


**DEPARTMENT OF HUMAN RESOURCES
SOCIAL SERVICES ADMINISTRATION
311 WEST SARATOGA STREET
BALTIMORE, MARYLAND 21201**

DATE: September 1, 2015

POLICY #: SSA - CW # 16-06

TO: Directors, Local Departments of Social Services
Assistant Directors, Local Departments of Social Services
Foster Care Supervisors, Local Departments of Social Services

FROM: Drew McKone, Chief of Staff 
Office of the Secretary

RE: Public Treatment Foster Care Program

PROGRAMS AFFECTED: Out-of-Home Placement Services

ORIGINATING OFFICE: Office of Child Welfare Practice and Policy

ACTION REQUIRED OF: All Local Departments

ACTION DUE DATE: September 15, 2015

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PURPOSE:

The purpose of this Policy Directive is to standardize policy and procedures for public treatment foster care programs. Public treatment foster care programs (PTFC) are treatment programs that are operated and administered by local departments of social services that have been approved by the Social Services Administration to administer a treatment foster care program. This policy directive pertains to the following policies and procedures:

- Eligibility determination
- Payment rates
- Treatment foster parents and homes
- Treatment Plans
- Treatment Teams
- Documentation and Review

BACKGROUND:

Public treatment foster care is a 24-hour substitute care program operated by a local department of social services (LDSS) for children with serious emotional, behavioral, medical or psychological conditions. It is a program designed to provide a high level of treatment services in a family setting. Treatment is defined as the coordinated provision of services and use of procedures designed to produce a planned outcome in an individual's behavior, attitude, or general condition based on a thorough assessment of possible contributing factors. Treatment services are provided according to a written treatment plan. An emotional or behavioral condition alone does not warrant treatment foster care. The emotional or behavioral condition must be serious. A serious emotional, behavioral condition means the limitation of an individual's capacity which adversely affects the individual's ability to perform:

- Daily living skills;
- Community living skills;
- Interpersonal relationships; and
- Appropriate educational activities.

Treatment foster care (TFC) should not be a continuous program. Only on rare occasions should a child's specific condition and care warrant extended continuity of the program. It is not simply more intensive foster care. Treatment foster care placement is a more restrictive placement and so must be justified in the record with an eligibility determination and a justification for payment different from the regular board rate. The need for treatment must be clearly documented in the record and reviewed periodically. Due to the complexity of the Public Treatment Foster Care program, a child should not be determined to be eligible simply because he/she may need therapy or be on a medicinal regime. A gradual discharge plan or "step-down" plan must be developed for all children who are placed in a public treatment foster care home when treatment is needed for emotional, behavioral and/or psychological conditions. The following Local Departments of Social Services operate Public Treatment Foster Care programs:

- Anne Arundel County Department of Social Services

- Baltimore County Department of Social Services
- Cecil County Department of Social Services
- Garrett County Department of Social Services
- Montgomery County Department of Health and Human Services
- Somerset County Department of Social Services

ELIGIBILITY:

According to COMAR 07.02.21.06A, a child is eligible for treatment foster care who:

1. Is committed to the LDSS or placed with the LDSS under a voluntary placement agreement and has one or more of the following conditions:
 - a. A serious medical condition including, but not limited to:
 - (i) HIV positive and symptomatic or has AIDS,
 - (ii) Multiple handicaps, or
 - (iii) A symptomatic drug-exposed newborn; or
 - b. A serious emotional, behavioral, or psychological condition including:
 - (i) Psychiatric diagnosis by appropriate qualified professionals, or
 - (ii) A developmental disability; or
2. Is in need of a high level of treatment in a family setting.

A serious medical condition includes the medically fragile child. **Medically Fragile** for the purpose of Treatment Foster Care is defined in COMAR 07.02.12.02. Medically fragile refers to a child or children:

1. Dependent at least in part of each day on mechanical ventilation;
2. Requiring prolonged intravenous administration of nutritional substances or drugs;
3. With daily dependence on other device-based respiratory or nutritional support, including tracheotomy tube care, suctioning, oxygen support, or tube feeding;
4. With prolonged dependence on other medical devices that compensate for vital body functions and who require daily or near daily nursing care, including:
 - a. Infants requiring apnea or cardio-respiratory monitors,
 - b. Children requiring renal dialysis as a consequence of chronic kidney failure, and
 - c. Children requiring other mechanical devices such as catheters or colostomy bags, as well as substantial nursing care in connection with the disabilities; or
5. With an unstable medical condition that requires ongoing, close medical monitoring and supervision.

PROGRAM APPLICATION AND DETERMINATION OF TREATMENT FOSTER CARE ELIGIBILITY:

Each local department operating a Public Treatment Foster Care program shall establish a Gate-keeping system (herein referred to as the Gatekeeper). The system may consist of one or more persons with the responsibility of screening a child into the Public Treatment Foster Care program. Only children in the custody of the local Department of Social Services that operates

the Public Treatment Foster Care program can be referred for placement. The screening consists of:

- Determination of Treatment Foster Care Eligibility
- Acceptance and placement in the Public Treatment Foster Care Program.

To apply to a public treatment foster care program, the child's caseworker must complete a DHR/SSA 818 (See Attachment A). The Gatekeeper shall use the DHR/SSA 818 to evaluate the child's eligibility to be a treatment foster child. According to COMAR 07.02.21.06A and 07.02.21.07 the local department of social services determines whether a child is eligible for the treatment foster care program. The local department determines eligibility according to COMAR 07.02.21.06A as delineated above. The determination must be documented in the child's record and include:

- Child's foster care or voluntary placement status,
- Documentation of serious medical, emotional, behavioral or psychological condition, or developmental disability. This shall include documentation from medical professionals of the serious medical condition and/or documentation from a psychiatrist, psychologist or other qualified professional (such as a social work clinician) of serious emotional, behavioral or psychological condition or developmental disability,
- Documentation that the child is in need of a high level of treatment in a family setting. This should indicate that the child requires a high degree of supervision and care and that a family can meet the child's treatment needs in the home.

The Gatekeeper shall respond in writing to the submitting caseworker. The response shall state that the child's needs are or are not at the public treatment foster care level. The fact that an infant may have been or has been exposed to alcohol or drugs does not make that infant automatically eligible for treatment foster care. If the child's needs require public treatment foster care level services, the response shall also state whether or not there is an appropriate placement available through the public treatment foster care program, or if the DHR/SSA 818 should be forwarded to all appropriate private treatment foster care programs. If it is determined that the child's needs are greater than the services provided through a public treatment foster care program, then the gatekeeper will advise the referring caseworker to seek a more restrictive level of placement (i.e. therapeutic group home, residential treatment center, hospitalization). If the child's needs are not treatment level, the response shall clearly state the reasons why and suggest services and/or funding that may aid a foster/adoptive family in meeting the needs of the child. The response should also include the opportunity for the caseworker to request a review of the decision with the administration of the local department of social services operating the program. Only children in the custody of the local department of social services operating the public treatment foster care program may be referred for treatment level services within that program.

DETERMINATION OF SERVICE INTENSITY LEVEL:

Service Intensity Level determination is an evaluation of the child's condition and needs, and the intensity of services needed to meet these needs. This evaluation is conducted by using the Service Intensity Level Indicators (SILI) (See Attachment B). The Service Intensity Level Indicators are divided into two main categories: Primary and Secondary. In each category there are different levels of indicators that reflect medical, emotional, behavioral and psychological conditions.

When determining the service intensity level, all the child's conditions according to the SILI are considered, however, the Level should be determined by the highest needs level in which the majority of needs are listed. If there is a single indicator that is higher and the need for services for that indicator is prevalent, then the Level should be at that higher level. The Primary Indicators are given the greatest level of consideration when determining the Level, but the Secondary Indicators can make the difference in the level when the Primary Indicators are spread and varied among the levels or when two levels are very close. Secondary Indicators represent those needs and influences, which should also be considered in Level determination, but do not carry the same determination weight as Primary Indicators. A child's strengths must also be considered in determining the Level.

There are four Service Intensity Levels, with Level I being the least intense level and Level IV being the most intense level. ***A child cannot enter the Public Treatment Foster Care Program on Level I.*** Level I is reserved for those children transitioning out of Treatment Foster Care, whether they are being stepped down to regular foster care or leaving the foster care system completely. The determination of a Level is necessary not only to formulate a service and treatment plan for the child, but also to set the public treatment foster care rate.

The determination of eligibility and the Level must be documented in MD CHESSIE. The gatekeeper will complete the Treatment Service Information Form for the child's record (See Attachment C). This form documents the eligibility determination and Level. Measurable outcomes for treatment are also to be entered on this form.

TREATMENT FOSTER CARE PAYMENT RATES:

Local department of social services treatment foster parents are paid both a board rate and a treatment foster care difficulty of care stipend. The board rate for a child determined to be eligible for treatment foster care is the Specialized Care Board Rate as set forth in SSA Circular Letter #11-19.

In addition to the board rate, the local department treatment foster parent will also receive a treatment foster care difficulty of care stipend. For those treatment foster care homes approved prior to the enactment of this policy directive, the amount of the stipend is determined by the local department's stipend rates and the needs of the child. For those treatment foster care homes approved after the issuance of this policy directive, the stipend is determined by the needs of the child according to the child's service intensity level. There are four levels:

TFC Level I (maintenance plus) \$350
TFC Level II (maintenance plus) \$500
TFC Level III (maintenance plus) \$650
TFC Level IV (maintenance plus) \$800

The TFC level which includes the stipend amount should be clearly conveyed to the treatment foster parent, as well as the circumstances under which the intensity of the child's services may be reduced to regular foster care, in which case the treatment foster care stipend would be no longer applicable. A step-down in intensity level should not preclude the child's ability to remain in the same TFC home. Such possibility should clearly be explained to the treatment foster parent who must agree to accept the terms.

All treatment foster care payments shall be made monthly and paid on a per diem basis. Payments will be for the previous month. The department may pay the **per diem board rate** for up to 30 days if the child is temporarily out of the placement as stated in COMAR 07.02.11.34C (2). However, the **treatment foster care stipend** is payable only for the times the child is residing in the placement. The local department may pay a per diem for any days that the treatment foster parent must be in attendance for training or assistance if the child is temporarily placed outside the home, in which event, the caseworker must end-date the TFC Level placement and enter a new regular foster care placement.

PERIODIC REVIEW FOR CONTINUED TREATMENT FOSTER CARE ELIGIBILITY:

The continued eligibility of a child for treatment foster care must be reviewed periodically (See Attachment D – Treatment Foster Care Periodic Review Form). This review must at a minimum be part of the 6-month re-evaluation, but can be done more often as part of the quarterly treatment team review, or as a separate review conducted by the local department. The child's record should document the continued eligibility and the periodic review in the case plan, in the treatment team minutes, or as a separate document. The child's condition, care needs, and progress should be taken into consideration when reviewing the child's continued eligibility for treatment foster care. The Periodic Treatment Review form is to be kept in the MD CHESSIE file cabinet with the Treatment Information Form. This form provides a place for documentation of changes in the child's service needs, level, and measurable outcomes. The review must include an assessment and determination about whether the child's progress indicates a reduction in service intensity level or discharge from treatment foster care. The Maryland Child and Adolescent Needs and Strengths (MD CANS) assessment must be completed for children over the age of five every six months in accordance with Policy Directive SSA# 12-14.

TREATMENT FOSTER CARE BED LIMITATIONS:

COMAR 07.02.21.09 limits the treatment foster home to two treatment foster care beds. The skill and training of the treatment foster parent(s) and the treatment and care needs of the child should inform the decision regarding the bed allowance. The full number of children in the home is limited by COMAR 07.02.25.13A (5) to six. This includes all the children in the treatment foster parents' home and the two treatment foster children. However, COMAR

07.02.25.13C (4) provides that the resource parent may care for a total of eight children if the foster care children include a sibling group.

It is important to place siblings together. This could mean the placement of a non-treatment foster child in a treatment foster home with his/her sibling. COMAR 07.02.21.06B allows for the placement of a non-treatment sibling in a treatment foster home. Documentation in MD CHESSIE should reflect that the treatment foster parent has been made aware, in advance of placement, that they will be reimbursed at the regular board rate (or intermediate if appropriate) for the non-treatment foster child and will not receive a treatment foster care TFC Level payment for the sibling.

BED LIMITATION EXCEPTIONS:

The local department may grant an exception to the public treatment foster care bed limitation under certain circumstances. One such circumstance is for the placement of a sibling in the same treatment foster home. A granted Exception is specific to the treatment foster home and children as listed on the Exception. Any change to the make-up of the public treatment foster home renders the Exception invalid and a new Exception would need to be pursued if appropriate.

An Exception may also be granted for a teen parent in treatment foster care and his/her infant, if the infant was born while the teen parent was in the treatment foster placement and the infant will be living in the home with the teen parent. The Exception request would need to clearly justify the placement and include verification that the treatment foster parent understands that their role for the infant is that of a regular foster parent and they would be responsible for the infant's care, including any necessary day care. If the infant is not committed to the local department, he/she would be the responsibility of the teen parent. The treatment foster parent would still receive a regular board rate for the infant under the Minor Mother Policy. The caseworker must complete a service log each month to reimburse the foster parent using the service, Minor Parent /with Child, if the infant is not committed. If the infant is committed, complete a regular foster care placement.

TREATMENT FOSTER PARENTS:

Treatment Foster Parents are foster parents who are approved by the Public Treatment Foster Care program to provide treatment foster care services. Only the jurisdiction operating the public treatment program may approve a treatment foster home. Referrals for regular foster parents to become treatment parents must be made in writing with the decision to approve or disapprove resting with the public treatment program gatekeeper. An approved regular foster/adoptive parent must complete an additional 8 hours of pre-service training, including CPR training within 60 days of approval. The reconsideration period should be adjusted to treatment approval date. Treatment foster parents are limited to an approval for two treatment foster placements, with the opportunity for a 3rd child in the case of an approved exception as detailed in the prior section.

Treatment Foster Parents' responsibilities include implementation of the treatment regime that is conducted in the home and monitoring the child's overall progress. COMAR 07.02.21.10 makes

the treatment foster parent responsible for treatment team meeting attendance and participation, and for keeping a systematic record of the child's behavior. Depending on the child's treatment needs and program, this record may be on a weekly, daily or even an hourly basis. Additional responsibilities of the treatment foster parent are included in the Treatment Foster Parent Agreement and Addendum (See Attachments E and F respectively).

RESPITE CARE:

COMAR 07.02.21.08 requires the treatment foster care placement provider (local department of social services) to provide treatment foster parents with both planned and crisis respite. Local departments and private providers with treatment foster care programs should develop respite family resources for all TFC parents. If a treatment child is particularly difficult to provide care for, an individual respite resource for that child may need to be developed.

Planned respite should be provided at a minimum of two days each month. The rate for local department treatment foster homes is \$50 per diem per child. The frequency of planned respite should be determined at placement of the child and be part of the treatment foster parent agreement for that particular child.

Crisis respite services must be determined dependent on the crisis and the child or children involved. The regular respite payment rate should be used for crisis respite if possible.

VISITATION:

COMAR 07.02.21.08A(3) and (5) require that the local department caseworker assigned to the home visit the treatment foster parents twice a month and that the child's caseworker have face-to-face contact with the child at least twice a month. The record must reflect the content of the contact that constitutes a visit. Documentation of a visit should include some indication of the discussion between the local department caseworker and the child/treatment foster parent. Contacts, such as taking a child to an appointment, without meaningful discussion will not be sufficient to constitute a visit. Visits should be made to assess progress or lack of progress in achieving the goals and outcomes identified in the treatment plan.

TREATMENT PLAN:

The treatment plan and the treatment team are essential to treatment accountability regarding the individual treatment foster child. The Treatment Plan is a written description of the objectives, goals, and services to address the needs of a child, including the child's projected length of stay in the program. The treatment plan provides the measurable time limited goals and written procedures for the child's treatment. The treatment team assesses the progress or lack of progress in achieving the outcome goals set forth in the plan.

A written treatment plan is required for each child in the treatment foster care program and must be developed within 30 days of acceptance in the program. See (Attachment G) for the recommended elements of a Treatment Plan. Public TFC programs may adopt their individual version of a Treatment Plan format, but it must contain all elements required for a treatment plan as stated herein. In order to define the role of the treatment foster parent in the child's treatment regime, the treatment plan should include:

- A. Child's diagnosis and treatment;
- B. Role of the treatment foster parent;
- C. Role of the caseworker;
- D. Specific tasks to be carried out by treatment parents during placement;
- E. Long-term goals of treatment, including criteria for discharge, projected length of stay in the program, projected post-treatment, aftercare services; and
- F. Identification of treatment team members who will assist in the provision of services.

(B-F are in accordance with COMAR 07.02.21.11)

- A. Child Diagnosis/Treatment Needs: This includes the specific diagnosis for the child and the details of the child's treatment and care needs. The service and treatment needs of the child are the major factors in determining placement in the appropriate treatment foster home or with a Purchase of Care Child Placement Agency (POC) and the roles and duties of the treatment foster parent.
- B. Role of Treatment Foster Parent: The role of the Treatment Foster Parent should be clearly defined in the treatment plan. The foster parent is a member of the service team for this child and the responsibilities should be made clear, including monitoring expectations. The role should be defined as related to the overall treatment plan and the care needs of the child.
- C. Role of Caseworker: For those local departments of social services with a treatment foster care program, the treatment foster care caseworker's responsibilities are delineated as those of the provider agency case manager. The LDSS may reference COMAR 07.02.21.08 A & B regarding caseworker roles to include in the treatment plan.
- D. If a child is placed in a public treatment foster care program across jurisdictions, including those placed by jurisdictions who are members of a multi-county program, the county operating the public TFC program will act as the case manager and the placing jurisdiction will have the responsibilities listed for the local department caseworker.
- E. If a child is placed in a public treatment foster care program by the operating county, the acceptance of the child in the treatment program must specify if TFC program staff is to assume any of the local department caseworker responsibilities.
- F. Specific tasks of the treatment foster parent: Any specific skills or additional training needed by the treatment foster parent should be identified in this section. Actions and services that the treatment foster parent will be required to perform should be listed in detail. Included should be even minute details such as, who will transport the child to medical visits and what meetings the treatment foster parent must attend on behalf of the child. Also listed should be any reporting requirements for the treatment foster parent. The reporting requirements would include documentation of any required monitoring by the treatment foster parent. Specific tasks of the treatment foster parents regarding training of the child for routine activities should also be included in this section.

G. Long-term goal of treatment: This includes the criteria for discharge from treatment foster care, the projected length of stay in the program, projected post-treatment services, and aftercare services/discharge criteria.

- 1) Criteria for discharge from program: This includes a description of what constitutes progress for the child to be discharged from the treatment foster care program. Also included are the expected treatment outcomes for the child. These should be detailed in the treatment plan. If the child requires treatment indefinitely, then the maintenance goals should be clearly listed. Re-evaluation of the child's eligibility for the treatment foster care program should be included.
- 2) Projected length of stay in the program: Each child's treatment plan must include a projection of how long the child will need the treatment. Children should not be placed in the treatment foster care program long-term. The stay in treatment foster care should be limited to decrease the child's level of care. There will be some children who will need treatment foster care indefinitely, this must be clearly stated and justified. However, the majority of children do not need long-term treatment foster care services. The time projections must be part of the treatment plan.
- 3) Projected post treatment services: Details should be included regarding any projected post treatment services such as specialized medical or somatic services, or continued therapeutic services after the treatment program is completed. These services could be ongoing or for the length of stay in foster care only. A timeframe should be included if appropriate for post treatment services.
- 4) Aftercare services and discharge criteria: This is the aftercare plan for the TFC child, whether the child is moving on to some type of permanence from TFC or the child is being stepped down to regular foster care. This should be a separate document. However, the treatment plan should acknowledge the discharge criteria and aftercare plan and also identify treatment team members who will assist in the provision of the planned care. According to COMAR 07.02.21.06C(2)(b) the aftercare plan should include:
 - The name, address, telephone number, and relationship of the individual to whom the child is being discharged,
 - A summary of the services provided during care,
 - A summary of the growth and achievements of the child during care and identified needs of the child which remain unmet and recommendations for services not available from the new placement.

The Treatment Plan must be reviewed on a regular basis. This review can take place as part of the 6-month re-evaluation, as part of the quarterly treatment team review, or as a separate review conducted by the local department at least annually. The child's record should document the review of the treatment plan in the form of an amended or revised treatment plan, in the treatment team minutes, or as a separate document.

TREATMENT TEAM MEETINGS:

Part of the duties of the treatment foster care placement provider indicated in COMAR 07.02.21.08A is to convene a team to evaluate the child's treatment plan at intervals not to exceed three months. If the child is part of the local department's treatment foster care program, then it is the local department's responsibility. The quarterly team meeting should include a review of the child's treatment plan. This review should examine the continued appropriateness of the plan based on the child's needs, progress made and any additional activities that should be added to the plan. The team meeting should result in a confirmation of the treatment plan being continued as is, amended, or revised. The team meetings provide the forum for all those involved in the child's treatment to discuss the treatment and the child's progress or changing needs. The team should regularly, at least every six months, determine and document the continued need for treatment foster care or if the child is ready for step-down or in need of step-up.

TREATMENT TEAM MEMBERS:

The Treatment Team convenes to evaluate the child's treatment plan at intervals not to exceed three months. Team members include:

- The treatment foster care caseworkers, including caseworkers assigned to the child and home,
- Parents or legal guardians, if appropriate,
- PTFC parents, and
- Any therapist, psychologist, psychiatrist, physician or professional involved in providing treatment services.

The Treatment Team includes but is not limited to the local department of social services, treatment foster parents, therapist and any other professional involved in the child's treatment. Each member of the treatment team has specific and general responsibilities in the treatment program of the particular child. The general role is to participate in treatment team meetings and contribute input regarding the child's needs, reactions to treatment and progress. The specific responsibilities are determined by the role of the team member. All members of the Treatment Team must be notified and invited. The child's record shall include documentation that all team members were invited to the meeting and that they were notified of the opportunity to share information regarding the child by other means, such as a letter, email, fax, or phone call in lieu of their attendance. See Attachment H for a Treatment Team Meeting Cover Sheet recommended format, which would fulfill all documentation requirements. Use of the Treatment Team Meeting Cover Sheet is not required, however, the local department must properly document both invitation and notification of all Treatment Team members.

RECORD DOCUMENTATION:

MD CHESSIE must contain a treatment plan for the child that is current within the last 6 months. Treatment team meetings, attendance and membership are also to be documented in the case record. While each person involved with the treatment of the child may not be able to attend the meeting, the record should reflect that each team member was notified of the meeting.

Documentation of team meetings must include indications of treatment plan review (confirmation that the current plan continues, a revised treatment plan or an amended treatment plan) and it should include minutes or notes.

The child's record must contain all record documentation requirements of COMAR 07.02.11.22. Additionally, the record must contain written documentation of eligibility for the public treatment program and documentation of a periodic review/assessment of continued eligibility for treatment foster care.

Treatment team meeting results may be filed in Section 9 (Case Conference Summaries). The treatment plan and eligibility determination may be filed in Section 12-Health or with the current case plan in Section 1.

ADMINISTRATIVE MONITORING:

SSA will monitor Public Treatment Foster Care Program cases on a regular basis, using the Business Objects Report RE 858. The TFC Coordinator may be contacted regarding questions related to format, schedule and review instrument.

Inquiries regarding Treatment Foster Care should be addressed to:

Shirley Brown
Public Treatment Foster Care Coordinator
Social Services Administration/Placement Services and Inter-Agency Initiatives
311 West Saratoga Street, 5th Floor
Baltimore, Maryland 21201
(410) 767-7152

REFERRAL UPDATE FOR PURCHASE OF CARE

Attachment A

To: _____
(Private agency or institution)

Worker's Name: _____

From: _____
(Local Department Of Social Services)

Phone Number: _____

Address: _____

Supervisor's Name: _____

Phone Number: _____

Date: _____

I. CHILD:

Name _____ Race _____ Date of Birth _____

II. REASON FOR REQUESTED CARE:

a. Need for and recommended type of institutional placement.

b. Present needs and behavior of the child and potential problem areas with the child and/or the child's relationship to significant others.

III. ATTITUDE TOWARD PLACEMENT:

a. Indicate child's attitude toward, and/or involvement in, the placement being proposed.

b. Indicate parent's attitude toward the placement being proposed and willingness for continuing involvement.

IV. CURRENT INFORMATION ON THE CHILD:

a. If child is living away from own home, give a brief description of child's behavior, relationships, and attitudes in most recent setting.

b. Describe the child's characteristics, which include: hobbies, problems, and special abilities.

c. Health: Physical and Mental.

1. Include: Current report of physical examination, TB test, and copy of immunization record.

2. List any unusual health problems: allergies, VD, disabilities.

3. Medication - if child is on medication, give name, dosage, and name of prescribing physician.

d. Type of school placement recommended.

e. Parent Surrogate appointed by Board of Education:

Yes [] No []

Name: _____

Address: _____

Phone Number: _____

f. Attach current caseplan forms, school reports and/or report cards, IEP, and if indicated, psychiatric and/or psychological reports.

V. CURRENT INFORMATION ON CHILD'S FAMILY:

a. Give a short description of the child's *current* natural family situation, and the child's relationship to his/her family.

This referral is approved by: _____

Date: _____

Purchase of care basic rate: _____

Special Services as Billed: _____

Social Work: _____

Health Related: _____

Special Education: _____

Co-Funding: _____

Service Intensity Indicators by Life Domain

- Behavioral/Emotional (Primary)
- Physical/Medical (Primary)
- School (collateral consideration indicator)
- Family and Significant Others (collateral consideration indicator)
- Strength Indicators (contributing determination factor)

Primary Indicator Considerations

A. Behavioral/Emotional Intensity Indicators

Level I

- Difficulty with adjustment to home
- Wanders
- Responds to authority despite verbal opposition
- Anxiety
- Age appropriate social development
- Difficulty in relationships with others
- Inconsistent development of age appropriate relationships
- Minor attachment problems
- Difficulty following schedules/time frames
- Some impulsive behaviors
- Poor personal hygiene
- Immaturity
- Infrequent temper tantrums
- Emotional response to discipline
- Withdrawn
- Denies problems which require treatment

Level II

- Oppositional defiant
- Mild retardation – behavior outcomes
- Stealing (emotional behavior)
- Crave/demands excessive attention
- Non-physical aggressive towards others
- Moderately retarded
- Inappropriate sexual promiscuity
- Infrequent drug/alcohol use induced behavior
- Risk taking behaviors
- Age inappropriate Enuresis/Encopresis
- Teen mother placed with child requiring intensive supervision

Level III

- Occasional and/or minor destruction of property
- Troubled peer relations
- Depression
- Frequent temper tantrums (can be verbally de-escalated)
- Chronic emotional problems
- Does not respond when disciplined
- Verbally abusive
- Extreme behavior with enuresis/Encopresis
- Stealing and lying without remorse
- Chronic runaway

Level IV

- Suicidal
- Physically assaultive with peers and/or adults
- Frequent drug/alcohol use or addiction
- Diagnosed severe mental illness – acute phase
- 5 or more disrupted placement in last year due to behavior
- Sexual aggressiveness or extreme misconduct
- Acute depression
- Unresponsive to any adult authority
- Extreme and dangerous risk taking behavior
- Frequent and intense temper tantrums of length and duration to require physical restraint
- Fire setting
- Maiming/killing small animals
- Extreme and/or threatening verbal abuse
- Child replaced from institutional setting
- Acting out sexually (open intercourse or masturbation, physically harmful masturbation)
- Extreme attachment disorder
- Severe age inappropriate Enuresis/Encopresis
- Diagnosed severe psychosis
- Self-mutilation
- Severe attention and hyperactivity problem (interferes with daily function or poses continual danger to self or others)

B. Physical/Medical Intensity Indicators

Level I

- Failure to thrive – responsive to treatment
- Feeding problems
- Premature – low birth weight (infants)
- Developmental delay/ mental retardation
- HIV+ (non-symptomatic)
- Wheel chair dependent
- Enuresis/Encopresis (consistent with age)
- Drug exposure (infant)
- Apnea monitor
- Diabetes – easily controlled
- Reactive allergies (occasionally life threatening)

Level II

- Medically obese, malnourished (current)
- Asthma – requiring frequent medical attention and/or hospitalization
- Ongoing physical or occupational therapy by caretaker
- Seizure disorder – controlled
- Fetal alcohol syndrome
- Severe age inappropriate Enuresis/Encopresis

Level III

- Diabetes – frequent medical attention and/or hospitalization
- Chronic disease/disorder requiring regular intervention by caretaker
- Anorexia/bulimia
- AIDS – symptomatic
- Seizure disorder – uncontrolled
- Level IV

Level IV

- Technology dependent
- Total care dependent
- Severely obese-malnourished – extreme physical disability or limitation
- Chronic physical bodily system failure
- Physical conditions with imminent surety of death
- Chronic disease/disorder requiring frequent hospitalizations (including transplants, chemotherapy, radiation treatment)

Collateral Considerations

A. School Intensity Indicators

Level I

- Achieving academically in school placement (regular or special education placement)
- Minimal problems on bus
- Behavior stable in school placement (regular or special education placement)

Level II

- Chronic truancy
- Occasional behavior problems
- Refuses to complete homework
- Need for crisis intervention
- Inappropriate school placement
- Chronic problems riding bus
- Resistant to school attendance

Level III

- Numerous major behavior problems
- Bus suspension
- Drop out
- School phobia

Level IV

- Frequent suspension from school
- Expulsion
- Home and hospital teaching

B. Family/Significant Others Intensity Indicators

Level I

- Family not able to care for child
- Routine visitation/contact
- Actively involved in planning for child with facility or agency

Level II

- Pattern of unkept promises to child
- Routinely misses appointments without prior notification
- Refuses to acknowledge problems that caused child to enter care

Level III

- Undermines plans for child
- Inappropriate interaction with child
- Conflict among family members over child
- Chronic drug/alcohol use
- Serious adverse reaction by child to visitation/contact

Level IV

- Terminally ill parent
- Supervised visitation required or no visitation allowed
- Threat to child's safety
- Pattern of drugs/alcohol use during contact with child/caretaker

Strength Indicators

(Contributing Factors For Level Determination)

- Accepts authority – cooperative
- Charming personality – engaging
- Makes and keeps friends – ability to form relationships
- Ability to transition – cooperates with change
- Verbal – expressive
- Honest
- Eager to learn
- Pro-social
- Creative, artistic, musical
- Resourceful
- Good athletic ability
- Good cognitive skills
- Sleeps well, eats well (infant and toddler – toilet trained)
- Accepts responsibility
- Good physical health

Treatment Service Information Form

Attachment C

Child's name	DOB	ID#
Caseworker	TFC Application Date	TFC Acceptance Date

Eligibility	<p>I. Determine child's eligibility for Treatment Foster Care in accordance with COMAR 07.02.21</p> <p>1. <input type="checkbox"/> Child qualifies for foster care placement AND</p> <p>2. (check all that apply)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Medically Fragile</td> <td><input type="checkbox"/> Developmentally Disabled</td> </tr> <tr> <td><input type="checkbox"/> Serious Medical Condition</td> <td><input type="checkbox"/> Serious Psychological/behavioral/emotional Condition</td> </tr> </table> <p>AND</p> <p>3. <input type="checkbox"/> Child in need of high level of treatment in a FAMILY setting</p> <p>Child must have a box checked in 1, 2 and 3 in order to meet basic eligibility criteria for Treatment Foster Care.</p>	<input type="checkbox"/> Medically Fragile	<input type="checkbox"/> Developmentally Disabled	<input type="checkbox"/> Serious Medical Condition	<input type="checkbox"/> Serious Psychological/behavioral/emotional Condition
	<input type="checkbox"/> Medically Fragile	<input type="checkbox"/> Developmentally Disabled			
	<input type="checkbox"/> Serious Medical Condition	<input type="checkbox"/> Serious Psychological/behavioral/emotional Condition			
	<p>II. Describe in detail how child meets the Eligibility Criteria</p>				
<p>III. Diagnosis Documentation</p> <p>Diagnosis completed by :</p> <p>Dated: _____ Copy in Diagnosis in Record: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Give a short summary of the diagnosis:</p>					
<p>IV. Alternate Service Options:</p> <p>Explain why the child's needs cannot be met with a regular foster family placement and additional services.</p>					

Service Intensity Level Indicators	Primary Indicators		
	Physical/Medical	Emotional/Behavioral	
	Secondary Indicators		
	Family and Significant Others	School	Strength Indicators

Level of Care	Entry Level: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV (Note: Child cannot enter on Level I – should be regular foster care intermediate level)			
	Level	Projected Date*	Actual Date	Progress/Regress
	I			
	II			
	III			
	IV			
Enter the word "INITIAL" as the projected date for entry level				

Measurable Outcomes:	<p>List the measurable outcomes of treatment for the child. The outcomes should take into consideration needs, strengths, behavior frequency and intensity. The outcomes should be based on services provided by the Treatment Team members.</p>
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Treatment Foster Care Periodic Review Form

Attachment D

Child's name	DOB	ID#	
Caseworker	TFC Application Date	TFC Acceptance Date	
I. TREATMENT TEAM RECOMMENDATION: <input type="checkbox"/> Child should be assessed by Gatekeeper for Service Intensity Level Change <input type="checkbox"/> Child should <ul style="list-style-type: none"> <input type="checkbox"/> Remain at current level <input type="checkbox"/> Increase level <input type="checkbox"/> Decrease level <input type="checkbox"/> Child recommended to be reviewed by Gatekeeper for continued Treatment Foster Care eligibility (change to Regular Foster Care) <input type="checkbox"/> No recommendation received from Treatment Team			
CURRENT LEVEL: <input type="checkbox"/> LEVEL II <input type="checkbox"/> LEVEL III <input type="checkbox"/> LEVEL IV			
Service Intensity Indicators			
Primary Indicators			
Physical/Medical		Emotional/Behavioral	
Secondary Indicators			
Family and Significant Others		School	Strength Indicators
REVIEW OF MEASURABLE OUTCOMES FOR CHILD			
Measurable Outcome	Progress/Regress	New Outcome Measure (date)	Pertinent to Step-down (yes/no)

Treatment Foster Care Periodic Review Form

GATEKEEPER FINDING:

_____ (CHILD'S NAME) IS

- Child should remain eligible for Treatment Foster Care Program and should
 - Remain at current level
 - Increase level
 - Decrease level
- Child no longer meets Treatment Foster Care eligibility and should be removed from the Treatment Program with an appropriate Treatment Aftercare plan
- Child continues to meet the eligibility requirement for Treatment Foster Care, but has need of a more restrictive placement with more intense services. Recommended that a (*check all that apply*) group home, assisted living unit, residential treatment center, or hospital placement be sought to meet the treatment and care needs of this child.

_____ GATEKEEPER

_____ DATE

Treatment Resource Parent Agreement

It is our/my desire to become a Treatment Resource Parent for the Department of Social Services (henceforth known as the Department). In so doing I/we understand that both I/we and the Department of Social Services have certain responsibilities with regard to any treatment foster child(ren) placed in my/our home. This agreement is by and between the Department, herein and hereinafter referred to as the Treatment Resource Parent(s) (henceforth known as Treatment Parents). This agreement constitutes my/our understanding as to the specific nature of those responsibilities.

I/we understand that the legal custody of any child placed in my/our home remains with the Department. I/we understand that foster care is a temporary situation and as Treatment Parents I/we agree to fully cooperate with the Department in its effort to reunify the child(ren) with his/her family. I/we understand that by becoming approved as Treatment Parents for the Department, we shall not be permitted to be licensed or approved by any other agency providing foster care, adoption or child placement services. I/we understand that I/we will NOT be permitted to provide day care for children.

I/we understand that as Treatment Parents, my/our role is to provide intensive temporary care to the child who cannot remain in his/her home. The care I/we provide is designed to meet the needs of the child's physical disabilities, emotional disturbances, behavioral problems, mental retardation care or other medically fragile condition. I/we understand that each child placed with me/us will be evaluated and assessed on a regular basis, including treatment team meetings, with the goal of stepping the child down in services and reducing the treatment foster care stipend.

LOCAL DEPARTMENT OF SOCIAL SERVICES RESPONSIBILITIES

In consideration for the special services expected in the care of a treatment foster child with special needs, the Department shall:

1. Provide a "Difficulty of Care Stipend" based upon the care needs of the child, as documented on the Treatment Resource Parent Addendum for each child placed, in addition to the regular board rate payment.
2. Provide reimbursement at the rate designated by the Maryland Department of Human Resources for travel mileage reimbursement for the transportation of the child(ren) to medical dental, and therapy appointments, as well as other meetings on behalf of the children.
3. Provide planned respite for days every month/ months at a rate of \$30.00 per bed per diem, and supplemented by the local department at the rate of per bed per diem. The Department reserves the right to allow limited grouping of planned respite only according to available resources.
4. Provide emergency respite at the rate of \$30.00 per bed per diem.
5. Review the child's needs and progress at regular intervals, and reserve the right to change the treatment foster care status of the child. If a child's treatment intensity is decreased, the Treatment Parents will be given the opportunity to either continue the placement of the child at the reduced difficulty of care stipend rate, or request that the child be replaced to another home.
6. Reserve the right to remove a child at the Department's discretion. The child shall not to be moved from the Treatment Parents home by anyone other than the child's worker without the written permission of the Department.
7. Provide regular consultation and case management two times per month.
8. Provide pre-service and in-service training opportunities.
9. Provide detailed information about the child placed in the Treatment Parents' home, including special needs and treatment expectations of the TFP regarding the child.
10. Conduct an annual reconsideration of the home to determine the continued appropriateness for Treatment Foster care home status.

11. Assist treatment resource parents in making referrals for additional evaluations and services if needed.
12. Provide planned and crisis respite care when needed.
13. Remain on-call to assist in crisis situations on a 24-hour basis.
14. Provide board rate payments which include a clothing allowances, and medical assistance to cover needed medical and dental care.
15. Provide Medical Assistance card and Health Passport for each child placed in the care of the Treatment Parents.
16. Assign a social worker to the child. This worker will provide guidance, support and supervision to meet the child's needs. This worker shall have ultimate authority in all matters and decisions regarding the child placed within the foster home.
17. Assign social worker for my/our foster/adoptive home. This worker will provide general guidance and support to us in our role as foster/adoptive parents. This worker may be the same as the worker assigned to the child placed in your home.
18. Establish a visitation plan for each child with his/her natural family, through the child's assigned caseworker. The plan will be developed in conjunction with the foster family and may include visits with the parents in the foster/adoptive home if deemed to be appropriate by the child's worker. The Department shall notify the foster/adoptive family of all Court Hearings to which they are entitled to notice pursuant to statute.
19. Retain the right to remove any child from my/our foster/adoptive home at its discretion or in order to comply with an Order of the Court.
20. Notify me/us as promptly as possible when a child is to be removed from our home.
21. Provide direction and support to me/us when I/we identify problems with the child in my/our care or which affect my/our ability to continue to be foster/adoptive parents.

TREATMENT RESOURCE PARENT RESPONSIBILITIES

Whenever a treatment foster/adoptive child is placed in my/our home, I/we shall:

1. Participate in a minimum of 20 hours of treatment foster care related training approved by the Department every year and to participate in any specialized training specific to a treatment child placed in my/our home when required by the Department.
2. Reserve bed space for one/two treatment foster children in my/our home with the understanding that I/we must fully explain any refusal of the placement of a child in my/our home for which I/we have received proper training to meet his/her care needs.
3. Provide 24-hour supervision with the understanding that one or both parents may work outside the home. One parent must be available for the child(ren) 24 hours a day for all emergencies, health/mental health appointments, and family visits.
4. Attend and participate in all interdisciplinary team meetings, treatment team meetings and all therapy sessions arranged by the worker and therapist as requested.
5. Work as a member of the Treatment Foster Care Team in developing an individual treatment plan for each treatment child placed in my home.

6. Work as part of the Treatment Foster Care Team for each treatment child placed in my home. This will include participation in quarterly Treatment Team meetings to develop and/or review the treatment plan and implement relevant parts of the treatment plan at home.
7. Monitor the implementation and progress of any treatment or behavior plan in the home and to provide documentation of said monitoring to the Treatment Team and the Department.
8. Provide transportation to and from medical and mental health appointments and to meet with the therapist after each therapy session or as needed.
9. Participate in the development and implementation of behavior management programs when recommended, including but not limited to maintaining behavior records as needed.
10. Dispense any prescribed medication and keep a log of the medication, reactions, complications, behavior changes, etc. Also to store medications in a safe manner as directed by the Department of medical professionals.
11. Attend school meetings if requested to do so (i.e. ARD meeting IEP meetings, Disciplinary actions meetings).
12. Participate in two days of respite care each month. I/we understand that it presents undue hardship on the agency to forego several months and group respite times together. To do so will require planning with the treatment child's caseworker and advance notice. The grouping of respite days will be denied if care arrangements are not available or reasonable for the department.
13. Notify the agency caseworker should any emergency situation arise such a medical emergencies, runaways, or incidents requiring police involvement or intervention.
14. Coordinate participation in recreational and leisure time activities to develop independence and self-esteem.

In addition, as a Treatment Resource Parent, I/we also has the following responsibilities toward a foster/adoptive child placed in the home:

1. To act as a reasonable substitute for the child's natural parents.
2. To accept the foster child as an important member of their family and attempt to help them with their problems and make decisions in their best interests.
3. To immediately inform the Department of any changes in the foster/adoptive child's circumstance and of any major and significant decisions regarding the child and his/her well being.
4. To share with the Department all information and documentation about the child in order to enable the department to provide for the child's needs.
5. To allow visits between the natural family and the foster child in the foster/adoptive home when appropriate and to cooperate with the visitation plan established for the child and family by the Department or ordered by Court.
6. To share appropriate information regarding the child's progress with the natural parents after consultation with the Department.
7. To uphold the child's and natural family's right to confidentiality and agrees not to divulge to others confidential information about the child and his/her family learned from the Department or other sources.
8. To independently pursue adoption, guardianship, or custody for any child placed in the foster home without first notifying the Department and obtaining the Department's written consent for such action.
9. To notify the Department within five working days of any changes in personal circumstances, including but not limited to: health, finances, household composition (addition or removal of individuals from our home), legal issues,

or any other factor which may impact on the ability of the foster/adoptive family to care for the children placed in the home.

- 10. To abide by the prohibition against any type of corporal punishment for foster children and to seek assistance of the Department's staff when dealing with disciplinary problems. The prohibition against corporal punishment precludes any type of hitting a child with the hand or any other implement, the use of physical exercise such as running laps or push-ups for the purpose of punishment, requiring a child to remain in an uncomfortable position for extended periods of time, the use of force to force compliance with any punishment, the shaking of a child, placement in a locked room and the use of any mechanical or physical restraints. Also prohibited is the use of verbal abuse, comments meant to degrade a child or his/her family, the denial of any essential service or program or the denial of meals, clothing, bedding, sleep, mail, visits with the natural family or threatening the child with the loss of his/her placement in the foster home.
- 11. To provide updated medical evaluations for all household members every two years after initial licensure or whenever requested by the Department.
- 12. To undergo criminal background checks including fingerprinting when requested by the Department, as well as all household members over the age of 18.
- 13. To comply with any additional requirements which the department may determine are necessary for specific children placed in my/our home.

I/we have read the above and agree to follow the terms of this Foster/Adoptive Parent Agreement. I/we understand that the Department's continued approval of our home for the placement of children may be denied for among other things our failure to adhere to the terms of this agreement.

Resource Parent 1: _____ Date

Resource Parent 2: _____ Date

Social Worker: _____ Date

Supervisor: _____ Date

Treatment Plan Elements

The process of child diagnosis/treatment needs includes the specific diagnosis for the child and as much of the details of the child's exact treatment and care needs as possible. The service and treatment needs of the child is the major factor in determining placement in the appropriate treatment foster home or with the Purchase of Care Child Placement Agency (POC) that can most succinctly meet the child's treatment needs, and the roles and duties of the treatment foster parent.

Role of Treatment Foster Parent: The role of the treatment foster parent should be clearly defined in the treatment plan. The foster parent is a member of the service team for the child, and the responsibilities should be made clear, including monitoring expectations. The role should be defined as related to the overall treatment plan and the care needs of the child.

Specific Tasks of Treatment Foster Parent: When the foster parent needs specific skills or additional training in the care of the child, they should be listed in this section. Actions and services that the foster parent will be required to perform should be listed in detail. Including such minute details such as who will transport the child to medical visits, and what meetings the foster parent must attend on behalf of the child. Also listed should be any reporting requirements of the foster parent. Reporting requirements would include documentation of any required monitoring by the foster parent. Specific tasks of the foster parents regarding training of the child for routine activities should also be included.

Role of Caseworker: The role of the caseworker is divided into two areas: the placement provider caseworker/manager and the local department caseworker. For those local departments of social services with a treatment foster care program, the responsibilities may be either by the treatment foster care caseworker, or if appropriate divided between the continuing foster care caseworker and the treatment foster care caseworker. In such instances, the treatment foster care caseworker's responsibilities are delineated as the placement provider caseworker/manager.

1. Role of the Placement Provider Case Worker/Manager

- Develop treatment plan within 30 days of acceptance (in conjunction with LDSS)
- Convene a team, including but not limited to LDSS, treatment parents and therapist (counselor, psychologist, etc.) to evaluate child's treatment plan (3 month intervals)
- Visit treatment parents twice monthly
- Provide child access to medical care
- Face to face contact with child twice monthly

- Provide services to child's biological family as required in permanency and treatment plans
- Attend citizens review board meetings, administrative hearings and court hearing
- Provide advance notice to LDSS regarding changes such as revisions to treatment plan, changes in placement, placement location or visitation plans
- Provide LDSS a written progress report every 3 months
- Provide treatment parents access to both planned and crisis respite care
- Maintain a written pre-service training curriculum

2. Role of LDSS Caseworker

- Participate in the development of a treatment plan with the provider agency
- Develop a permanency plan within 30 days (involving the provider agency in the permanency planning process)
- Inform citizen review board and court of child's placement with provider agency
- Review with provider case manager the quarterly progress reports
- Depending on child's legal status and permanency plan, meet with child and biological family every 6 months in consultation with child's case manager to update treatment plan
- Attend citizen review board meetings, administrative hearing and court hearings
- Meet with child in placement at minimum once every three months (efforts should be made to visit child in placement after any placement change regardless of 3 month time frame)

NOTE: LDSS TFC caseworker still has same service and documentation requirements as traditional foster care (including visits and permanency planning)

3. Long-Term Goal of Treatment: This includes the criteria for discharges from treatment foster care, the projected length of stay in the program, projected post treatment, and aftercare services/discharge criteria.

- Criteria for discharge from program: This includes a description of what constitutes progress by the child to be discharged from treatment foster care program. Also included are the preferred outcomes from the treatment. These should be as detailed as possible in the treatment plan. If this child will require treatment indefinitely, then the maintenance goals should be clearly listed. Some references should also be made to re-evaluation of the child's eligibility for the treatment foster care program.
- Projected length of stay in the program: Each child's treatment plan must include a projection of how long the child will need the treatment. Children should not be placed in the treatment foster care program and left there. The time in the treatment foster care should be limited to the time necessary for the intense services to address the child's needs. There will be some children who will need this level of service

indefinitely, this must be clearly stated and justified. However, the majority will not. The time projections must be part of the treatment plan.

- **Projected post treatment:** Details should be included regarding any projected post treatment services such as specialized medical or somatic services, or continued therapeutic services after the treatment program is completed. These services could be ongoing or for the length of stay in foster care only. A timeframe should be included if appropriate for post treatment services.
 - **Aftercare services and discharge criteria:** This is the aftercare plan for the TFC child, whether the child is moving on to some type of permanence from TFC or the child is being stepped down to regular foster care. This should be a separate document, however, the treatment plan should acknowledge the discharge criteria and aftercare plan and also identify those treatment team members who will assist in the provision of the planned care. According to COMAR 07.02.21.06C(2)(b) the aftercare plan should include:
 - The name, address, telephone number, and relationship of the individual to whom the child is being discharged,
 - A summary of the services provided during care,
 - A summary of the growth and achievements of the child during care, and identified needs of the child which remain unmet and recommendations for services not available from the new placement.
4. **Identification of treatment team members:** This should include all responsible persons involved in the treatment plan for the child. Includes, but is not limited to parent(s) or legal guardian(s), treatment parents, therapists or clinicians, medical or mental health professional, teachers, mentors, and monitors.

The Treatment Plan must be reviewed on a regular basis. This review can take place as part of the 6-month re-evaluation, as part of the quarterly treatment team review, or as a separate review conducted by the local department at least annually. The child's record should document the review of the treatment plan in the form of an amended or revised treatment plan, in the treatment team minutes, or as a separate document.

Treatment Team Meeting Cover Sheet

Child Name	ID #
Caseworker	Meeting Date

Name	Invitation Type & Date	Response	Attendance Signature

Comments: