


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

DATE: March 1, 2018

POLICY #: SSA-CW #18-15

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

FROM: Rebecca Jones Gaston 
Executive Director
Social Services Administration

RE: Local Department Referrals to Private Treatment Foster Care Programs

PROGRAMS AFFECTED: Out-of-Home Placement Services

ORIGINATING OFFICE: Office of Child Welfare Practice and Policy

BACKGROUND: Original Policy

ACTION REQUIRED OF: All Local Departments

ACTION DUE DATE: Immediately

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Purpose

The purpose of this Policy Directive is to standardize policy and procedures governing Local Department of Social Services referrals to Private Treatment Foster Care programs. Private Treatment Foster Care programs are treatment programs that are operated and administered by private child placement agencies that contract with the state of Maryland to deliver services for the placement of children in foster care, treatment foster care, adoption, and independent living programs.

Background

Private Treatment Foster Care is a 24-hour substitute care program, operated by a licensed private child placement agency, designed to provide a high level of treatment services in a family setting for children with serious emotional, behavioral, medical or psychological conditions. 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, behavioral, medical or psychological condition alone does not warrant treatment foster care. The emotional, behavioral, medical or psychological condition must be "serious". A serious emotional, behavioral, medical or psychological condition is evidenced by 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 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 intense foster care. Treatment foster care placement is a more restrictive placement and so must be justified in the case 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 case record and reviewed periodically. Because of the complexity of the 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 treatment foster care home when treatment is needed for emotional, behavioral and/or psychological conditions.

Eligibility

According to COMAR 07.02.21.06A, a child is eligible for treatment foster care if the local department determines that the child:

1. Is committed to the LDSS or qualifies for foster care under COMAR 07.02.11.04 and has one or more of the following conditions:
2. 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
3. A serious emotional, behavioral, or psychological condition including:
 - (i) Psychiatric diagnosis by appropriate qualified professionals, or
 - (ii) History of an ongoing substance abuse problem; or
 - (iii) Developmental disability; or
4. 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 purposes of Treatment Foster Care is defined in COMAR 07.02.12.02(B)(22). 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 on a daily basis; or
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.

Referral Process

- A. The local department shall:
 1. Determine that a child is eligible for treatment foster care; and
 2. Send each potential provider agency, which has contracted with the Department of Human Services and with which the local department seeks to place a child, the following:
 - a) A referral for purchase of care;
 - b) A current case plan drafted within 180 calendar days before the date of referral;
 - c) Relevant medical records within 1 year before the date of referral to the provider agency; and

- d) The psychological or psychiatric evaluations performed within 1 year before the date of referral to the provider agency if eligibility is based on a serious emotional, behavioral, or psychological condition.

B. A provider agency shall:

- (a) Have a written admission policy which includes the acceptance criteria; and
- (b) Respond in writing to the referring agency within 14 working days, accepting or denying admission of a child and giving the reason for a denied admission.

A child placement agency may not accept for placement youth parents with infants or children, including pregnant youth, unless the agency is licensed to provide parent-child foster care.

Post-Acceptance Responsibilities

A. The Local Department shall:

- (1) Within 30 calendar days of the child's acceptance by the provider agency, develop a permanency plan in conjunction with the provider agency;
- (2) Inform the foster care review board and the court of a child's placement with the provider agency and the name of the child's case manager;
- (3) Review quarterly, with the child's provider agency case manager, the written progress report on the treatment plan;
- (4) Meet with the child and the child's biological family every six months in consultation with the child's provider agency case manager to update the plan; and
- (5) Attend foster care review board hearings and court hearings.

B. The provider agency shall:

- (1) Within 30 calendar days of a child's acceptance into the program, develop a treatment plan in conjunction with the local department;
- (2) Convene a team, including but not limited to the local department of social services, treatment parents, and therapist to evaluate each child's treatment plan at intervals not to exceed 3 months;
- (3) Visit the treatment foster parents at least twice a month;
- (4) Provide a child access to medical care;

- (5) Have face-to-face contact with a child at a minimum of twice a month;
- (6) Provide services to the biological family of a treatment foster care child as required in the permanency and treatment plans;
- (7) Attend foster care review board hearings and court hearings;
- (8) Provide advance information to the local department on changes affecting services to a child which could result in revisions to the treatment plan, such as changes in placement, placement location, or visitation plans;
- (9) Provide the local department with a written progress report on the treatment plan every three months;
- (10) Provide the treatment foster parents all medical and psychological information necessary for the care of a child;
- (11) Provide treatment foster parents access to both planned and crisis respite care of their treatment foster children; and
- (12) Maintain a written pre-service and in-service training curriculum specific to the population serviced.

Treatment Foster Care Bed Capacity Exceptions

COMAR 07.02.21.09 sets a limit of two foster children to be placed in a treatment foster care home. The Social Services Administration may grant an exception to the treatment foster care limitation of two foster children and allow the placement of only one additional child. The Social Services Administration may also grant an exception for the placement of a minor mother and her infant child in a treatment foster home if the home is not part of a Minor Mother Program. A granted exception is specific to the treatment foster home and children as listed on the exception request form. Any change to the make-up of the treatment foster home renders the exception invalid.

Legislation passed in 2017 raised the limit to three foster children who may be placed together without the requirement of an exception when placing siblings together. Accordingly, a local department may place up to three children who require treatment in an eligible treatment foster care home if at least two of the children are siblings and it is in the best interests of the siblings to be placed together.

The treatment foster placement agency and the local department must jointly prepare the Exception Request Packet (DHR/SSA Form 1310). Either the treatment foster placement agency or the local department may submit the completed Packet to the appropriate OLM Licensing Coordinator. The submitting party is responsible for gathering all information and documentation, including written acknowledgement from all local departments having children

placed in the home in question. The form must be completed electronically. The submitted packet must include DHR/SSA Forms 1310-A, B, C, and D to be considered complete. Incomplete packets will be returned without consideration.

Valid documentation of a determination on each treatment child in the home and the child for which an exception is requested is stated in COMAR 07.02.21.06 as:

- Documented serious medical condition;
- Documented serious emotional, behavioral or psychological condition (documentation must include psychiatric diagnosis by appropriate qualified professionals);
- Documentation of need of a high level of treatment in a family setting;
- Written policy for planned discharge of child from treatment program (documentation that discharge plan revisited on regular basis).

Factors considered by the Social Services Administration in the approval or disapproval of an exception include but are not limited to the following:

- Sibling placements;
- Child's eligibility for Treatment Foster Care services;
- Treatment needs of child and other children in home;
- Skills and abilities of Treatment Foster Parent;
- Previous exception requests for child/siblings;
- Services needed and offered for Treatment children and family;
- Changes in Treatment foster parent responsibility.

Exceptions are granted only with Supervisory approval at the local level. Exceptions are for non-related children only. No more than a total of two non-related treatment foster children with special needs or three treatment level siblings may reside in a home at the same time. TFC families with two or more children are not to be used as respite families for an additional child.

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 treatment foster care. In order to define the role of the treatment foster parent in the child's treatment regime, the treatment plan shall include:

- A. Child's diagnosis and treatment;
- B. Role of the treatment foster parent;
- C. Role of the provider;
- 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 planned care.

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. 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, 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 includes but is not limited to the child's TFC case manager, local department of social services case worker, treatment foster parents, therapists, 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 and 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 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.

TFC Program Aftercare

There are two instances where a child is considered to be in TFC aftercare. This does not equate to the level of aftercare services for foster care. If a child is “stepped” up into a more intensive living arrangement (i.e. therapeutic group home, RTC) or “stepped” down into regular foster care, the treatment program should hold that child in treatment aftercare status for up to 3 months. This is to aid in the transition of services, whether the services are more or less intense or down to regular foster care. The responsibilities of the treatment case manager would be limited to maintaining visitation levels and assisting the new caseworker in assuming responsibility for case management for the aftercare period to ensure that the child transitions successfully.

Retention of Jurisdiction

The LDSS shall retain responsibility for the permanency plan and sufficient involvement with the child to determine all matters relating to custody, supervision, care, treatment and disposition of the child’s care. This responsibility will be retained until the child is returned home, placed with relatives, adopted, reaches majority age, becomes self-supporting, discharged with the concurrence of the appropriate authority (if placement from another state) or the case is rescinded by court order.

Record Documentation

The record 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 from team meetings must include indications of treatment plan review (confirmation the current plan continues, revised treatment plan or 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. Additionally, the record must contain written documentation of eligibility for the private 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.

MD CHESSIE

Documentation of all Treatment Team Meetings and Treatment Plan Reviews shall be recorded in MD CHESSIE. The documentation of Contacts shall include all members of the team that participated in the meeting and outline the results of the meeting. A copy of the treatment plan shall be scanned into the file cabinet in MD CHESSIE. The paper copy of the treatment plan shall be placed in the paper record.

