State 0f Michigan Department of Health and Human Services
Bureau of Grants and Purchasing (BGP)
PO Box 30037, Lansing, MI 48909
Or
235 S. Grand Avenue, Suite 1201, Lansing, MI 48933

CONTRACT NUMBER: RFCAN xxx
Between
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
And

CONTRACTOR	PRIMARY CONTACT	EMAIL
xxx	xxx	xxx

CONTRACTOR ADDRESS	TELEPHONE
xxx	- -

STATE CONTACT	NAME	TELEPHONE	EMAIL
Contract Administrator	xxx	- -	xxx@Michigan.gov
BGP Analyst	xxx	- -	xxx@Michigan,gov

CONTRACT SUMMARY			
SERVICE DESCRIPTION	Residential Foster Care Abuse Neglect		
GEOGRAPHIC AREA	Statewide		
INITIAL TERM	EFFECTIVE DATE*	EXPIRATION DATE	AVAILABLE OPTION YEARS
xxx		xxx	2
MISCELLANEOUS INFORMATION			
ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION	$xxx		
CONTRACT TYPE	Per Diem		

The effective date of this Contract shall be the date listed in the "Effective Date" box above, or the date of Michigan Department of Health and Human Services (MDHHS) signature below, whichever is later.

FOR THE CONTRACTOR:

XX

Contractor

Signature of Director or Authorized Designee

Print Name

Date

FOR THE STATE:

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Signature of Director or Authorized Designee

Print Name

Date

Anticipated Total Contract Value: $XX

This Contract will be in effect from the date of MDHHS signature through xxx. No service will be provided and no costs to the state will be incurred before xxx, or the effective date of the Contract, whichever is later. Throughout this Contract, the date of MDHHS signature or xxx, whichever is later, shall be referred to as the begin date.

At the discretion of MDHHS, this Contract may be renewed in writing by an amendment not less than 30 days before its expiration. This Contract may be renewed for up to two additional one-year periods.

1. PROGRAM REQUIREMENTS

1.1. Client Eligibility Criteria

a. Eligible Clients

Services provided by the Contractor under this Contract are limited to those children and families for whom MDHHS can legally provide care and services and for whom MDHHS makes a State payment.

County child-care funded children referred to MDHHS for care and supervision by probate court but for whom MDHHS may have no legal responsibility to make a payment are also eligible clients.

b. Determination of Eligibility

MDHHS shall determine the children and families' eligibility and document this in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS).

1.2. Referrals

The referring MDHHS caseworker/PAFC provider shall provide to the Contractor referral material which complies with this Contract.

a. At the time of referral, the referring MDHHS caseworker/PAFC provider shall provide the Contractor with a referral packet, which shall include:

1) A copy of the commitment order or placement and care order from the court, or appropriate documentation of authorization from the local law enforcement agency.

MDHHS shall not refer a child for placement prior to a fully executed Individual Service Agreement (DHS 3600). In event of an emergency placement, the DHS-3600 shall be fully executed no later than the first working day following placement.

2) A copy of the Case Service Plan (DHS-441), and DHS-69 from prior placement(s) if applicable. If any of these documents are incomplete at placement, the completed materials must be forwarded to the Contractor within 10 business days of the child's placement.

3) A MiHealth card or the Medicaid recipient identification number, if the child is active for Medicaid and the MiHealth card is not available. If the child is to be enrolled in Medicaid, MDHHS shall provide a copy of the Medicaid recipient ID number to the Contractor as soon as it is issued or the status of the Medicaid ID number application of activation.

4) Educational reports, when available.

5) Copies of current Psychotropic Medication Informed Consent (DHS-1643) for current prescriptions. (See FOM 802-1, Psychotropic Medication in Foster Care). The referring MDHHS/PAFC caseworker shall coordinate with the attending medical provider to ensure the child has a minimum of a 14-day supply of prescribed medications AND a prescription for all current medications, OR a 30-day supply of all medications.

6) Child's behavioral history including incidences of aggression, prior hospitalizations, etc.

7) Child's placement history.

8) Treatment plans from prior residential placements.

b. Within 10 business days of a child's placement, the referring MDHHS/PAFC provider shall provide the following:

1) A photocopy of the birth verification or copy of the request for verification. MDHHS shall immediately forward a copy of the birth verification upon receipt.

2) A photocopy of the Social Security Card or verification provided by MDHHS identifying the child's Social Security Number.

3) A copy of the Medical Passport (DHS-221).

4) If available, a copy of the Youth Health and Dental Record or other documentation of physical and dental examination(s) within the past 12 months and history including immunization record.

5) An Initial Placement Outline and Information Record (DHS-3307), if required, and other documentation required by MDHHS policy as specified in FOM.

6) Court studies and reports, when available.

7) Copies of all psychological/psychiatric reports, evaluations, assessments, medication monitoring visits related to mental health care.

8) Psychological assessments are not to be routinely required for intake decision-making. If the Contractor requests a psychological evaluation and the local MDHHS office agrees that a psychological evaluation is appropriate, the local MDHHS office shall arrange and pay for the evaluation within the allowable payment maximum.

   If the local MDHHS office does not agree that an evaluation is necessary, the Contractor is responsible for arranging the evaluation. The cost of the evaluation may be billed to the child's medical insurance provider if the service is covered, if not the costs are covered by the per diem reimbursement rate.

9) Copy of the Child Protective Services Transfer Summary as specified in the FOM 722-01.

10) Exception request approval from DCWL for the placement of an adjudicated delinquent child in an abuse/neglect program. Court order required for the specific contracted abuse/neglect program.

1.3 Admission Criteria

The behavior and diagnoses which the Contractor shall accept are as submitted to DCWL. The criteria as outlined in program information submitted to DCWL shall identify the behaviors and characteristics of children for whom the Contractor can provide services. It is understood by both parties to this Contract that behaviors of one child or some children in a program can affect the Contractor's ability to serve children who are referred subsequently. It is also understood by both parties to this Contract that combinations of behaviors may influence intake decision making.

1.4. Service Planning and Delivery

a. MDHHS shall cooperate with the Contractor in completing the DHS-3600 and developing a service plan for the child and family. MDHHS shall ensure the Contractor receives the DHS-3600 at the time of the child's admission in the identified residential care program type. In event of an emergency placement, the DHS-3600 shall be completed and signed no later than the first working day following placement.

b. When a child is placed in an out-of-county, private, child-caring institution and the MDHHS caseworker may request monitoring service from the local MDHHS office where the child is placed. In that event, the MDHHS caseworker responsible for placement shall ensure that the DHS-3600 clearly states which local MDHHS office is responsible for ongoing monitoring of the child's care, as well as determining if the MDHHS caseworker or the Contractor will be responsible for ongoing service to the child's family. In the event of an emergency placement, the MDHHS caseworker responsible for placement shall ensure that the DHS-3600 is completed and signed no later than the first working day following placement.

c. The MDHHS caseworker/PAFC provider responsible for placement shall review and approve or request modification of the Contractor's 30-day DHS-365 and each DHS-366 submitted by the Contractor.

d. The MDHHS caseworker responsible for placement shall assure that the child has a basic wardrobe, as defined and documented by the DHS-3377 upon entering the Contractor's care.

e. The MDHHS worker responsible for placement, except in emergencies or when constrained by a court order or parental demand, shall give at least 30 calendar days notification to the Contractor of any discharge decision made without the Contractor's concurrence.

f. In the event that the Contractor provides a written notification of the decision to terminate a child's placement in 30 calendar days, the MDHHS caseworker/PAFC provider responsible for placement shall:

    1) Acknowledge receipt of the notification within five business days.
    2) Provide at least weekly contacts with the Contractor to advise of progress in arranging another placement.
    3) Arrange transfer of the child from the Contractor's care within 30 calendar days, unless the MDHHS caseworker/PAFC provider supervising the placement and the Contractor agree in writing on a later date.

g. Upon the Contractor's request, the MDHHS caseworker/PAFC provider shall remove a child who is in danger to himself/herself or others per the conditions specified in Section II. U., 2) of this Contract, within 24 hours.

h. The MDHHS caseworker/PAFC provider responsible for placement shall visit the child every month, which includes observing the child's daily living and sleeping areas (FOM-722-06H, Caseworker Contacts). The Contractor shall allow the MDHHS caseworker/PAFC provider responsible for placement to meet in private with the child during a portion of each monthly visit.

i. The Contractor shall allow the assigned MDHHS caseworker/PAFC provider responsible for placement, or another staff designated by the MDHHS caseworker/PAFC provider responsible for placement, to visit the child face-to-face upon request, and shall provide a place for them to meet privately, if requested.

j. The MDHHS caseworker/PAFC provider responsible for placement shall invite the local community mental health provider the child will be referred to upon discharge to FTM's.

k. The MDHHS caseworker/PAFC provider responsible for placement shall make ongoing efforts to identify a step-down placement for the child upon discharge. The efforts shall be shared with the Contractor during quarterly FTM's.

l. If a MDHHS caseworker/PAFC provider responsible for placement does not meet the responsibilities outlined in this Contract, the Contractor shall notify the local MDHHS office County Director responsible for child welfare case management. If the dispute is not resolved, the Contractor is to contact the MDHHS Director of Field Operations, located in MDHHS Central Office Administration.

1.5. Legal or Court Related

MDHHS shall not transfer legal responsibility for any child to the Contractor except as provided herein.

MDHHS shall involve the Contractor, to the extent allowed by law, in matters relating to any legal or court activities concerning the child while in the Contractor's care. If the Contractor is to be involved in the court proceedings, MDHHS shall provide the Contractor with written reports for court use upon request, subject to confidentiality requirements imposed by statute.

The Contractor shall ensure all directives and services ordered by the court are completed to the satisfaction of the court within the timeframes ordered.

2. CONTRACTOR RESPONSIBILITIES

2.1. Email Address

The Contractor authorizes MDHHS to use the contact information below to send Contract related notifications/information. The Contractor shall provide MDHHS with updated contact information if it changes.

Contact email address:

2.2. Requests for Information

The Contractor may be required to meet and communicate with MDHHS representatives and from time to time MDHHS may require that the Contractor create reports or fulfill requests for information as necessary to fulfill the MDHHS' obligations under statute and/or Dwayne B. v. Snyder, et al., 2:06-cv-13548, herein referred to as the Implementation, Sustainability, and Exit Plan (ISEP).

2.3. Geographic Area

The Contractor shall provide services described herein in the following geographic area: Statewide

The Contractor may, by arrangement with the local MDHHS office and the MDHHS Children's Services Agency, provide services to MDHHS-referred children and families from other areas of the State.

2.4. Licensing Requirements and Number of Children in Care

The MDHHS Division of Child Welfare Licensing (DCWL) is the licensing agency for Child Caring Institutions (CCI). A license is issued to a certain person or organization at a specific location, is non-transferable, and remains the property of the Department. Therefore, an institution must be established at a specific location.

The Contractor shall ensure that, for the duration of this Contract, it shall maintain a license for those program areas and services that are provided for in this Contract. If the Contractor fails to comply with this section, MDHHS may terminate this Contract for default.

The Contractor is licensed to provide service under this Contract under the following license number: xxx

At no time shall the number of children in care exceed the licensed capacity of the facility specified in the Contractor's license. On no day during this Contract period, shall there be more than xxx children in placement for whom MDHHS has the responsibility to make a State payment. MDHHS does not guarantee any minimum number of referrals or children in care at any point in time. If the Contractor is able to admit more than the contracted number of youth (but not

more than the licensed capacity), a Bed Cap Exception must be obtained through DCWL prior to placement.

2.5. Location of Facilities

The Contractor shall provide services described herein at the following location(s):

xxx

2.6. Program Name and Statement

Program Name: xxx

Residential Program Type xxx

The Contractor shall provide MDHHS with copies of its program statements for the program covered under this Contract. The program statement shall comply with the requirements of MDHHS DCWL standards specific to the license listed in Section 2.4 above and with all federal laws related to the mixing of abuse/neglect and juvenile justice programs.

The Contractor shall inform MDHHS of any changes made to the program statement at any point during the term of this Contract and provide copies of the new statement to MDHHS.

2.7. Provider Numbers

MiSACWIS Provider Number: xxx

Bridges Provider Number: xxx

2.8. Credentials

The Contractor shall assure that appropriately credentialed or trained staff under its control, including Contractor employees and/or subcontractors, shall perform functions under this Contract.

2.9. Compliance Requirements

a. The Contractor shall comply with all applicable MDHHS policy Children's Foster Care Manual (FOM) and MDHHS policy amendments, including interim policy bulletins.

b. Throughout the term of this Contract, the Contractor shall ensure that it provides all applicable MDHHS policy and MDHHS policy amendments (including interim policy bulletins) and applicable Administrative Codes to

social service staff. The Contractor shall ensure that social service staff complies with all applicable requirements.

MDHHS policies, amendments and policy bulletins, are published on the following internet link: https://dhhs.michigan.gov/olmweb/ex/html/. Administrative Codes are published at on the following internet link: http://michigan.gov/lara/0,4601,7-154-35738_5698-118524--,00.html

c. Michigan Department of Health and Human Services (MDHHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identity or expression, sexual orientation, political beliefs, or disability.

The above statement applies to all MDHHS supervised children, and to all licensed and unlicensed caregivers and families that could potentially provide care or are currently providing care for MDHHS supervised children, including MDHHS supervised children assigned to a contracted agency.

d. The Contractor shall provide services within the framework of Michigan's Child Welfare Practice Model, MiTEAM. The Contractor shall utilize the skills of engagement, assessment, teaming and mentoring in partnering and building trust-based relationships with families and children by exhibiting empathy, professionalism, genuineness and respect. Treatment planning shall be from the perspective of family/child centered practice.

e. The Contractor shall comply with the following provisions of 2015 PA 53. Specifically, once a Contractor accepts a referral from MDHHS, by doing either of the following:

1) Submitting to MDHHS a written Contract to perform the services related to the particular child or particular individuals that the Department referred to the Contractor; or
2) Engaging in any other activity that results in the MDHHS being obligated to pay the Contractor for the services related to the particular child or particular individuals that the Department referred to the Contractor.

The Contractor acknowledges that it has waived any legal protections under MCL 722.124e, MCL 722.124f, and/or MCL 710.23g to decline to provide such services based on an assertion that to do so would conflict with the Contractor's sincerely held religious beliefs contained within its statement of faith, written policy, or other document adhered to by the Contractor.

f. The Contractor shall ensure compliance with all applicable provisions and requirements of the Dwayne B. v. Snyder, et al., 2:06-cv-13548, Implementation, Sustainability, and Exit Plan.

Additional Compliance Provisions

The contractor shall also comply with the provisions of:

1) 1984 Public Act, 114, as amended being M.C.L. 3.711 *et seq*., Interstate Compact on the Placement of Children.
2) 1975 Public Act 238, as amended, being M.C.L. 722.621 *et seq*., Child Protection Law.
3) 1982 Public Act 162, as amended, being M.C.L. 450.2101 *et seq.,* Michigan Nonprofit Corporation Act.
4) 1994 Public Act 204, as amended, being M.C.L. 722.921 *et seq.,* Michigan Children's Ombudsman Act.
5) 1973 Public Act 116, as amended, being M.C.L. 722.111 *et seq.,* Michigan Child Care Organization Act.
6) 1939 Public Act 288, Chapter X, being M.C.L. 710.1 *et seq.,* Michigan Adoption Code.
7) 1984 Public Act 203, as amended, being M.C.L. 722.951 *et seq.,* Michigan Foster Care and Adoption Services Act.
8) The Social Security Act as amended by the Multiethnic Placement Act of 1994 (MEPA); Public Law 103-382, and as amended by Section 1808 of the Small Business Job Protection, the Interethnic Adoption Provision (IEAP).
9) The Indian Child Welfare Act (ICWA); Public Law 95-608 being 25 U.S.C. 1901 *et seq.*
10) 1976 Public Act 453, as amended, being M.C.L 37.2101 *et seq.,* Elliott-Larsen Civil Rights Act.
11) Fostering Connections to Success Act of 2008
12) Preventing Sex Trafficking and Strengthening Families Act, Federal PL113-183
13) Social Security Act, 42 USC 671(a)(20)
14) 2017 Public Acts 246 through 255, Michigan Opioid Laws
15) Rehabilitation Act of 1973, Section 504 Protecting Students with Disabilities
16) Free Appropriate Public Education (FAPE) as per the Rehabilitation Act of 1973
17) Individuals with Disabilities Act (IDEA)

2.10. Services to be Provided

Services provided under this Contract shall be trauma informed and be evidence-based, evidence-informed or identified as a promising practice to effect optimal outcomes.

A child welfare trauma-informed approach understands and recognizes that the vast majority of children in foster care have experienced complex trauma, which can significantly harm individual and familial development. In response, the Contractor shall educate parents and caregivers on the potential developmental impact of trauma, screen children for trauma, refer or provide clinical trauma assessments, collaborate with mental health providers to link children to evidence-based and supported trauma services, develop resiliency-based case plans and recognize the necessity of building workforce resiliency both at the individual staff and organizational levels.

Services must be delivered according to each child's assessed needs with interventions aligned with the identified needs and desirable outcomes. Resources for evidence-based, evidence-informed interventions and promising practices can be found at:

- American Academy of Pediatrics; http://www2.aap.org/commpeds/dochs/mentalhealth/KeyResources.html
- SAMHSA's National Registry of Evidence-based Programs and Practices; www.nrepp.samhsa.gov
- California Evidence-Based Clearinghouse for Child Welfare; http://www.cebc4cw.org
- The National Child Traumatic Stress Network; www.NCTSN.org
- American Academy of Child and Adolescent Psychiatry (AACAP); www.aacap.org.

The Contractor, within the constraints of the agency's Contract, shall incorporate normalcy activities into residential programing. These activities must comply with the reasonable and prudent parent standard to help children develop skills essential for positive development.

a. Residential Care

The Contractor shall ensure that each child in its care shall be provided with the elements of residential care outlined in the MDHHS DCWL Child Caring Institution standards specific to the license listed in Section 2.4. of this Contract.

The referring MDHHS/Placement Agency Foster Care (PAFC) provider shall identify a residential care program type for each child in its care based on the child's assessment of needs and strengths as well as the treatment plan. The residential care program types are as follows:

1) General Residential
2) Mental Health Behavior Stabilization
3) Developmentally Disabled and Cognitively Impaired
4) Substance Abuse Treatment

5) Sexually Reactive
6) Mother/Baby
7) Specialized Developmental Disability
8) Intensive Stabilization
9) Human Trafficking

Definitions, symptomology, and program specific services which the Contractor must make available to each child in its care are listed in Attachment A of this Contract.

b. Standardized Assessment Tools:

The Contractor shall utilize the following assessment tools to assess the child's needs and strengths while in the residential program:

1) Child Assessment of Needs and Strengths (CANS)
2) Casey Life Skills Assessment (CLSA) or Daniel Memorial Assessment (For children 14 years of age and older)

The Contractor may utilize additional standardized and reliable assessment tools to assess overall progress in functioning. Additional program specific assessment tools are identified within each program type in Attachment A.

The Contractor shall administer the assessment tools within 30 calendar days of admission, and quarterly thereafter until planned discharge. An unplanned discharge is defined as an immediate (one calendar day or less) move from the Contractor's program as directed by the court or caseworker. Children who are Absent Without Legal Permission (AWOLP) are also considered an unplanned discharge.

Throughout the term of this Contract the Contractor shall maintain the capability to provide services 24 hours a day, 365 days a year as specified in the treatment plan for each child and his/her family accepted for care.

The range of services specified within each residential care program type establishes a range and number of services to be provided. Services provided to each child shall be individually determined based on the CANS, and shall be documented in the child's treatment plan.

c. Referral and Intake Process

1) Referral Packet

At the time of referral, the MDHHS caseworker or PAFC provider shall provide the contractor with a complete referral packet as outlined in 1.2 Referral Packet of this Contract.

2) Referral

a) The Contractor shall accept and act on referrals from either a MDHHS caseworker or a PAFC provider upon receipt of a complete referral packet. The referring MDHHS case worker or a PAFC provider shall not be required to complete an application or other Contractor forms for inclusion in the agency case record or agency files or for any other purpose.
b) The MDHHS caseworker/PAFC provider responsible for placement shall be notified, within five working days of receipt of a complete referral packet, see Section 1.2, of:
   a) the decision to set up an initial interview (if needed),
   b) the rejection or acceptance of the child for placement, and if accepted,
   c) the admission date or status on a waiting list.
c) The Contractor shall not accept a child for placement prior to a fully executed Individual Service Agreement (DHS 3600). In event of an emergency placement, the DHS-3600 shall be fully executed no later than the first working day following placement.

3) Intake

The Contractor shall develop an assessment-based treatment plan within 30 calendar days of placement. The Contractor shall document the assessment-based treatment plan on the identified Children's Foster Care Residential Care Case Plan. The Contractor shall ensure that licensed clinical personnel (master's level social worker, master's level counselor, licensed psychiatrist, and/or psychologist) conduct a bio-psychosocial evaluation, or review a recent bio-psychosocial evaluation (within the past year) that includes:

a) Psychiatric history, as necessary.
b) Social history.
c) Mental status examination.
d) Trauma screen and assessment results, if completed.
e) Intelligence and projective tests, if necessary.
f) Behavioral appraisal.
g) Family, environmental, cultural, and religious or spiritual preferences.
h) Educational and vocational goals and needs.
i) Strengths, skills, and special interests.
j) Behaviors that necessitated a more restrictive placement setting for the child.

d. <u>Staffing</u>

The Contractor shall provide trained staff sufficient to adequately fulfill the terms of this Contract and shall demonstrate a good faith effort to recruit and employ staff that reflect the racial, ethnic and cultural composition of the Contractor's client population.

The Contractor shall designate individual(s) trained in making decisions using the reasonable and prudent parent standard and who are authorized to consent to the youth's participation in activities. A designated individual(s) is to be onsite to exercise the reasonable and prudent parent standard. The designated individual shall take reasonable steps to determine the appropriateness of the activity in consideration of the child's age, maturity, and developmental level. The designated individual(s) is to consult with social work or treatment staff members who are most familiar with the child at the residential program in applying and using the reasonable and prudent parent standard.

1) Childcare

Childcare is defined as those activities necessary to meet the daily physical, social and emotional needs of the child. Specific direct care staffing ratios are defined within each program category within Attachment A.

i. Provide a minimum of a half-time (.5 FTE) Permanency/Educational Specialist position for every eight children. Refer to Section 2.10 items n. through u. of this Contract for expected activities.
ii. Assure the availability, within 10 minutes, of on-call Contractor support staff or contracted staff for emergency assistance at all times.
iii. Have available to all staff a written emergency plan for contacting police, fire, or emergency medical staff.
iv. Develop and implement standard operating procedures relative to emergency planning which is shared with all staff and contains at a minimum the following:

i. Procedures that provide direction to staff encountering the following situations:
- Bomb threat/device
- Chemical spill
- Fire
- Natural disaster (tornado, heavy snow, flood, etc.)
- Loss of utilities (heat, electricity, water, or other power outages)
- Other disruptions (hostage situations, armed intruders, etc.)

ii. A list of emergency telephone numbers (Police, Fire Department, Ambulance and Utilities)

iii. Clear direction:
- For emergency evacuation, including type of evacuation and exit route assignments.
- To employees who remain to operate critical plant operations before they evacuate.
- To employees performing rescue or medical duties.
- To ensure notification of administration.
- To account for all children and staff
- For contacting emergency services.
- Notification of the department of the emergency no later than the next business day.

Directions must be placed in areas readily available to staff. The Contractor shall review and annually update (or more frequently as needed) the emergency plans and written directions.

2) Staff Education and Experience Qualifications

a.) All program staff shall possess the following minimum qualifications:

i. A non-judgmental, positive attitude toward children with mental health and behavioral problems
ii. Training, education and experience in the area of human services
iii. Experience working with at risk children and families
iv. Cultural and ethnic sensitivity, as well as diversity competency
v. Knowledge of and skills in the area of mental health, substance abuse, child sexual behavior and child development
vi. Ability to engage with, and relate to, children with multiple problems
vii. Skills in crisis intervention, assessment of potentially violent situations and short-term goal setting

b.) Therapy services shall be provided by one of the following:

i. Licensed Master's Level Social Worker
ii. Licensed Master's Level Counselor
iii. Limited License Master's Level Psychologist
iv. Licensed Psychologist, Ph.D.

v. Limited License Master's Level Counselor or Limited License Masters Level Social Worker under the supervision of a Licensed Counselor or a Licensed Masters Level Social Worker
vi. Psychiatrist trained to work with youth and families; Board Certified in Child/Adolescent Psychiatry is preferred.

If therapy services are subcontracted, the Contractor must ensure the subcontracted provider has the appropriate credentials outlined in this Contract.

c.) The Educational Planner/Permanency Planning Specialist must have a bachelor's degree in a human services/education field.

3) Staff Training Requirements

The Contractor shall provide 50 hours of training during a new hire's first year of employment. The Contractor shall provide a minimum of 40 clock hours within the first 30 calendar days of employment. Sixteen of the 40 hours of training shall occur prior to direct care staff having contact with children. The remaining hours shall be completed prior to the end of the first year of employment.

a) Orientation shall include topics identified in R400.4128, as well as the Child Protection Law, Mandated Reporting Requirements, Family/Child/Youth Engagement, Interpersonal Communication, Appropriate discipline, crisis intervention, child handling and de-escalation techniques and basic group dynamics.

b) A minimum of 25 hours per year of staff development shall be provided to direct care staff.

c) Based on the assessment of a staff persons identified training needs, annual training topics shall be selected from but not limited to the areas identified in R400.4128 and the following:

i. Working as part of a team.
ii. Relationship building.
iii. Family/Child/Youth Engagement.
iv. Understanding and analyzing problem behaviors.
v. Positive Behavior Support.
vi. Setting Clear Limits.
vii. Interpersonal communication.
viii. Appropriate discipline, crisis intervention, and children handling and de- escalation techniques.

ix. The significance of the birth family, value of visitation, importance of attachment and strengthening family relationships, impact of separation, grief and loss issues for children in foster care, and child's need for permanency.
x. Understanding and recognizing the emotional and behavioral issues and/or physical needs of abused/neglected children.
xi. Medication Management: Administration, monitoring, recording, secure storage, medication side effects and procedure for reporting side effects, medication reviews and process for obtaining informed consents for medication changes.
xii. Cultural competency.
xiii. Effects of trauma.
xiv. Suicide prevention and/or intervention.
xv. Child Development.
xvi. Trauma informed practices.
xvii. Strength-based interventions and interactions.
xviii. Defusing threatening behaviors.
xix. Solution focused assessment and case planning.

All program staff will be trained to serve as a role model for appropriate social skills, prioritizing needs, negotiation skills, accessing local resources, hygiene and grooming preparation, food preparation and anger management.

All program staff shall be provided with annual trauma-focused program training to maintain a trauma-informed milieu and treatment environment. Trauma-focused programming must be based on an evidence-based, evidence-informed or promising practice treatment model.

e. Reporting

1) The Contractor shall develop and submit to the MDHHS caseworker/PAFC provider responsible for placement: all service plans, case summaries, incident reports, arrests, death notifications and other reports as required in the Children's Foster Care Manual (FOM) and the MDHHS DCWL standards specific to the Contractor's license specified in Section 2.4 of this Contract. Service Plans shall be completed on the age appropriate Children's Foster Care Residential Initial Service Plan, (DHS 365) and the Children's Foster Care Residential Updated Service Plan (DHS-366). The Foster Care/Juvenile Justice Action Summary (DHS-69) shall be utilized as identified in the FOM.

2) The Contractor shall submit a photo of the child to the MDHHS caseworker/PAFC provider responsible for placement taken at the time of placement. A copy of the photo shall be maintained in the child's file and replaced with a new photo annually. The Contractor shall submit a new updated photo to the MDHHS caseworker/PAFC provider responsible for placement at least annually in an electronic format or a format which is suitable for scanning into an electronic file.

f. Restraint and Seclusion:

The Contractor shall not use Positive Peer Culture, peer-on-peer restraint, chemical restraint, or any form of corporal punishment.

The Contractor shall report the use of seclusion/isolation and restraint within 24 hours (or the next business day) of the use of seclusion/isolation or restraint. The Contractor will utilize the MDHHS Incident Reporting Form in MiSACWIS to record all incidents of seclusion/isolation and restraint.

g. Transitional and Discharge Planning

The Contractor shall develop and/or review a transition/discharge plan in collaboration with the child, parent or guardian, agency with placement responsibility, foster parents, relative caregiver, local community mental health providers the child will be engaged with upon completion of residential treatment and Lawyer Guardian ad Litem (LGAL) during all subsequent Family Team Meeting following admission. Transition and discharge planning shall begin at the time of admission. The child's transition/discharge plan along with a projected date for discharge shall be included in each child's service plan. The child's transition/discharge plan will include the level of care projected to be needed at discharge. The plan will include recommended services, transfer of information (e.g. medical records, mental health records, etc.) and a graduated visitation schedule, all to prepare the family/caregiver(s) for a well-supported discharge placement.

The Contractor shall ensure the child's transition/discharge plan is reviewed and updated during quarterly team meetings.

h. Realignment of Program Type

A child's residential care program type may be changed upon completion of a reassessment of the child's functional status and as recommended by the child's treatment team. A request for change in residential care program type must be submitted within 45 calendar days of the child's placement with the Contractor. The request for change in residential care program type must be submitted in writing to the MDHHS caseworker/PAFC provider responsible for placement and approved by the MDHHS child welfare director/county

director. The request shall include: child's identifying information, residential care program type recommended, reason for recommended residential care program type change, how the new residential care program type is in the child's best interest, plan to prepare the child for transition, and projected discharge date plan.

The Contractor shall receive a decision in writing from the MDHHS caseworker/PAFC provider responsible for placement within 15 working days of receipt of the request.

i. Family Team Meetings

Family Team Meetings are an essential component of MiTEAM and serve as the primary forum for collaborative case planning for the child and family. The overall goals of the Family Team Meetings are used to plan and review for the child ensuring the child receives an appropriate array and quantity of services necessary to stabilize him/her clinically and behaviorally and to prepare him/her to succeed in less restrictive community-based settings after discharge.

Upon admission, the Contractor shall coordinate with the MDHHS caseworker/PAFC provider responsible for placement, the family and the child to identify members of the child's team for ongoing participation in case planning Family Team Meetings facilitated by MDHHS/PAFC or designee. The Contractor shall incorporate relevant planning goals/action steps regarding the child(ren) from previous Family Team Meetings into the Contractor developed initial case plan due 30 days from admission. The Contractor and child(ren) shall participate in quarterly Case Planning Family Team Meetings facilitated by the assigned MDHHS caseworker/PAFC provider/designee, and align Contractor developed quarterly case plans with Family Team Meeting/Parent Agency Treatment plans.

For youth who are developmentally appropriate to participate in a Family Team Meeting, the Contractor shall facilitate a Pre-Meeting Discussion with the child at least 24 hours prior to the Family Team Meeting. The Contractor shall participate with the youth in person or via phone conference at all Case Planning/Case Plan Reassessment Family Team Meeting.

The Contractor shall work with the child, family, treatment team, MDHHS caseworker/PAFC provider and local CMH provider to assist the child in developing ties to his/her community and other non-family resources. These ties provide assistance and connections with caregivers to help meet the child's relationship needs.

j. Legal or Court Related

The Contractor shall cooperate with the MDHHS caseworker/PAFC provider responsible for placement of the child in matters relating to any legal or court activities concerning the child. These activities may include, but are not limited to:

1) Transportation of the child to and from court hearings.

2) Supervision of the child during transport or while present at the hearing.

3) Court testimony, recommendations, and reports to the court as requested by the court.

Safety of the child must always be a priority concern when considering the child's transportation needs. If determined that a child is presenting safety concerns and is unable to be safely transported to a court hearing, the Contractor shall immediately notify the child's LGAL and the MDHHS caseworker/PAFC provider responsible for the child's placement.

k. Absent Without Legal Permission

The Contractor shall have a clearly defined process for determining when a child is AWOLP from the placement. The process shall delineate how the facility and grounds are searched, what personnel will be involved in the search, and how the determination will be made that the child is AWOLP from the placement.

Once determined that a child is AWOLP from the placement, the Contractor shall:

1) **Immediately** notify law enforcement agencies that the ward under their care has failed to return at the expected time.
2) **Immediately** file a missing person report with law enforcement.
3) **Immediately** notify the local office the MDHHS caseworker/PAFC provider responsible for placement or designee of the child's AWOLP status.

l. Independent Living Preparation

Independent living preparation is defined as a comprehensive and coordinated set of activities that will assist all children in preparing for a state of independence or providing care of oneself socially, economically, and psychologically.

The Contractor shall provide Independent Living activities for all children aged 14 and older which shall include but are not limited to: budgeting and money management; employment seeking skills; communication skills;

relationship building; establishing health and hygiene; household maintenance and upkeep; educational assistance; preventive health services; parenting skills and accessing community services.

The Contractor shall identify Independent Living activities in the child's DHS-365 and DHS-366 regularly, following the child's 14th birthday, according to the FOM 722-03C, Older Youth: Preparation, Placement, and Discharge. For children with developmental disabilities, the contractor shall provide relevant adult self-care, daily living skills, community engagement and mobility skills within the aforementioned domains.

m. Individual or Group Therapy

The Contractor shall provide at least weekly direct therapy services for each child individually and/or in group sessions. If the child is provided with group therapy, then at least one session out of four must be an individual therapy session. Individual and/or group therapy shall be provided in accordance with the child's treatment needs as identified in the child's service plan.

n. Inclusion and Involvement of parents, other family members, or caregivers:

Families (including incarcerated parents) and placement caregiver(s) shall be included as extensively as possible from the beginning of the admission process through discharge, transition and aftercare. Families and caregiver(s) shall be supported and involved in all aspects of the child's treatment and reintegration planning whenever possible. Family and caregiver(s) involvement shall remain the center of the child's programming. All services shall be provided in a manner that ensures children, families and placement caregiver(s) receive comprehensive, culturally competent interventions.

The Contractor shall, in accordance with each child's individual treatment plan:

1) Include the family (birth, relative, identified adult support or permanent caregiver) in the development of the DHS-365 and specifically document the family's involvement in the service plan and permanency goal.
2) Provide routine transportation and flexible hours to meet the family's time schedule to facilitate the family's accomplishment of the treatment goals. Routine transportation is defined as any travel, including travel for family visitation, required by the child or family for treatment purposes which occurs in the Contractor's geographic area to be served, that may not reasonably be provided by the parents or other funding source. The Contractor shall coordinate/collaborate with the

MDHHS caseworker/PAFC provider responsible for placement to resolve transportation barriers.

3) If the distance of a family from the agency is identified as a barrier, describe the agency's plan to reduce the barrier to ensure ongoing family contact as outlined in the FOM 722-06I, Maintaining Connections Through Visitation and Contact.
4) Provide an identifiable area for family visits which offer privacy and comfort.
5) In collaboration with the agency responsible for placement, allow for sibling visitation and other required sibling interaction as outlined in FOM 722-06I, Maintaining Connections through Visitation and Contact, and provide supported intervention, based on the child's treatment needs, to encourage and strengthen sibling relationships.
6) Include a specific plan to address the family's needs, to assist the family in meeting the needs of the child in placement, and to attain the family goals, as well as delineation of roles of the Contractor, assigned caseworkers, and family to accomplish these goals. The Contractor shall coordinate with the MDHHS caseworker/PAFC provider responsible for placement to identify, recruit and prepare any identified family for eventual placement or involvement with the child.
7) Withholding of family contact (in any form) as a method of discipline is prohibited.
8) For children available for adoption without an identified adoptive family, the Contractor shall make reasonable efforts to ensure the child is present for identified special recruitment activities. If there are safety concerns or other identified treatment concerns, the Contractor shall consult with the assigned MDHHS caseworker/PAFC provider responsible for placement

o. Religion and Cultural

The Contractor shall respect the religious preference of the child and his/her parent(s) or legal guardian.

The Contractor shall ensure each child is afforded opportunities to attend religious services or activities in his/her religious faith of choice. The Contractor shall arrange for or ensure reasonable means are provided for transportation of a child to services or activities on or off site. Safety of the child must always be a priority concern when transporting and supervising child.

The Contractor shall not require or coerce a child to participate in religious services or activities, shall not discipline, discriminate against, or deny privileges to any child who chooses not to participate. The Contractor shall recognize and take into consideration the racial, cultural, ethnic and religious backgrounds of a child when planning various activities or religious activities.

p. Education

The Contractor shall ensure every child is provided with appropriate educational services. Those services shall be provided in accordance with the requirements set forth in the FOM and MDHHS Division of Child Welfare Licensing standards for the license specified in Section 2.4 of this Contract, and as detailed in the Implementation, Sustainability, and Exit Plan
In addition, the contractor shall:

1) Collaborate with the child's identified school to screen for possible educational disabilities; and if a disability is suspected, refer the child for an Individual Education Program Team (IEPT) evaluation within the first 30 calendar days to assess, plan and place the child in the most appropriate educational/vocational program.
2) Request prior educational assessments within 30 calendar days of placement to assist in assessing the current educational needs. Documentation of diligence in requesting records must be included in the child's file.
3) For children with identified disabilities for whom discharge is planned, an exit review of the educational plan shall be initiated at least 30 calendar days prior to discharge and forwarded to the assigned MDHHS caseworker/PAFC provider responsible for placement.
4) Assure that program staff is available to the school program in crisis situations to assist in managing the crisis or to call for assistance.
5) Notify the school administration where the child is enrolled, in writing, of the name of the person who is supervising the child's foster care case and who is responsible for attending IEPT meetings. Documentation of the notification is to be contained in the Education section of the child's foster care case record.
6) Provide or arrange structured educational and/or vocational activities for children suspended from or expelled from school, or who have passed their General Education Development (GED) test, (i.e., structured homework time, additional reading or writing activities, online educational programming, independent study assignments and independent living skills). This shall include Free Appropriate Public Education (FAPE) to all students with disabilities.
7) Take an active role in monitoring and maintaining school progress for children whether or not they attend a structured school program. Interventions may include, but are not limited to, obtaining school assignments, monitoring completion of homework, capturing and reporting grades and test scores when and where available, and additional tutoring.
8) Provide tutorial services to a child, as necessary, based on the child's Individualized Education Plan (IEP) or treatment plan. Tutorial staff must have appropriate educational credentials to provide tutorial

services. Appropriate educational credentials are determined by the Contractor's Permanency/Educational Specialist. Tutorial services shall not be a substitute for special education and related services.

9) Provide advocacy and service planning for children that are expelled.
10) Be in compliance with Michigan's Department of Education rules and requirements if they operate a school on the Contractor's ground.

q. Medical and Dental Care

The Contractor shall assure that each child receives routine and non-routine medical and dental care as required in the FOM 801, Health Services for Foster Children and the MDHHS DCWL standards for the license specified in Section 2.4 of this Contract and as detailed in the Implementation, Sustainability, and Exit Plan. The Contractor shall provide all medical and dental information to the assigned MDHHS caseworker/PAFC provider responsible for placement to facilitate maintenance of the Medical Passport (DHS-221). In addition, the Contractor shall assure that specific health care is provided, including:

1) Rehabilitative, physical or dental procedures by medical personnel as necessary.
2) Utilization of enrolled Medicaid providers or a board-certified physician or dentist volunteering his/her time for health procedures.
3) Provision of medication as prescribed by a treating physician. Agency must have a Standard Operating Procedure for dispensing and storage of medication.
4) Special diets provided as needed and regularly reassessed utilizing appropriate specialized personnel.
5) The Contractor shall forward the above-DCWL required medical and dental examination reports the MDHHS caseworker/PAFC provider within five working days of completion.

r. Wardrobe/Personal Possessions

The Contractor shall assure that each child has an adequate wardrobe as defined by and documented on the Clothing Inventory Checklist (DHS-3377) while in placement and upon leaving placement. When the child is absent or at the conclusion of the placement, the Contractor shall have a process in place to keep the child's wardrobe and possessions safe until claimed by the child or MDHHS. If the possessions are not claimed within 90 calendar days, the Contractor may dispose of the items at its discretion.

s. Recreation Activities

The Contractor shall provide daily access to appropriate recreation activities as defined by MDHHS DCWL standards for the license specified in Section 2.4 of this Contract.

t. Psychological and Psychiatric Services

The Contractor shall provide the following in accordance with the treatment plan for each individual child. The costs of these elements may be billed to the child's medical insurance provider if the service is covered. If not, the costs are to be covered by the per diem reimbursement rate:

1) Psychological Services

Psychological services are defined as various professional activities or methods, provided by a licensed Masters Social Worker, licensed Professional Counselor, licensed psychologist or a limited licensed psychologist, including therapy with children individually or in groups, consultation with staff, administering and interpreting psychological tests and work with families.

a) The Contractor shall provide psychological services to an individual child on an as needed basis, per the child's Residential Initial Treatment Plan or Residential Updated Treatment Plan.

b) The Contractor shall provide psychological testing as necessary for assessment and treatment planning.

c) The Contractor shall provide psychological consultation to staff as necessary to assist staff in understanding the child's background or needs, test results, implications for treatment and interventions most appropriate for the child.

2) Psychiatric Services

Psychiatric services are defined as various professional activities or methods, performed by a licensed physician with expertise in mental/behavioral health care as evidenced by:

a) Certification in Youth and Adolescent Psychiatry by the American Board of Psychiatry and Neurology (ABPN), or

b) Certification in general psychiatry by the ABPN and clinical experience with children and adolescents.

c) Services may include diagnostic assessment, individual psychotherapy with evaluation and management, medication review with minimal psychotherapy, individual or group therapy with the resident(s) and consultation with agency staff. Telepsychiatry may be used when a local psychiatrist is not available.

i. The Contractor shall provide psychiatric services to an individual child, on an as needed basis, according to the child's DHS-365 or DHS-366. The Contractor shall engage the parent(s), medical and educational staff and any other relevant individuals involved in the child's treatment in the initial and ongoing evaluation process.

ii. The Contractor shall provide psychiatric consultation or supervision of Contractor staff as necessary to assist staff in understanding the results of the psychiatric evaluation(s), implications for the child's treatment and identification of treatment interventions most appropriate for the child.

iii. Psychotropic Medication must be prescribed or adjusted by a child/adolescent psychiatrist or a psychiatrist with experience working with children and adolescent youth or the child's primary care physician if a psychiatrist is not available via telepsychiatry. For temporary wards, the child's parents must be engaged in the consultation either in person or by phone conference **witnessed by the Foster Care Psychotropic Medication Oversight Unit (FC-PMOU). For state wards, the child's caseworker must be engaged in the consultation either in person or by phone conference witnessed by the FC-PMOU.** Appropriate consent must be obtained for administration to a child of each psychotropic medication. The Contractor shall follow FOM 802-1, Psychotropic Medication in Foster Care.

iv. Within 30 calendar days of the child's placement, if necessary from the child's treatment plan, the psychiatrist must assess the child and coordinate with the licensed clinical personnel completing the psychosocial assessment. The psychiatrist shall review the child's medication history, current needs and prescriptions. This includes adjustment of medications and dosage as necessary.

v. After the first 45 calendar days of a child's placement, the psychiatrist shall review the child's current medical and psychiatric needs and prescription or adjustment of medications and dosage as necessary.

u. Transitional Service Following Discharge

1) Planned Discharge

The Contractor shall provide the following transitional services to children discharged from the program in a planned discharge:

a) Submit a discharge service plan to the MDHHS caseworker/PAFC provider responsible for placement utilizing the DHS-69, which complies with the requirements of the MDHHS DCWL standards specific to the Contractor's license specified in Section 2.4 and also contains a summary of services provided during care.

b) Six months prior to discharge, coordinate with the caseworker to make a referral to Community Mental Health (CMH) for assessment and case management services and continue coordination with CMH until discharge. If the child does not meet eligibility requirements for CMH services, maintain transitional psychosocial services until the child is scheduled to attend an initial appointment with a community based psychosocial service provider. Document services needed to continue to meet the child's needs and identified providers for such services in order to provide continuity of services.

c) A statement for each child receiving psychotropic medication, including the name of the child's next treating psychiatrist/primary care physician, date of last medication review, date of last signed informed consent, date of medication review following discharge (within five days of discharge), and date the psychiatric information was provided to the next psychiatrist/primary care physician.

d) Provide medical information, including a medication regime, a complete Prescription Information form (DHS-2840) signed by the Contractor's medical staff or clinical supervisor, and at least a 14-day supply of medication to the responsible party at the time of discharge.

e) Assign a social services worker to maintain contact with the child and family for the first 30 calendar days following discharge, if the child is placed in a family setting. Contact shall include at least two home visits within the 30-calendar day period and at least one successful phone contact per week to both the parent and child for 30 calendar days following discharge to assist in re-establishing family equilibrium.

For children placed in a family setting out-of-state or within the state more than 150 miles from the residential facility, the Contractor shall make two successful face to face contacts via Skype or through other software technology and at least one successful phone contact per week to both the parent and child for the first 30 days following discharge.

This shall be completed in accordance with the child's individual treatment plan.

f) Provide the assigned MDHHS/PAFC caseworker with a written report utilizing the DHS-69 with an assessment of the child/family situation at the end of the 30-day transition period and summarize the Contractor's services, contacts, concerns, and agency and family activities needed to achieve unmet goals and objectives. This shall be provided within 60 days after the child's discharge date.

2) Unplanned Discharge

An unplanned discharge shall be defined as one of the following:

a) When the Contractor requests removal of the child from placement prior to the child successfully achieving the treatment goals. The Contractor shall continue services to the child for a period of up to 30 calendar days following written notification to the referring MDHHS caseworker/PAFC provider responsible for placement of the decision to discharge the child from placement.

b) An immediate (within one day or less) move of the child from the Contractor's program to another program/facility as directed by the court or MDHHS caseworker/PAFC provider responsible for placement.

In the event of an unplanned discharge, the Contractor and MDHHS caseworker/PAFC provider shall identify the specific treatment needs of the child and possible alternative placements.

The Contractor may request the MDHHS caseworker/PAFC provider to remove a child from the Contractor's program in less than 30 days if the following conditions are met:

i. The behaviors or their intensity that endanger the child or others were not made known to the Contractor before admission, **And**

ii. The behavior considered dangerous to self or others is significantly deviant from what the Contractor has specified as acceptable.

And

iii. The child makes actual physical attacks upon other persons and requires frequent restraint to prevent harm to self or others, **Or**

iv. The child makes an overt suicide attempt and hospitalization is necessary.

In such cases, the MDHHS caseworker/PAFC provider shall respond promptly to the request for new placement to ensure the health and safety of the child and the well-being of other children in the program. If the child poses a threat to self or others, the Contractor may be approved to provide 1:1 staffing ratio. The approval for 1:1 staffing must be requested in writing to DCWL by email or fax. The 1:1 staffing will be approved while the conditions i. and ii. above continue to exist.

2.11. Program Performance Objectives

During the contract period, the Contractor shall track individual youth for the performance objectives listed below. The Contractor shall submit the data quarterly on the template provided by MDHHS. This data will be used for the purpose of identifying trends and establishing future outcome measures.

a) The number and percentage of all children supervised by the Contractor who were victims of substantiated maltreatment by facility staff.
b) The percentage of children supervised by the Contractor who have a planned discharge within nine months of placement.
c) The percentage of children who have a planned discharge to a less restrictive setting.
d) The percentage of children discharged from the Contractor's program due to AWOLP status.
e) The percentage of children with a documented need on the Child Assessment of Needs and Strengths (or CAFAS) who show an improved score at time of discharge. The improved score must be on at least one of the top three identified needs at the time of admission.
f) For children functioning below grade level, what percentage meet or exceed at minimum of one of the educational goals defined in their treatment plan or their IEP, if applicable.

2.12. Audit Requirements

Contractor/Vendor Relationship

This Contract constitutes a contractor/vendor relationship with MDHHS. The Contractor must immediately report to the MDHHS Bureau of Audit any audit findings of fraud, and Going Concern, financial statement misstatement, or accounting irregularities, including noncompliance with provisions of this Contract.

2.13. Financial Audit Requirements

a. Required Audit or Audit Exemption Notice
Contractors must submit to the Department either a Single Audit, Financial Statement Audit, or Audit Exception Notice as described below. If submitting a Single Audit or Financial Statement Audit, Contractors must also submit a Corrective Action Plan for any audit findings that impact MDHHS-funded programs, and management letter (if issued) with a response.

1) Single Audit
Contractors that are a non-profit organization and that expend $750,000 or more in federal awards during the Contractor's fiscal year, must submit a Single Audit to the Department, regardless of the amount of funding received from the Department. The Single Audit must comply with the requirements of Title 2 Code of Federal Regulations, Subpart F.

2) Financial Statement Audit
Contractors exempt from the Single Audit requirements with fiscal years that receive $750,000 or more in **total funding** from the Department in State and Federal grant funding must submit to the Department a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS).

3) Audit Exemption Notice
Contractors exempt from the Single Audit and Financial Statement Audit requirements (1 and 2 above) must submit an Audit Exemption Notice that certifies these exemptions. The template Audit Exemption Notice and further instructions are available at http://www.michigan.gov/mdhhs by selecting Inside MDHHS menu, then MDHHS Audit, then Audit Reporting.

b. Due Date and Where to Send
The required audit and any other required submissions (i.e. Corrective Action Plan and management letter with a response), or Audit Exemption Notice must be submitted to the Department within nine months after the end of the Contractor's fiscal year by e-mail to the Department at MDHHS-AuditReports@michigan.gov. The required submissions must be in PDF files and compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. The Department reserves the

right to request a hard copy of the audit materials if for any reason the electronic submission process is not successful.

c. Penalty

1) If the Contractor does not submit the required Single Audit or Financial Statement Audit, including any management letter and applicable corrective action plans within nine months after the end of the Contractors fiscal year, the Department may withhold from the current funding an amount equal to five percent of the audit year's contract funding (not to exceed $200,000) until the required filing is received by the Department. The Department may retain the amount withheld as a penalty if delinquency reached 120 days past due. The Department may terminate the contract if the Contractor is 180 days delinquent in meeting the audit requirements.
2) Failure to submit the Audit Exemption Notice, when required, may result in withholding from the current funding an amount equal to one percent of the audit year's funding until the Audit Exemption Notice is received.

d. Other Audits
The Department or federal agencies may also conduct or arrange for "agreed upon procedures" or additional audits to meet their needs.

2.14. Cost Reporting

The Contractor shall submit annual financial cost reports based on the state's fiscal year which begins October 1 and ends September 30 in the following calendar year. The reports shall contain the actual costs incurred by providers in delivering services required in this Contract to MDHHS clients for the reporting period. Costs for non-MDHHS children are not to be included. Reports will be submitted using a template provided by MDHHS. The financial reports shall be submitted annually, and will be due November 30 of each fiscal year. The Contractor must comply with all other program and fiscal reporting procedures as are or may hereinafter be established by MDHHS. Reports shall be submitted electronically to MDHHS-Foster-Care-Audits@michigan.gov with the subject line: RFCAN Cost Report.

Failure to meet reporting responsibilities as identified in this Contract may result in MDHHS withholding payments until receipt of annual financial cost report. MDHHS may withhold from current payments an amount equal to five percent of the Contractor's reporting year MDHHS revenue (not to exceed $60,000) until the required filing is received by the Department. MDHHS may retain withheld funds as a penalty if delinquency reaches sixty (60) days past due. MDHHS may terminate the contract if the Contractor is ninety (90) days delinquent in submitting the required annual financial cost report.

2.15. Service Documentation

The Contractor agrees to maintain program records required by MDHHS, program statistical records required by MDHHS, and to produce program narrative and statistical data at times prescribed by, and on forms furnished by, MDHHS.

2.16. Private Agency MiSACWIS

The Contractor shall ensure that residential payment staff has access to the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) through a web-based interface, henceforth referred to as the "MiSACWIS application." Requirements for MiSACWIS for CCI contracts may be found at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_7199---,00.html

2.17. Billing

The Contractor shall submit through the MiSACWIS system the bi-weekly roster for any child in the Contractors care per the instructions within the MiSACWIS system. The billing shall only indicate the units of service provided by the Contractor and shall be submitted to MDHHS within 30 days from the end of the billing period.

No original request for payment submitted by the Contractor more than one year after the close of the two week billing period during which services were provided shall be honored for payment.

When the Contractor's financial records reveal that payment for a child has not been provided by MDHHS within 30 days of receiving all necessary documentation, the Contractor will seek payment resolution by contacting the direct supervisor of the assigned MDHHS worker in writing. Any concerns over a payment authorization or issuance that cannot be resolved within 30 days of the written notice must be reported to the MDHHS County Director for immediate resolution. The Contractor will apprise MDHHS Office of Child Welfare Services and Support of any ongoing, unresolved payment concerns.

2.18. Fees and Other Sources of Funding

The Contractor guarantees that any claims made to MDHHS under this Contract shall not be financed by any source other than MDHHS under the terms of this Contract. If funding is received through any other source, the Contractor agrees to deduct from the amount billed to MDHHS the greater of either the fee amounts, or the actual costs of the services provided.

The Contractor may not accept reimbursement from a client unless the Contract specifically authorizes such reimbursement in the "Contractor Responsibility"

Section. In such case, a detailed fee scale and criteria for charging the fee must be included. If the Contractor accepts reimbursement from a client in accordance with the terms of the Contract, the Contractor shall deduct these fees from billings to MDHHS.

Other third-party funding sources, e.g., insurance companies, may be billed for contracted client services. Third party reimbursement shall be considered payment in full unless the third-party fund source requires a co-pay, in which case MDHHS may be billed for the amount of the co-pay. No supplemental billing is allowed.

2.19. Recovery of Funding and Repayment of Debts

a. Recovery of Funding

If the Contractor fails to comply with requirements as set forth in this Contract, or fails to submit a revised payment request within allotted time frames established by MDHHS in consultation with the Contractor, MDHHS may require the Contractor to reimburse payments made under this Contract which MDHHS has determined that the Contractor was not entitled. If the Contractor becomes aware of any situation involving payments received under this Contract to which the Contractor was not entitled the overpayment amount must be repaid to MDHHS within 30 days of the Contractor becoming aware. The Contractor is liable for any cost incurred by MDHHS in the recovery of any funding.

Upon notification by MDHHS that repayment is required, or upon any other awareness of an overpayment to the Contractor, the Contractor shall make payment directly to MDHHS within 30 days or MDHHS may withhold future payments made under this or any other Contract(s), between MDHHS and the Contractor.

If the Contractor fails to: (1) correct noncompliance activities identified by MDHHS, (2) submit revised billings as requested as part of a Corrective Action Plan when required; or (3) remit overpayments or make arrangements to have the overpayments deducted from future payments within 30 days, such failure shall constitute grounds to terminate immediately any or all of MDHHS' Contracts with the Contractor. MDHHS shall also report noncompliance of the Contractor to Michigan's Department of Technology, Management and Budget. Such report may result in the Contractor's debarment from further contracts with the state of Michigan.

b. Repayment of Other Amounts due MDHHS

By entering into this Contract, the Contractor agrees to honor all prior repayment Contracts established by MDHHS with the Contractor or

Contractor's predecessors. In the absence of a repayment Contract for amounts due MDHHS, the Contractor agrees to make monthly payments to MDHHS at an amount not less than 5% of any outstanding balance and to begin on the date this Contract is executed. If any of these required payments are made more than 30 days past the due date, MDHHS may reduce or withhold future payments made under this or any other Contract(s) between MDHHS and the Contractor.

The payment reduction will be made at the amount originally established in the repayment Contract or at an amount not less than 5% of any outstanding balance effective on the date this Contract was executed.

2.20. Child Protection Law Reporting Requirements

a. The Contractor shall ensure that all employees who have reasonable cause to suspect child abuse or neglect shall report any suspected abuse or neglect of a child in care to MDHHS for investigation as required by Public Acts of 1975, Act Number 238.
b. Failure of the Contractor or its employees to report suspected abuse or neglect of a child to MDHHS shall result in an immediate investigation to determine the appropriate corrective action up to and including termination of the contract.
c. Failure of the Contractor or its employees to report suspected child abuse or neglect two or more times within a one-year period shall result in a review of the contract agency's violations by a designated Administrative Review Team, which shall include the Director of CSA and the Director of DCWL or its successor agency, that shall consider mitigating and aggravating circumstances to determine the appropriate corrective action up to and included license revocation and contract termination.

2.21. The Division of Child Welfare Licensing (DCWL)

DCWL shall be responsible for review of the Contractor's compliance with the Contract and any court orders, via an Annual Compliance Review (ACR) and Special Investigations. DCWL may review, analyze and comment on all activities covered within the terms of the Contract or court order. If the ACR of Special Investigation reveals that the Contractor has not complied with the requirements of this Contract or court order, the following procedures shall be implemented:

a. DCWL shall notify the Contractor of the Contract or court noncompliance. This notification shall occur verbally during an exit conference and be followed with a written report of the findings. The Contractor may request a meeting to discuss and examine the identified Contract or court noncompliance.

b. Following the identification of the Contract or court noncompliance, DCWL will request the Contractor submit a Corrective Action Plans (CAP) to DCWL within 15 days of receiving the written report of findings.
c. After the Contractor's CAP has been reviewed and approved by DCWL, the Contractor's compliance with the CAP shall be reviewed in accordance with time frames established by DCWL in the written notification of acceptance of the CAP.
d. Based on the severity or repeated nature of cited violations, a recommendation may be made by DCWL at any time to place a moratorium on new placements with the contractor or to cancel the contract. If either recommendation is made, a meeting will be convened with the director of the contracted agency, the division director of DCWL and the Children's Services Agency (CSA) director or designee to provide the contractor with the opportunity to provide documented information on why the moratorium or cancellation of the contract should not occur.
e. If a moratorium on new placements is put into place, it shall be for a minimum of 90 days to allow the contractor to remedy cited violations and comply with any agreed-on CAP. If the cited violations are not corrected during the period of the moratorium or additional serious violations are cited, consideration shall be given to cancellation of the agency's contract. Final decisions regarding the cancellation of a contract shall be made by the CSA director.

2.22 Corrective Action Requirements

If a program review by MDHHS reveals a lack of compliance with the requirements of this Contract, the Contractor shall:

a. Meet with MDHHS to discuss the noncompliance.

b. Prepare a corrective action plan within 30 days of receiving MDHHS' written findings.

c. Achieve compliance within 60 days of receipt of MDHHS' approval of the corrective action plan (unless other time frames are agreed to in writing by MDHHS) or MDHHS may terminate this Contract, subject to the standard contract terms.

2.23 Criminal Background Check

As a condition of this Contract, the Contractor certifies that the Contractor shall, prior to any individual performing work under this Contract, conduct or cause to be conducted for each adult working in the Child Caring Institution, either an employee, subcontractor, subcontractor employee:

a. A criminal records check of national crime information databases and a National and State Sex Offender Registry check.

   The Michigan Public Sex Offender Registry web address is http://www.mipsor.state.mi.us.

   The National Sex Offender Public Website address is http://www.nsopw.gov.

b. A Central Registry (CR) check.

   Information about CR can be found at http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_48330-180331--,00.html

c. Clients under this Contract, or who has access to client information, an Internet Criminal History Access Tool (ICHAT) check and a National and State Sex Offender Registry check.

   Information about ICHAT can be found at http://apps.michigan.gov/ichat.

   For all but sex offender registry, the required criminal checks are to be obtained through the below procedure:

   - Prior to employment, each adult must thoroughly complete the 1326-CCI Staff form including all requested information for processing.
   - The CCI must submit the completed 1326-CCI-Staff forms for processing to the: MDHHS-LASO-DCWL@michigan.gov mailbox.
   - The subject line of the email must note a NEW hire for timely processing.
   - Within 48 business hours, DCWL will process the CCI-1326 and provide notification of eligibility. The email will include a scanned copy of the completed 1326-CCI-Staff form.
   - The notification is needed for the prospective staff to begin working.
   - DCWL will also send a paper copy of the completed 1326-CCI Staff form via US mail for your records.
   - The Contractor shall require each employee, subcontractor, subcontractor employee; or volunteer who works directly with clients or who has access to client information; under this Contract to timely notify the Contractor in writing of criminal convictions (felony or misdemeanor) and/or pending felony charges or placement on the Central Registry as a perpetrator.

Additionally, the Contractor shall require each new employee, employee, subcontractor, subcontractor employee or volunteer who works directly with clients under this Contract or who has access to client information and who has not resided or lived in Michigan for each of the previous ten (10) years to sign a waiver attesting to the fact that they have never been convicted of a felony or identified as a perpetrator, or if they have, the nature and recency of the felony.

The Contractor further certifies that the Contractor shall not submit claims for or assign to duties under this Contract, any employee, subcontractor, subcontractor employee, or volunteer based on a determination by the Contractor that the results of a positive criminal records check (fingerprint based or ICHAT) and/or a CR response or reported criminal felony conviction or perpetrator identification make the individual ineligible to provide the services.

The Contractor must have a written policy describing the criteria on which its determinations shall be made and must document the basis for each determination. As indicated in CPA Licensing Rule R400.12212 the Contractor may consider the recency and type of crime when making a determination. Failure to comply with this provision may be cause for immediate cancellation of this Contract.

If MDHHS determines that an individual provided services under this Contract for any period prior to completion of the required checks as described above, MDHHS may require repayment of that individual's salary, fringe benefits, and all related costs of employment for the period that the required checks had not been completed.

3. MDHHS RESPONSIBILITIES

3.1. Payment

MDHHS shall make payments to the Contractor pursuant to MCL 17.51-17.57 and State of Michigan Financial Management Guide, Part II-Accounting and Financial Reporting, Chapter 25, Section 100, “Prompt Payment for Goods and Services.”

Per Diem Unit Definition: One unit equals the initial calendar day of placement of a referred child or any 24-hour period thereafter where a child is receiving basic supervision and care, and any specialized services as defined by this Contract. The last day of a child’s placement shall not be counted as a unit.

The Contractor shall be reimbursed for care on a per diem basis for each child based upon the child’s program type. For each residential care program type,

the Contractor shall be reimbursed according to the rate set for children in that program type as provided below.

Bridges Provider Number xx
MiSACWIS Provider Number xx
Residential Program Type xx

The per diem rate(s) for services provided under this Contract shall be

Service Code	Per Diem Rate	Effective Date
xxx	$xxx	xxx
xxx	$xxx	xxx
xxx	$xxx	xxx

For County Child Care Fund funded children, MDHHS is not statutorily obligated to make payment to the Contractor. Payment for these children is the statutory responsibility of the County. If payment is not made, MDHHS shall make reasonable efforts to assist the Contractor to obtain payment.

3.2. Performance Evaluation and Monitoring

The services provided by the Contractor under this Contract shall be evaluated and assessed at least annually by MDHHS on the basis of the criteria outlined in Section 2.11.

MDHHS shall perform contract monitoring through activities such as:

a. Auditing expenditure reports.
b. Conducting on-site monitoring.
c. Reviewing and analyzing written plans and reports.

4. INSERT Standard Contract Terms

Attachment A: Residential Foster Care Program Types

REMOVE ALL PROGRAM TYPES BELOW EXCEPT FOR THE PROGRAM TYPE IDENTIFIED IN THE CONTRACT.

The Contractor shall ensure access to the elements of residential care outlined in the MDHHS DCWL standards specific to the license listed in Section 2.4. Additionally, the Contractor shall ensure access to those services outlined in Section 2.10 of this Contract for each residential program type.

1. **General Residential**

Definition
The General Residential Program provides a discharge focused, interdisciplinary, psycho-educational, and therapeutic 24 hour a day structured program with community linkages, provided through non-coercive, coordinated, individualized care, and interventions with the aim of moving individuals toward a stable, less intensive level of care or independence. Interventions should be evidence-based and include trauma-focused interventions.

Symptomology
The child presents risk in school, home and/or community. The child has presented risk to self, others and property. The child has exhibited a behavior(s) that has interfered with his or her ability to function adequately in a less restrictive setting. Such behaviors could include, but may not be limited to: aggressive episodes, stealing or petty theft; vandalism; inappropriate social interactions (threatening behavior, inappropriate language, disruptive school behavior, consistent failure to adhere to rules, incorrigibility in not following adult directives), and/or reactions to past trauma, which results in maladaptive behaviors.

Standardized Assessment Tool
The contractor shall utilize assessment tools identified in Section 2.10, b., to assess the child's overall progress in functioning while in the residential program.

The Contractor shall administer the assessment tools within 30 calendar days of admission and quarterly thereafter until planned discharge as defined in Section 2.10, u.

Services
For a child in the General Residential Program, the Contractor shall ensure access to the elements of residential care outlined in the MDHHS DCWL standards specific to the license listed in Section 2.4. Additionally, the Contractor shall ensure access to those services outlined in Section 2.10 of this Contract.

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every xx children during waking hours.
b. Maintain a minimum of one on-duty direct care worker for every xx children during sleeping hours. All of these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Program Performance Objectives

During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this Contract.

2. Mental Health and Behavior Stabilization

Definition

The Mental Health and Behavior Stabilization Residential Care Program type provides intensive and frequent services and has a lower staff to child ratio than General Residential. The staffing, structure, and environment make more intensive child supervision possible. The Mental Health and Behavior Stabilization Program provides for the application of a comprehensive array of services that include psychiatric and clinical assessments and evaluations and corresponding interventions designed to stabilize and treat the conditions of mental health/behavioral instability. Level of service intensity is tailored to and based on the needs of the child and the child's diagnosis at the time of intake and ongoing progress in the program.

Symptomology

A child currently experiencing or with a history of active unstable symptoms which may include: severely aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations, suicidal/homicidal ideations), and/or frequent severe emotional episodes. The child is non-compliant with and/or not stabilized on medication. The child has a high risk of serious self-harm and aggression. Lack of intact thought process.

Standardized Assessment Tool

The contractor shall utilize assessment tools identified in Section 2.10, b., to assess the child's overall progress in functioning while in the residential program.

The Contractor shall administer the assessment tools within 30 calendar days of admission, and quarterly thereafter until planned discharge as defined in Section 2.10, u.

Services

The child shall have a psychiatric consultation within seven calendar days of the child's admission into the program. The consultation shall include current and past psychiatric history, medical/developmental history, social history, family

history, and medication review. The consultation shall be conducted face to face or via telepsychiatry if face to face is not possible.

The child shall have a comprehensive psychiatric evaluation within 15 calendar days of the child's admission into the program. The evaluation shall include mental status exam and a diagnosis and treatment recommendation. The evaluation shall be conducted face to face or via telepsychiatry if a face to face is not possible

a. Nurse oversight of physical interaction with psychotropic medication.
b. Individual therapy, family therapy, and/or group therapy shall occur more than one time per week based on the individual needs of the child.
c. Self-help groups as needed.
d. Family activity programs.
e. Independent living skills assessment/preparation and community reintegration.
f. 1:1 staff/child ratio, if required for child safety. The request for 1:1 staffing must be requested in writing to DCWL by email or fax.

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every xx children during waking hours.
b. Maintain a minimum of one on-duty direct care worker for every xx children during sleeping hours. All of these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Program Performance Objectives

During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this Contract.

3. Sexually Reactive Program

Definition

A Sexually Reactive Program uses a bio-psychosocial approach to address the symptoms of compulsive behaviors, Post-Traumatic Stress Disorder (PTSD), and childhood sexual and/or non-sexual abuse. The Contractor shall provide individualized treatment plans in a variety of evidence-based modalities. Therapeutic approaches may include Cognitive-Behavioral Therapy (CBT), experiential therapies, psycho-educational presentations, psychopharmacological interventions, family systems theory, and integrative therapies.

Treatment approaches are gender specific and age appropriate. Treatment options for residents with aggressiveness, attachment problems, sadistic behaviors, grief and loss issues, and impulse control problems are included in

the residential program. Skills training in aggression replacement, anger management, social skills, activities for daily living, coping skills, and communication skills shall be provided.

Symptomology

A child who has been exposed to sexualized awareness via sexual abuse or exposure to sexualized materials and is suffering from the impact of child sexual abuse, including sexual addiction/compulsivity (including internet addiction), PTSD, and/or other psychological or physiological effects of abuse and trauma such as anxiety and anger. A child that has a history of displaying problematic sexualized behaviors including, but not limited to, sexual behavior that appears inappropriate due to age or the nature and/or extent of the sexual behavior; behavior that is sexually abusive in nature; behavior that is sexually aggressive, etc. This child may or may not be exhibiting outward sexualized behaviors (touching others) but may display poor physical boundaries, expose themselves to others, touch themselves publicly, engage in frottage (rubbing against others), etc. This child is not involved in any known sexual offending behaviors as a result of the sexual awareness.

Standardized Assessment Tool

In addition to the assessment tools outlined in Section 2.10, b., the contractor shall utilize the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) or Juvenile Sex Offender Assessment Protocol (J-SOAP) to assess the child's overall progress while in the residential program.

The Contractor shall administer the assessment tools within 30 calendar days of admission, and quarterly thereafter until planned discharge as defined in Section 2.10, u.

The tool shall be utilized by a professional trained in the utilization of the identified tool.

Services

a. Individual therapy shall occur more than one time per week,
b. Group and/or family therapy shall be provided as outlined in the child's treatment plan.
c. Interventions focusing on and treating any history of trauma as well as any sexualized behavior is required.
d. Additional life skills interventions.
e. Sexual abuse group therapy, which shall include anger management, sex education, recidivism prevention, and victim awareness and empathy.

The Contractor shall have a phased approach to service delivery. The various phases generally include the following:

a. Orientation – Children become oriented to the phases of interventions and program expectations.

b. Accountability – Children are encouraged to fully disclose their actions that led them to the program and accept responsibility.
c. Boundaries – Clarification of values system will be developed to help establish and maintain healthy interpersonal and sexual boundaries.
d. Empathy – Children will begin to understand the impact of violating sexual boundaries on primary and secondary victims.
e. Relapse Prevention – Children will develop healthy and effective responses to their high-risk sexual behaviors.
f. Transition – Children will develop a plan for a healthy transition to a lower level of care.

The length of time a child is in any particular phase is dependent on the individual child and treatment plan.

Service Provider Qualifications
Therapists shall be persons that meet the qualifications outlined Section 2.10, d., 2), and have experience working with children who have displayed sexually inappropriate behavior or be supervised by a therapist with the experience and qualifications outlines in Section 2.10, d., 2).

Staffing Ratios/Room Assignments
The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every xx children during waking hours.
b. Maintain a minimum of one on-duty direct care worker for every xx children during sleeping hours. All of these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Single occupancy rooms are highly recommended. If children must share a room, frequent (every 10 but no less than 15 minutes) and random room checks shall be conducted, regardless of the use of video monitoring systems.

Program Performance Objectives
During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this Contract in addition to the outcomes identified below. The Contractor shall submit the data quarterly on the template provided by MDHHS.

a. The percentage of children who had a relapse prevention plan upon a planned release.
b. The percentage of children who demonstrate Stage of Change improvement/progress related to the identified assessment tool.

4. Developmentally Disabled and Cognitively Impaired Program

Definition

Services for children with developmental disabilities consists of individualized services that include structure and support in mastering activities of daily living, developing positive self-protective skills, community integration, behavior plans and interventions, including mental health treatment as needed. Services are designed and delivered to engage the client at his or her level of functioning. Residential providers support children in their treatment, school programs, adult transition planning, transition planning to a less restrictive placement and, when it is a part of the child's individual plan, preserving connection with their families.

Intellectually disabled is defined as mild to moderate (IQs 45 to 69), intellectually impaired children, with or without substance use or dependence symptoms. This also includes children with severely or profound cognitive impairments (IQ below 45), those with classic autism spectrum disorder that exhibit severely restricted functioning levels, and severely multiply impaired, which includes those with a combination of cognitive and physical impairments and may also include mental and/or emotional impairments.

Developmentally disabled is defined as an individual diagnosed with a mental disorder which significantly impacts their adaptive functioning and ability to care for themselves and generally is considered a lifelong condition.

Symptomology

Children experiencing significant adjustment problems at home, in school, and/or in the community as a result of serious emotional disturbance (SED) with or without substance use or dependence symptoms, concurrent with cognitive impairments.

Children experiencing significant adjustment problems at home, in school, or in the community concurrent with cognitive impairment or developmental disability, emotional impairment and behavioral concerns that cannot be addressed in a less restrictive placement.

Children may be currently experiencing or have a history of active unstable symptoms which may include: severely aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations, suicidal/homicidal ideations), and/or frequent severe emotional episodes. The child is non-compliant with and/or not stabilized on medication. The child has a high risk of serious self-harm and aggression. Lack of intact thought process.

Standardized Assessment Tool

The Contractor shall utilize a standardized assessment tool as defined in the Contractor's program statement to assess the child's overall progress in functioning while in the residential program.

The Contractor shall administer the assessment tools within 30 calendar days of admission, and quarterly thereafter until planned discharge as defined in Section 2.10, u.

The tool shall be utilized by a professional trained in the utilization of the identified tool.

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every xx children during waking hours.
b. Maintain a minimum of one on-duty direct care worker for every xx children during sleeping hours. All of these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services

a. Nurse oversight of side effects with psychotropic medications
b. Intensive activity-based individual or specialized group therapy.
c. Self-help groups as needed.
d. Family therapy and/or family activity programs.
e. Independent living skills assessment/preparation and community reintegration.
f. Adjunctive therapy, provided either on site or in the community, including recreational therapy, occupational therapy, music therapy, art therapy, speech therapy, physical therapy, and respiratory therapy when these or any other interventions are prescribed by a treating physician or required by an IEP.
g. Peer support groups that focus on social norms, learning how to interpret social cues and problem solve responses that are acceptable.
h. Family therapy directed toward the establishment and utilization of positive behavioral management and strengthening family relationships.
i. Aftercare service planning, connecting the children with services that include coordinating a referral and initial appointment with a local Community Mental Health center for casework services for persons with developmental delays.
j. 1:1 staff/child ratio, if required for child safety, upon documentation of safety issues and with written approval from DCWL.

Program Performance Objectives

During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this Contract in addition to the outcomes identified below. The Contractor shall submit the data quarterly on the template provided by MDHHS.

a. The percentage of clients who demonstrate progress in receptive and expressive skills as shown by a communication skills assessment prior to discharge.

b. The percentage of clients who demonstrate an understanding of their environment and manage their response as shown by a reduction in negative behaviors and an increase in the ability to appropriately express feelings and needs at the time of discharge.

5. Substance Abuse Rehabilitation

Definition

A comprehensive array of services to address substance abuse, prevent substance use, and support recovery. Interventions are co-occurring, capable, and address the full range of related issues including:

a. recognizing the harmful effects of chemicals on the child;
b. develop skills to avoid chemical use;
c. identify alternate methods of meeting the needs previously met by chemical use;
d. achievement and maintenance of sobriety or abstinence;
e. health and mental health needs;
f. counseling and/or psychotherapy;
g. education;
h. improved social, emotional, psychological, cognitive, and vocational functioning.

Symptomology

Children experiencing substance use disorders with a significant impairment in an area of functioning.

Standardized Assessment Tool

In addition to the assessment tools outlined in Section 2.10, b., the Contractor shall utilize a published standardized assessment tool as defined in the Contractor's program statement to assess the child's overall progress in functioning while in the residential program.

The Contractor shall administer the assessment tools within 30 calendar days of admission and quarterly thereafter until planned discharge as defined in Section 2.10, u.

The tool shall be utilized by a professional trained in administering the identified tool.

Staffing Qualifications

Therapists shall have appropriate certifications as outlined in the Michigan Certification Board for Addiction Professionals.

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every xx children during waking hours.

b. Maintain a minimum of one on-duty direct care worker for every xx children during sleeping hours. All of these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services

a. Individual therapy at least one time weekly.
b. Specialized group, multi-family or didactic group therapy as identified in the child's treatment plan.
c. Self-help groups and/or sober leisure skill development.
d. Family therapy and/or family activity programs.
e. Level appropriate community or campus-based education.
f. Intensive school supports services e.g., testing, monitoring, tutoring.

Program Performance Objectives

During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this Contract in addition to the outcomes identified below. The Contractor shall submit the data quarterly on the template provided by MDHHS.

a. The percentage of children who have a plan including relapse prevention and recommended services upon a planned discharge.

6. Mother/Baby

Definition

The Mother/Baby Residential Program provides a discharge-focused, interdisciplinary, psycho-educational, and therapeutic 24-hour-a-day structured program with community linkages, provided through non-coercive, coordinated, individualized care, and interventions with the aim of moving individuals toward a stable, less intensive level of care or independence. Interventions should be evidence-based and include trauma-focused interventions.

The Mother/Baby Program shall offer an intensive array of services to meet the short term and longer-term needs of pregnant and parenting youth in the Michigan child welfare system. Research has shown that successful programs incorporate three elements that offer a pregnant and parenting youth the supports needed to succeed: socialization, nurturing and support, structure and discipline. To best support pregnant and parenting youth in Michigan, the program shall be designed as a continuum of care approach. The continuum may consist of three levels. Level 1 is highly structured with 24-hour supervision. Level 2, a step down to a less restrictive living situation where the level of supervision is decreased, and the youth obtains more responsibility for managing her own money. Level 3 includes a step to a less restrictive non-residential setting. The tiered level approach encourages youth participation and investment in the program while working on their long-term goal of being self-sufficient.

The Mother/Baby Program service delivery can be offered in several different modalities. Ideally, the program should provide a continuum of services to allow the youth to transition from a residential/group home setting to a non-residential setting. The approach should include supervision, staffing, home settings, and basic program standards.

The objectives of Mother/Baby Residential Program type are:

a. Youth will acquire skills necessary to successfully maintain placement in a less restrictive home setting.
b. The youth will engage in educational or vocational programming while participating in the program.
c. Youth and infants/toddlers will be monitored and assessed for special health and/or mental health care needs and developmental delays.
d. Pregnant or parenting youth will demonstrate appropriate expectations of her infants/toddler's behavior and needs.
e. The youth will understand typical child development.
f. The youth will have a supportive adult connection upon discharge to assist with transitioning from the program into independence or to next placement.
g. Children of parenting youth will remain with the parent without substantiated reports of abuse or neglect.
h. The youth will demonstrate an ability to prioritize her child's needs above her own.
i. The youth will have the ability to reflect on her own parenting strengths and challenges

Eligibility

The Mother/Baby Program is available to youth ages 13 and older who are pregnant and/or parenting and the youth's infants/toddlers. The Contractor shall have the ability to serve both pregnant and parenting youth and the youth's infant/toddler(s).

Symptomology

The youth presents risk in school, home and/or community. The youth has presented risk to self, others and property. The youth has exhibited a behavior(s) that has interfered with his or her ability to function adequately in a less restrictive setting. Such behaviors could include, but may not be limited to: aggressive episodes, stealing or petty theft; vandalism; inappropriate social interactions (threatening behavior, inappropriate language, disruptive school behavior, consistent failure to adhere to rules, incorrigibility in not following adult directives), and/or reactions to past trauma, which results in maladaptive behaviors.

Standardized Assessment Tool

In addition to the assessment tools outlined in Section 2.10, b., the Contractor shall utilize the Adult-Adolescent Parenting Inventory (AAPI) to assess parenting skills progress.

The Contractor shall administer the assessment tools within 30 calendar days of admission and quarterly thereafter until planned discharge as defined in Section 2.10, u.

The tool shall be utilized by a professional trained in the utilization of the identified tool.

Services

For a child in the Mother/Baby Residential Program, the Contractor shall ensure access to the elements of residential care outlined in DCWL standards specific to the license listed in Section 2.4. Additionally, the Contractor shall ensure access to those services outlined in Section 2.10 of this Contract in addition to the following:

a. Interventions through infant mental health or Early On shall be provided as needed and/or recommended for at-risk infants/toddlers.
b. Intensive school supports services e.g., testing, monitoring, tutoring.
c. Transportation Assistance - Assist the parenting youth in accessing necessary transportation to obtain or maintain employment, attend school or vocational training, attend medical appointments and therapy appointments.
d. Access to Mentors - Encourage and develop opportunities for pregnant and parenting youth to be matched with mentors in the community that will provide additional support and a potential long-term connection.
e. Recreational Activities - Provide recreation activities defined as a planned, age appropriate, regular, and recurring set of staff-supervised leisure time events designed to support the youth's treatment plan. These recreational activities shall be supported by appropriate supplies and equipment that are well maintained and in useable condition.

The Contractor shall:

a. Provide activities which shall contain a variety of physical, intellectual, social and cultural opportunities indoors and outdoors.
b. Assign a minimum of one staff for every eight youth/infants to directly supervise the activities.
c. Parenting Skills Training - Parenting Skills Training and interactive training activities shall be utilized in accordance with the outcomes specified in the case service and treatment plan, including child development, improvement and reinforcing of age appropriate social, communication and behavioral skills. Classes and referrals shall address issues which include, but are not limited to:

    (i) Infant care/early infant brain development.
    (ii) Stages of growth in infants.
    (iii) Safe Sleep.
    (iv) Infant/toddler safety.

(v) Parenting preparation.
(vi) Child development.
(vii) Child health care.
(viii) Infant/toddler emotional and social needs.
(ix) Child management skills and positive discipline.
(x) Parent/child roles and communication.
(xi) Responsible fatherhood.
(xii) Developing secure attachment.
(xiii) Securing appropriate childcare.
(xiv) Stress management and coping skills.
(xv) Domestic violence.
(xvi) Changes in parent mood and awareness of surroundings under the influence of recreational drugs or alcohol.
(xvii) How to access community resources.

In addition to parenting classes, programming shall address specialized bonding and attachment sessions and activities to promote secure attachments between the parent and infant. Research indicates early attachments lay the foundation for social, emotional and academic skills. Interactive parenting activities shall include opportunities to capitalize on teachable moments with the adolescent parent, promote the value of family literacy with teaching nursery rhymes, songs, etc. and offer various interactive play activities that engage both the youth and her baby.

a. Community Referrals - Referrals shall be made to community resources such as Early Head Start, Early On, Parent Infant Program, Infant Mental Health or other in-home programs and documented in the service plan. Research has shown that participation in this type of programming is linked to several positive impacts on parenting, child development, and economic self-sufficiency.

b. Childcare Assistance - The youth shall be provided assistance in obtaining appropriate childcare while she is participating in programming to enhance her self-sufficiency. Childcare can be provided on site or off site by a licensed childcare provider.

   The Contractor shall ensure the infant/toddler childcare is of high quality that promotes the child's social, emotional, cognitive and verbal development.

c. Outreach to Fathers - Unless documented that it would be contrary to the best interest of the child and/or mother or if required in a court order, the contractor will make extensive efforts to engage fathers to foster involvement in the infant/toddler's life and to assist the pregnant/parenting youth in obtaining a supportive support network. The program shall allow for the father's select participation in parenting skills trainings, visitations with child and child-parent

activities. The father should be encouraged to attend prenatal and/or well-baby medical appointments.

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every XX youth, infant/toddler during waking hours.
b. Maintain a minimum of one on-duty direct care worker for every XX youth, infant/toddler during sleeping hours. All of these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

The staffing ratio includes the youth infant/toddler.

Additional Staff Training Topics

The Contractor shall provide the following training topics in addition to those outlined in Section 2.10, d., 3), of this Contract:

a. Medical, physical, and psychological aspects of pregnancy.
b. Prenatal and postnatal care.
c. Infant and toddler development.
d. Safe Sleep practices.
e. Childcare.
f. Parenting skills training techniques.
g. Attachment theory.

Reporting

The Contractor shall include youth in the development of the treatment plan. The treatment plan must:

a. Assist the youth in her preparation and transition to adult living and responsible parenting.
b. Include outcomes identified through the Independent Living assessments.
c. Identify the youth's educational and/or vocational goals.
d. Outline the youth's other personal goals.

In addition to the youth's goals, the treatment plan shall address the following:

a. The infant's/child's daily needs, establishing daily exclusive time with the infant, providing stimulating development and educational activities with the infant.
b. The infant's/child's daily routine or schedule.
c. The youth's coordination and arrangement of medical care for the infant and other necessary services.
d. The youth's participation in parenting skills classes.

Program Performance Objectives

During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this Contract in addition to the outcomes identified below. The Contractor shall submit the data quarterly on the template provided by MDHHS.

a. The percentage of youth who show improvement in her parenting skills upon discharge from the Mother Baby Program based upon the findings documented in the AAPI.
b. The percentage of youth who demonstrate an increase in understanding of her infant's/toddler's needs as measured by the Casey Life Skills supplemental or Daniel Memorial assessment as applicable to the teen parent.
c. The percentage of infant's/toddlers who remain placed with his/her mother after discharge from the residential setting.

Unit Definition: One unit equals one day in residence for a pregnant youth and/or mother with infant. The unit rate includes care and services provided to a youth's infant/toddler.

7. Specialized Developmental Disability (SDD)

Definition

The Specialized Developmental Disability (SDD) program provides enhanced residential treatment to youth with intensive and specialized service needs related to developmental disabilities, including autism, and intellectually disabled youth, who have deficits in social communication skills, sensory activity, and a limited ability to conduct daily living tasks without intensive support.

Symptomology

A child whose level of developmental impairment warrants a significant sensory sensitive individualized treatment setting.

Program is designed for youth diagnosed with Autism Spectrum Disorder; or youth with intellectual or developmental disability.

Children experiencing significant deficits in social communication skills, sensory sensitivity and a limited ability to conduct daily living tasks without intensive support which prevents youth from adjusting satisfactorily to a lessor restrictive treatment environment.

Children who will benefit from a controlled environment that is tailored to their developmental and functioning level.

Standardized Assessment Tool

The assessment tools identified in Section 2.10, b. of this contract are not required for youth served under the SDD program type.

The Contractor shall utilize one or more of the following assessment tools for all youth entering the program, regardless of any previous assessments conducted by any provider:

- Autism Diagnostic Observation Schedule (ADOS)
- Pearson's Expressive Vocabulary Test (PEVT)
- Assessment of Functional Living Skills (AFLS)

Assessments will be completed by a Board-Certified Behavior Analyst (BCBA) or by a professional trained in the utilization of the identified tool.

The Contractor shall administer the assessment tool within 21 calendar days of admission, and quarterly thereafter until planned discharge as defined in Section 2.10, u.

Services

The child shall have an Applied Behavior Analysis (ABA) treatment plan within 30 days of placement if ABA services are appropriate to the individual youth.

a. An Applied Behavior Analysis (ABA) treatment plan within 30 days of placement if ABA services are appropriate to the individual youth
b. Nurse oversight of side effects with psychotropic medications
c. Family engagement and enrichment activities.
d. Intensive activity-based individual or specialized group therapy at least one time weekly.
e. Independent living skills assessment/preparation and community reintegration to the extent identified as appropriate for the individual youth.
f. Adjunct therapy provided either on site or in the community when these or any other interventions are prescribed by a treating physician or required by an assessment/IEP. *(Examples include recreational therapy, occupational therapy, music therapy, art therapy, speech therapy, physical therapy, and respiratory therapy)*
g. Peer support groups.
h. Family therapy directed toward the establishment and utilization of positive behavioral management and strengthening family relationships.
i. Aftercare service planning as described in Section 2.10. u. (Transitional Service Following Discharge).

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every XX children during waking hours.
b. Provide an additional floating staff that will be able to provide supervision when children are new to the program or display significant behavior outburst or

significant needs associated with daily living activities. This program is not eligible for additional 1:1 service payment.

c. Maintain a minimum of one on-duty direct care worker for every four children during sleeping hours. All these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Program Performance Objectives

During the contract period, the Contractor shall track youth for only the outcome measures a, c, & d listed in Section 2.11 of this Contract in addition to the outcomes identified below. The Contractor shall submit the data quarterly on the template provided by MDHHS.

a. Percentage of youth who demonstrate progress in expressive and receptive communication skills (verbal and non-verbal) as shown by a communication skills assessment.
b. Percentage of youth with an increased ability to tolerate changes in routine or environment via an increase in score of approved assessment.
c. The percentage of youth who demonstrate an understanding of their environment and manage their response as shown by a reduction in negative behaviors and an increase in the ability to appropriately express feelings and needs at the time of discharge.

8. Intensive Stabilization

Definition

The Intensive Stabilization (IS) program provides a therapeutic environment for youth who are in current crisis or have not been able to maintain stabilized behavior. This program offers intensive specialized services in a trauma-informed short-term program. The intent of the program is to stabilize crisis while diagnostic services and supports are provided to meet the short-term treatment goals of the youth and has a lower staff to child ratio than other residential programs. The program will help identify short and long-term treatment goals, community supports, and secure an appropriate living situation for youth which will allow the youth to return to a community-based setting as soon as possible.

Symptomology

A youth with significant behavior challenges, youth being stepped down from a hospitalization program or youth experiencing repeated placement instability. Children may be currently experiencing or have a history of active unstable symptoms which may include: severely aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations, suicidal/homicidal ideations), and/or frequent severe emotional episodes. The child is non-compliant

with and/or not stabilized on medication. The child has a high risk of serious self-harm and aggression. Lack of intact thought process.

Standardized Assessment Tool

In addition to the assessment tools outlined in Section 2.10, b., the Contractor shall utilize the following types of assessments:

a. Biopsychosocial Assessment
   The youth and family (whenever possible) participate in the development of a comprehensive, individualized, strength-based, trauma informed, family-focused, culturally responsive assessment that informs and guides service delivery, discharge planning and aftercare services. Assessment is completed by a Therapist within 3 days of admission to the program. Assessments are integrated to address multiple life domains, assess for co-occurring mental health and substance use condition, and include a summary of symptoms and a diagnosis. Assessments are conducted face-to-face and include an assessment of natural supports and resources. Screening tools may be used as part of the assessment process.

b. Psychiatric Assessment is completed within 72 hours of admission to the facility. Parent, guardian, caregiver, or support person identified are required to attend the Psychiatric Assessment. It is critical that the youth, Parent/Guardian/Caregiver/Support Person participate in the Psychiatric Assessment. If any medication changes are made the parent or guardian will need to sign a medication consent form. New medications cannot be started without this consent in place.

c. Nursing Assessment will be completed with 24 hours of admission. This assessment will also include an assessment of nutritional needs

There may be identified conditions, needs, or issues that require further assessment by practitioners of other disciplines. Psychiatric stability will be important for the validity of any additional assessments so consultation with the Psychiatrist will occur prior to scheduling additional assessments. The Therapist will coordinate with referral source in coordinating and making referrals for those assessments. In such instances, an authorization to release information is signed by the guardian/family so that the referral may be made. Examples of additional assessments include but are not limited to neurological, psychological, developmental, occupational, speech, hearing, nutritional, and medical.

The tools shall be utilized by a professional trained in the utilization of the identified tool.

Treatment planning:

An initial treatment plan will be developed within 4 days of admission. All stabilization services and interventions mush be directly related to the goals and objectives established in each youth's individual service plan (ISP). The ISP is developed by the youth/family/treatment team in collaboration with the provider agency. Family/caregiver involvement is extremely important and unless contraindicated, should occur from the beginning of treatment and continue as frequently as possible, as determined appropriate in the ISP.
The ISP must identify the youth's interests, preference, and needs as determine to be appropriate by the treatment team, in the following areas:

- Physical and emotional well-being
- Risk and safety factors
- Nutrition
- Personal care needs
- Cognitive and education abilities
- Recreation and leisure time
- Community participation
- Communication
- Religion and culture
- Social and personal relationships
- And other areas determined important by the youth

The goal of treatment will focus on stabilizing youth in crisis, supporting and assisting the youth in achieving greater independence and fulfillment in their life, while improving the youth's functioning, participation and reintegration into the family home/resource home/ or potentially transition in to an alternative out of home living situation.

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every xx children during waking hours.
b. Maintain a minimum of one on-duty direct care worker for every xx children during sleeping hours. All of these staff shall be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services

a. Nurse oversight of side effects with psychotropic medications
b. Intensive activity-based individual or specialized group therapy.
c. Family therapy and/or family activity programs.
d. Independent living skills assessment/preparation and community reintegration.
e. Family therapy directed toward the establishment and utilization of positive behavioral management and strengthening family relationships.

f. Aftercare service planning, connecting the children with services that include coordinating a referral and initial appointment with a local Community Mental Health center for casework services for persons with developmental delays.
g. 1:1 staff/child ratio, if required for child safety, upon documentation of safety issues and with written approval from DCWL.

Program Performance Objectives
During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this Contract in addition to the outcomes identified below. The Contractor shall submit the data quarterly on the template provided by MDHHS.

9. Human Trafficking Survivor

Definition
The Intensive Stabilization HTS (ISHTS) program provides a therapeutic intervention and stabilization environment for youth who are in crisis due to sex or labor trafficking or other severe forms of sexual exploitation. ISHTS provides intensive, trauma-informed Integrated Behavioral Health stabilization services focused on youth who are typically rescued from trafficking situations. The intent of the program is to stabilize the youth while diagnostic services, supportive relationships and treatment goals are established. The anticipated length of stay could be from 3 to 9 months depending on the familial relations, youth needs and relationship to the trafficker. It is an important consideration to explore power and control dynamics between the youth and the trafficker. When the role of the trafficker is identified as a parent, trusted family member or familial acquaintance, the trafficker has ruptured the youth's perception of trust therefore posing complex and complicated challenges toward possible solutions to build positive relations with others. The program team implements crisis and safety care plans as well as identify short and long-term treatment goals. Preparation toward community reintegration will be contingent upon development of community supports and an appropriate living situation. Final preparation and implementation of discharge plan will be established in the program.

Symptomology
A youth who has experienced significant trauma and behavioral challenges resulting from commercial sexual exploitation or sex trafficking. Youth may have required psychiatric hospitalization due to history or experiencing active unstable symptoms which may include aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations), suicidal/homicidal ideations, serious self-injurious behaviors and/or frequent severe emotional episodes.

Standardized Assessment Tool
In addition to the assessment tools outlined in Section 2.10, b., the Contractor shall utilize the following types of assessments:

a. Biopsychosocial Assessment - The youth and family (whenever possible) participate in the development of a comprehensive, individualized, strength-

based, trauma informed, family-focused, culturally responsive assessment that informs and guides service delivery, discharge planning and aftercare services. Screening Tools and Assessments are completed by a clinically trained professional as part of the admissions process. Assessments are conducted face-to-face and integrated to address multiple life domains, assess for co-occurring mental health and substance use condition, and include a summary of symptoms, diagnosis and treatment recommendations.

b. Psychiatric Assessment is completed during the admission process and may include youth, parent/guardian, caregiver or support person. Recommendations for psychotropic medications may be discussed to reduce distressful symptoms in addition to evidence-based treatment modalities. If any medication changes are made, the parent or guardian will need to sign a medication consent form. New medications cannot be started without this consent in place.

c. Comprehensive Nursing Assessment is completed during the admission process to include youth's history, assessment of physical, behavioral and mental state, vital signs and other measurements as needed based upon current medical condition. The specially trained registered nurse has the credential as a sexual assault nurse examiner to support sexually assaulted victims and provide a medical forensic examination.

d. Integrated Behavioral Health Team Assessment may include a thorough review from a multi-disciplinary team approach if severity of trauma responses and ongoing psychiatric instability exceeds the anticipated timeframe for improvement noted in the treatment plan.

There may be identified conditions, needs, or issues that require further assessment by practitioners of other disciplines. Psychiatric stability will be important for the validity of any additional assessments so consultation with the Psychiatrist and Pediatrician will occur prior to scheduling additional assessments. The Therapist and/or Nurse will coordinate with referral source for making referrals. In such instances, an authorization to release information is signed by the guardian/family so that the referral may be made. Examples of additional assessments include but are not limited to neurological, psychological, developmental, occupational, speech, hearing, nutritional, and medical.

The assessment tools shall be utilized by a professional trained in the identified tool.

<u>Treatment planning:</u>
An initial treatment plan will be developed within 30 days of admission. All stabilization services and interventions mush be directly related to the goals and objectives established in each youth’s individual service plan (ISP). The ISP is developed by the youth/family/treatment team in collaboration with the provider agency. Family/caregiver involvement is extremely important and unless

contraindicated, should occur from the beginning of treatment and continue as frequently as possible, as determined appropriate in the ISP.

The ISP must identify the youth's interests, preference, and needs as determine to be appropriate by the treatment team, in the following areas:

- Physical and emotional well-being
- Risk and safety factors
- Nutrition
- Personal care needs
- Cognitive and education abilities
- Recreation and leisure time
- Community participation
- Communication
- Religion and culture
- Social and personal relationships
- And other areas determined important by the youth

The goal of treatment will focus on stabilizing youth in crisis, supporting and assisting the youth in achieving greater independence and fulfillment in their life. Treatment will focus on improving the youth's functioning, participation and reintegration into the family home/resource home or potentially transition into an alternative out of home living situation (independent living).

Staffing Ratio

The Contractor shall:

a. Provide a minimum of one on-duty direct care worker for every XX youth during school hours, and 3 for therapeutic hours.
b. Maintain a minimum of one on-duty direct care worker for every XX youth during sleeping hours. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services

a. Nursing oversight of medication side effects and supportive services to include sexual assault examination if applicable.
b. Expressive therapeutic activities or specialized group therapy.
c. Independent living skills assessment/preparation and community reintegration.
d. Family therapy and/or family activity programs focused on strengthening family relationships and positive familial coping during crisis
e. Aftercare service planning by connecting the youth with services that include coordinating a referral and initial appointment with a local Community Mental Health center
f. 1:1 staff/child ratio, if required for youth safety, upon documentation of safety issues and with written approval from DCWL.

Program Performance Objectives

During the contract period, the Contractor shall track youth for the outcome measures listed in Section 2.11 of this agreement. The Contractor shall submit the data quarterly on the template provided by MDHHS.

Attachment B: Glossary of Acronyms and Forms

AAPI:	Adult-Adolescent Parenting Inventory
ABA:	Applied Behavior Analysis
ABPN:	American Board of Psychiatry and Neurology
AFLS	Assessment of Functional Living Skills
ADOS:	Autism Diagnostic Observation Schedule
AWOLP:	Absent Without Legal Permission
BCBA:	Board Certified Behavior Analyst
DCWL:	Division of Child Welfare Licensing
CANS:	Child Assessment of Needs and Strengths
CBT:	Cognitive Behavioral Therapy
ERASOR:	Estimate of Risk of Adolescent Sexual Offense Recidivism
FOM:	Foster Care Online Manual
GED:	General Education Development
IEP:	Individualized Education Plan
IEPT:	Individual Education Program Team
ISEP	Implementation, Sustainability, and Exit Plan
J-SOAP:	Juvenile Sex Offender Assessment Protocol
LGAL:	Legal Guardian ad Litem
MiSACWIS:	Statewide Automated Child Welfare Information System
PEVT	Pearson's Expressive Vocabulary Test
PAFC:	Placement Agency Foster Care Provider
PTSD:	Post-Traumatic Stress Disorder
SED:	Serious Emotional Disturbance

DHS-441:	Case Service Plan
DHS-69:	Foster Care Juvenile Justice Action Summary
DHS-221:	Medical Passport
DHS-365:	Residential Initial Treatment Plan
DHS-366:	Residential Updated Treatment Plan
DHS-1643:	Psychotropic Medication Consent
DHS-3307:	Initial Placement Outline and Information Record
DHS-3377:	Clothing Inventory Checklist
DHS-3600:	Individual Service Agreement
DHS-4765-YA:	Young Adult Voluntary Foster Care Invoice