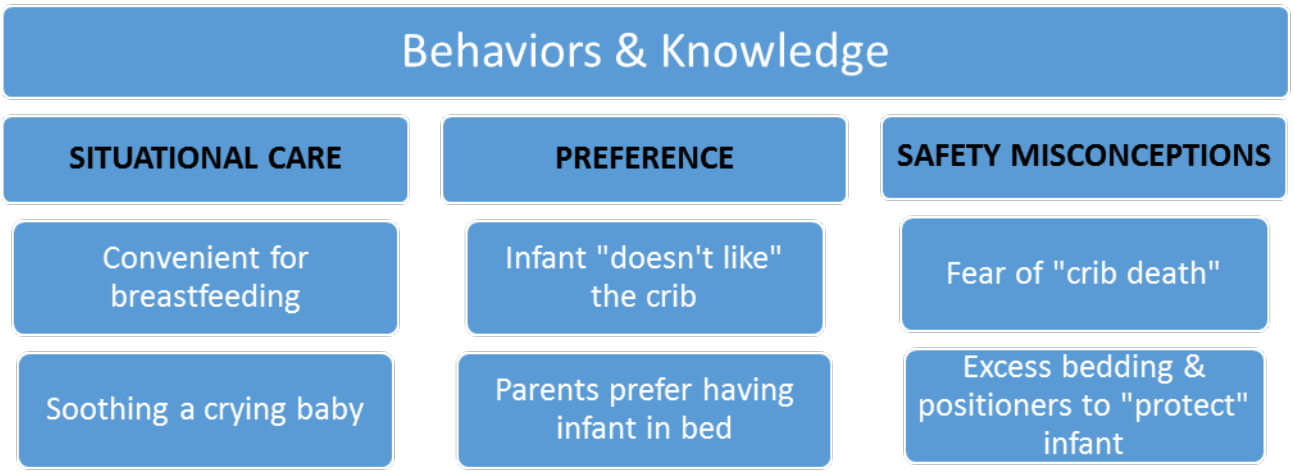
sleep recommendations and follow the parents' decisions regarding safe sleep for their child. The following steps will assist you when discussing infant safe to sleep strategies with families:

Step 1: Understand why some parents may not follow the recommendations

Understanding the parent's/caregiver's behaviors and knowledge and the barriers for either following or not following the recommendations is critical to addressing this issue.

In the instance of the case study as noted above, the father was trying to protect his child. The pillows, however, caused an unsafe situation due to the possibility of suffocation. Laying the baby on his stomach and on an adult bed added additional risks. It is also common for caregivers to lay their baby back to sleep and in a crib only at nighttime. The baby is frequently laid on other surfaces for naptime, and often, due to the perception of better comfort, the baby is laid on his stomach. Caregivers should be reminded that it is back to sleep for every sleep.

The chart below helps to conceptualize some of the reasons parents and caregivers choose unsafe sleep behaviors that do not follow the AAP recommendations.



A parent's/caregiver's behavior is influenced by his or her knowledge but also by other factors, including situational care, preference and safety misconceptions, which are all of value when discussing safe to sleep practices. Parents or caregivers would like to be treated as if they are capable of making appropriate decisions regarding their child especially with an issue such as sleep. The recommendations are not mandated, but are suggested and recommended, and ultimately remain entirely the choice of the parent/caregiver. Acknowledging their fears and misconceptions allows the parents/caregivers to understand

the situation which then helps to empower them in making healthy decisions for their child(ren).

Another area of importance to remind parents/caregivers is that the recommendations are not necessarily forever. The most vital time for vigilance is the first four to six months. Once an infant is able to roll over back to front and front to back, studies show that there is no need to reposition the baby. Additionally, the majority of SIDS/SUIDS deaths occur in infants under 6 months.

Step 2: Increase your awareness

Become familiar with the current AAP recommendations (listed above) and infant safe sleeping practices before engaging caregivers. Understand how to explain the recommendations to parents and caregivers in a manner that promotes acceptance of protective behaviors by completing the following:

1. Participate in training as provided by the DFCS Education and Training website on Safe to Sleep for Infants.
2. Review available materials for additional educational information (e.g., brochures and websites such as the National Institute of Child and Health Development website at http://www.nichd.nih.gov/sts/materials/Pages/default.aspx.)
3. Learn about local resources to assist parents/caregivers with newborn care (e.g., parenting classes, crib distribution, etc.)

Step 3: Share what you have learned

1. Discuss safe infant sleep practices with parents/caregivers during all contacts of a parent/caregiver of a child under the age of 1 with the agency (e.g., direct services staff during home visits, etc. and Office of Family Independent staff (OFI) during applications, renewals, etc.).
    a. Respectfully engage parents/caregivers in a conversation about the connection between sleeping practices and sleep-related infant death.
    b. Share videos and written material on the subject of safe infant sleep practices and how they help reduce SIDS and SUID.
2. Refresh the parent's/caregivers' memory of safe to sleep practices during any interaction to promote retention.

3. Ask parents/caregivers to describe specific steps they will take (starting today) to create a safe sleeping environment for their infant(s).

4. Ask parents/caregivers if any assistance or resources are needed to implement their plan of action.

5. Provide caregivers with links to community and national resources that may provide helpful information and support (e.g., Department of Public Health's Safe Sleep Liaison or Child Injury Prevention Program, DFCS Safe Sleep Liaison, Department of Early Care and Learning for child care and safe care for home visitation services, etc.).

6. Advise parents/caregivers to ensure that everyone who cares for their infant is aware of safe to sleep practices for infants and is committed to following them during all sleep times.

7. Discuss any issues or concerns regarding parent/caregiver responses with a supervisor to determine the appropriate intervention.

Step 4: Document and monitor how parents/caregivers respond

Social Services, Direct Services Staff:

1. Document in the case record when and where discussions regarding safe infant sleep practices are conducted.

2. Document in the case record how the parents/caregivers respond to the information shared, including but not limited to:

    a. The parent's/caregiver's prior knowledge of safe infant sleep practices;

    b. Expressions or signs of disagreement with any of the recommendations for creating a safe sleep environment for their infant(s);

    c. The parent's/caregiver's willingness to implement any of the infant safe to sleep recommendations; and

    d. Are the parents/caregivers able to demonstrate an understanding of the recommendations by being able to explain how each recommendation supports a safe sleeping environment for their infant?

3. Discuss any issues or concerns regarding parent/caregiver responses with a supervisor to determine the appropriate intervention.

Step 5: Other recommendations to share on infant well-being to share with caretakers:

Social Services, Direct Services Staff and Non-Direct Services Staff:

1. Place infants on their stomachs when they are awake and being supervised. This helps the infant's head, neck and shoulder muscles become stronger and helps prevent Positional Plagiocephaly or flat spots from developing on the infant's head.
2. Monitor recommended immunizations which may help protect against sudden infant death syndrome (SIDS).
3. Smoking should not occur by anyone near an infant.
4. Support parents who want to breastfeed or feed their children breast milk.
5. Have a plan to respond if there is an infant medical emergency.

What Does a Safe Sleep Environment Look Like?

Source: http://www.nichd.nih.gov/sts/about/environment/Pages/look.aspx

Safe Sleeping Practices in Group Settings

The aforementioned infant safe to sleep practices are universal and may be applied in any setting. However, there are specific guidelines that are applicable in group settings such Family Child Care and Group Child Care centers. Below are links to access the specific guidelines for these types of licensed facilities and the page number on which the Safe Infant Sleep and Resting Requirements begin.

- **Family Day Care Home**

  http://www.decal.ga.gov/documents/attachments/FDCHRulesAndRegulations.pdf

- **Group Day Care Home**
  http://www.decal.ga.gov/documents/attachments/GDCHRulesandRegulations.pdf

Links to Useful Resources

For more information about the prevention of sleep related deaths, please visit the following websites:

- Division of Family and Children Services - http://dph.georgia.gov/safetosleep
- Department of Public Health - http://dph.georgia.gov/safetosleep
- The U.S. Consumer Product Safety Commission: http://www.cpsc.gov/en/Safety-Education/Safety-Guides/Kids-and-Babies/Cribs/
- American Academy of Pediatrics: http://www.aappolicy.org
- 2011 AAP Expanded Recommendations: www.pediatrics.org/cgi/doi/10.1542/peds.2011-2284
- Georgia Department of Early Care & Learning (DECAL): http://www.decal.ga.gov/
- Georgia Department of Public Health (DPH): http://dph.georgia.gov/safetosleep
- National Institute of Child Health and Human Development (NICHD) Safe to Sleep Campaign: http://www.nichd.nih.gov/sts/Pages/default.aspx

References

- Willinger, M., James, L.S., & Catz, C. (1991). Defining the sudden Infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of Child Health and Human Development. *Pediatr Pathol, 11(5)*, 677-684.
- SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. Task Force on Sudden Infant Death Syndrome. *Pediatrics.* Originally published online October 17, 2011. DOI: 10.1542/peds.2011-2284. Retrieved March 10, 2015, from http://pediatrics.aappublications.org/content/128/5/e1341.full
- New York State Office of Children and Family Services; Administrative Directive Safe Sleeping of Children in Child Welfare Cases, February 2013.
- Moon, R., & Fu, L. (2012). Sudden Infant Death Syndrome: An Update=.*Pediatrics in Review, 33*, 314-314.
- Mosley, J., Stokes, S., & Ulmer, A. (2007). Infant Sleep Position: Discerning Knowledge From Practice. *American Journal of Health Behavior, 31*(6), 573-582.
- Moro reflex. (2013). Retrieved from http://www.nlm.nih.gov/medlineplus/ency/article/003293.htm
- Ostfeld, B., Esposito, L., Perl, H., & Hegyi, T. (2010). Concurrent Risks In Sudden Infant Death Syndrome. *Pediatrics, 125*, 447-453.