



Michael R. Bloomberg
Mayor

Ronald E. Richter
Commissioner

**THE CITY OF NEW YORK
ADMINISTRATION FOR CHILDREN'S SERVICES
Limited Secure Placement
Negotiated Acquisition**

PIN: 06813N0004

NA RELEASE DATE: March 25, 2013

PROPOSALS DUE DATE: April 25, 2013

RETURN TO: Administration for Children's Services
Office of Procurement
150 William Street, 9th Floor
New York, NY 10038
Attention: Michael Walker

This Negotiated Acquisition ("NA") must be obtained directly from the Administration for Children's Services ("ACS") in person or by downloading it from the ACS Web site, www.nyc.gov/acs. If you obtained a copy of this NA from any other source, you are not registered as a potential proposer and will not receive addenda ACS may issue after release of this NA, which may affect the requirements and/or terms of the NA.

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AUTHORIZED AGENCY CONTACT PERSON

Proposers are advised that the Authorized ACS Contact Person for all matters concerning this NA is:

Name:	Michael Walker
Address:	Administration for Children's Services Office of Procurement 150 William Street, 9th Floor New York, New York 10038
Telephone #:	(212) 341-3617
E-mail Address:	michael.walker@dfa.state.ny.us

SECTION I – TIMETABLE

A. Questions and Requests or Information:

All questions and requests for additional information concerning this Negotiated Acquisition (“NA”) must be directed to the authorized Agency Contact Person:

Name: Michael Walker
Address: Administration for Children’s Services
Office of Procurement
150 William Street, 9th Floor, New York, NY 10038
Phone: (212) 341-3617
Fax: (917) 551-7329
Email: michael.walker@dfa.state.ny.us

B. Pre-Proposal Conference:

Date: April 9, 2013

Time: 10:00 AM

Location: 150 William Street, 19th Floor, New York, NY 10038

Attendance by proposers is optional but recommended by ACS.

C. City-Leased Site Visits:

ACS is offering site visits to the Brooklyn Residential Center and Staten Island Residential Center on April 11, 2013 and a site visit to the Bronx Residential Center on April 12, 2013. Details are given in Section II D (10). City-Leased Site Floor Plans are available in Appendix 7.

D. Proposal Due Date and Time and Location:

Date: April 25, 2013

Time: 2:00 PM

Location: ACS, Office of Procurement
150 William Street, 9th Floor
New York, NY 10038
Attention: Michael Walker

ACS will not accept e-mailed or faxed proposals.

Proposals received at this location after the Proposal Due Date and Time are late and shall not be accepted by ACS, except as provided under New York City’s Procurement Policy Board Rules. ACS will consider requests made to the Authorized Agency Contact Person to extend the Proposal Due Date and Time prescribed above. However, unless ACS issues a written addendum to the NA that extends the Proposal Due Date and Time for all proposers, the NA Due Date and Time prescribed above must remain in effect.

E. Anticipated Contract Start Date:

The anticipated contract start date is July 1, 2013. The anticipated program start date for all programs is October 1, 2013

SECTION II - SUMMARY OF THE NEGOTIATED ACQUISITION

A. Purpose of the Negotiated Acquisition

1. Through this Negotiated Acquisition (“NA”) solicitation, the New York City Administration for Children’s Services (“ACS”) is seeking qualified Contractors to provide Limited Secure Placement (“LSP”) services through the operation of LSP Program sites and LSP Aftercare for youth who have been placed into the custody of ACS by a Family Court judge pursuant to Family Court Act Article 3 and who have been deemed by the court or ACS to be appropriate for LSP. LSP will be part of a residential care continuum for adjudicated Juvenile Delinquents (“JD”) in New York City overseen by ACS pursuant to the Close to Home legislation.
2. Through the Close to Home legislation, after the New York State Office of Children and Family Services (“OCFS”) approves ACS’ plan, New York City is authorized by New York State to provide juvenile justice services, including residential non- and limited secure placement sites, to adjudicated delinquent youth who reside in the City. “Adjudicated delinquent youth” is the term used to describe young people who have been adjudicated by the Family Court to be a JD in a proceeding brought pursuant to Article 3 of the Family Court Act. Pursuant to the Close to Home legislation, adjudicated youth who need to be confined in LSP Program sites will no longer be placed into the custody of the New York State Office of Children and Family Services (“OCFS”) as was previously done, but instead will be placed into the custody of ACS.
3. The goal of Close to Home and, thus of this NA, is to improve outcomes for youth in the juvenile justice system, and increase community safety. Recidivism rates will be reduced when youth, whether they are in the community or in residential care, are able to take advantage of local programs and opportunities, and when families and other discharge resources are given tools to participate in their youth’s rehabilitation.
4. LSP Program sites shall be largely self-contained sites, meaning the majority of services for youth and families are provided onsite. The services provided must include, but are not limited to youth care, food, clothing, transportation, recreation, court-related services, social work and case planning services, social skills instruction, access to mental health and substance abuse treatment, coordination of education and health care, and the monitoring and supervision of these services. The LSP Program sites shall consist of general and specialized programs that offer high-level and intensive clinical services for youth who need this structure. All General and Specialized Program sites must utilize a practice model or approach as a basis for LSP program services.
5. Safety of the youth, staff and community is of paramount concern to ACS with respect to the operation of LSP Program sites. Contractors shall utilize best practices, de-escalation techniques that are research and data supported to be successful, and a youth development approach that shall best ensure a safe environment both within an LSP Program site and in the surrounding community. The LSP treatment approach shall not be a traditional correction model, but instead shall utilize rehabilitative and therapeutic approaches that provide support and supervision to youth in LSP Programs.
6. Continuity of services when youth transition from residential placement back to the community is an essential component of LSP Program services. LSP Aftercare services shall be provided to assist in the transition of youth back to their home communities by providing intensive in-home services that promote behavior change in the youth's home environment. LSP Aftercare services shall be provided by the Contractors through the implementation of an evidence-based model (“EBM”), adaptation of an evidence based model (“AEBM”) or promising practice model (“PPM”) directed at reducing delinquency and recidivism, improving school attendance and achievement, and improving family functioning and relationships.
7. In order to build positive and ongoing relationships between youth and their communities, Contractors shall form Community Advisory Boards for their LSP Program sites, participate in local Community

Partnership Programs (“CPP”) and work to develop local networks of service providers, community members and other stakeholders with the goal of assisting families and offering safety and support in communities where the youth reside. Contractors may form linkages to bring community-based programming into the LSP Program site for the benefit of the youth in consultation with ACS. Upon discharge of youth from LSP Program sites, Contractors shall link the youth and their families, or other discharge resources, they serve with local social service and recreational programs, so that youths may engage in pro-social activities and families can obtain the support they need in their own communities. Pro-social activities are activities for youth, often recreational in nature, that provide positive peer-to-peer interaction for the youth. While ACS requires Contractors to participate in CPP, for the purposes of establishing local networks, ACS expects proposers to have linkages and therefore proposers are required to have a minimum of three (3) linkage agreements, to be submitted prior to the LSP program start date, with local programs that can provide pro-social activities for the youths served by the Contractor prior to the program start date.

B. Target Population

1. The youth placed in LSP Program sites are New York City youth, who have been adjudicated by New York City Family Court for having committed, before the age of sixteen (16) an act that would constitute a crime had they been an adult. The Family Court Act provides that youth between the ages of seven (7) and twenty-one (21) may be in placement in LSP Program sites. Most youth residing in LSP Program sites will be between the ages of fourteen (14) to eighteen (18), however, there may be occasions where LSP Program sites will serve older or younger youth.
2. It is anticipated that the majority of youth in LSP will present with mental health and/or substance abuse needs. Of youth admitted to OCFS-operated LSPs in 2010, 26% were re-arrests or returns from AWOL; 32% were new admissions; and 42% were modifications of placement. 90% of the youth admitted to OCFS LSP in 2010 presented with substance abuse or mental health needs, both in new admissions and modifications of placement. Over 75% of youth require treatment for conduct/oppositional defiant disorders, and the girls admitted to LSP present with higher frequency of DSM-IV Axis 1 diagnoses than the boys. Forty-eight percent of new admissions to LSP were admitted for misdemeanor offenses, 10% for non-violent felony offenses and 40% for violent felony offenses. OCFS data reflect that 50% of female new admissions were fourteen (14) years old or younger, while 16% of the new admissions of males were fourteen (14) or younger.

C. Service Options

1. There are five (5) Service Options, as indicated in the chart below. Proposers may submit a proposal to one (1), multiple, or all of the Service Options.

Service Options	Total # of Beds
Service Option 1: General LSP (“General LSP”).	108
Service Option 2 - Specialized LSP: Must propose to serve the two listed populations Youth With Intellectual/Developmental Disabilities (“IDD”) – (6 Beds) Youth with Serious Emotional Disturbance (“SED”) – (6 Beds)	12
Service Option 3- Specialized LSP: Youth With Who Have Demonstrated Problematic Sexual Behaviors (“PSB”)	12
Service Option 4 - Specialized LSP: Must propose to serve the three listed populations Youth With Intellectual/Developmental Disabilities (“IDD”) – (6 Beds) Youth with Serious Emotional Disturbance (“SED”) (12 Beds) Diagnosis and Youth Who Have Demonstrated Fire Setting Behaviors (4 designated beds within SED)	18
Service Option 5 – Specialized LSP: Intensive Short Term Support (“IS”)	8

2. Proposers must submit separate proposals for each Service Option being proposed.
3. For each Service Option, each proposal must serve youth from all five boroughs and serve males and females. Males and females will not be served at the same time except as designated in Service Option 5, or on a case by case basis when adhering to the ACS LGBTQ policy (attached as Appendix 3).
4. ACS anticipates approximately 11 contracts will be awarded through this solicitation.
5. ACS anticipates awarding multiple contracts in Service Option 1 to cover the total allotment of beds available. . This Service Option includes services at three City leased sites listed below in (Section II(D)(10)(a), and will provide services located in at least one non-City-leased ADA accessible site.
 - a. Proposers proposing for Service Option 1 in a non-City-Leased Site must propose sites with twelve (12), or twenty-four (24) beds.
6. ACS will only award one contract per Service Options 2, 3, 4 and 5.
 - a. Proposers proposing for Service Options 2, 3, 4 and 5 must propose the total number of beds as indicated in the chart above. Additionally all beds must be located at one (1) LSP Program site per Service Option. The City-Leased Sites are not available for Service Options 2-5.

D. LSP Program Sites

1. All LSP Program sites shall be located in or in close proximity (up to 25 miles outside of New York City) to the New York City communities in which the youth and their families live, so that:
 - a. families, attorneys and other adults significant to the youth may travel easily by public transportation to the LSP Program sites in order to participate actively in the youth’s rehabilitation and
 - b. youth and families are provided with community-based aftercare services that begin working with the youth and families before the placements end.
2. Proposers must indicate on the Cover Form (Attachment A) the Proposer’s intent to operate a LSP Program in one of the following types of sites:
 - a. City-Leased Site (for Service Option 1 only),
 - b. Proposer’s own site within one of the five boroughs of New York City.
 - c. Proposer’s own site outside of New York City (within twenty-five (25) miles of New York City),

or

d. A site To Be Determined within the five boroughs of New York City.

3. City-Leased Sites are available only to Service Option 1 - General LSP. General LSP proposers also have the option of proposing their own site within the five boroughs of New York City, a site outside New York City within 25 miles, or a site To Be Determined within the five boroughs of New York City.
4. Specialized LSP proposers have the option of proposing their own site within the five boroughs New York City, a site outside New York City, or a site To Be Determined within the five boroughs of New York City.
5. Proposers submitting a proposal for Service Option1 - General LSP shall indicate on the Cover Form (Attachment A) whether they are willing to move their proposed program to a City-Leased Site. ACS may consider this if there are insufficient technically viable proposers for these sites. Additionally, if a technically viable Proposer proposes for a City-Leased Site that has already been awarded to another Proposer, the Proposer may be considered for an award in another City-Leased Site or a site to be determined by also indicating their willingness to move and /or find another site on the Cover Form (Attachment A).
6. ACS will recommend an award to the highest scoring technically viable site within the five boroughs of New York City that is readily accessible to and useable by individuals with disabilities or will by the program start date and within the start-up funding listed below in sections G and H.
7. ACS strongly prefers Proposers to identify the site in which the Proposer intends to operate its LSP Program. In the event that there are insufficient technically viable providers submitting proposals that identify a site, ACS may consider proposals where a site has not yet been identified by the Proposer. Proposers submitting a proposal for Service Option 1 – General LSP at a City Leased site, shall also indicate on the Cover Form (Attachment A) whether they are willing to identify a site within the five boroughs of New York City if they are not awarded a City-Leased Site.
8. ACS also strongly prefers all LSP Program sites be located within the five boroughs of New York City. In the event that there are insufficient technically viable Contractors offering sites that are located within the five boroughs of New York City, ACS may consider proposed LSP Program sites located up to 25 miles outside of New York City. ACS, in its sole discretion, and subject to its determination that such LSP Program sites are reasonably accessible to New York City (within twenty-five (25) miles of New York City). Proposers proposing LSP Program sites outside of New York City must submit a plan to move to a site within the five (5) boroughs of New York City within two (2) years of the effective date of the OCFS approved Close to Home LSP Plan for New York City.
9. All sites must be approved by all applicable regulatory agencies, including but not limited to ACS, OCFS, Department of Buildings, Department of Environmental Protection, and local fire departments prior to accepting youth.
10. City-Leased Sites
 - a. The three (3) City-Leased Sites that ACS is offering are the following:
 - 1) Brooklyn Residential Center (20 beds)
1125 Carroll Street
Brooklyn, NY 11225
 - 2) Bronx Residential Center (20 beds)
170 East 210th Street
Bronx NY, 10467

- 3) Staten Island Residential Center (20 beds)
1133 Forest Hill Road
Staten Island, NY 10314
- a. ACS is offering site visits to General LSP Proposers. ACS will provide transportation as outlined below for the site visits. Proposers that propose to operate General LSP at one or more City-Leased site(s) must attend the site visit(s) for each site that is being proposed.
- b. Proposers must RSVP by 5:00PM April 5, 2013, via email to lizette.diaz@dfa.state.ny.us. The RSVP must include the following information:
- 1) The site visit(s) the Proposer will attend;
 - 2) The name of the Proposers organization;
 - 3) The number of people attending each visit;
 - 4) Indicate if the Proposer will be utilizing ACS transportation (described below);
 - 5) If using ACS transportation, the number of people.
- c. ACS is offering site visits to the Brooklyn Residential Center and Staten Island Residential Center on April 11, 2013.
- 1) Departing 150 William Street New York, NY 10038 – vans will be located on Fulton Street (between William and Gold Streets) directly outside the entrance to Lots for Less at 9:30AM on April 11, 2013
 - 2) Arriving at Brooklyn Residential Center at 10:15AM
 - 3) Departing Brooklyn Residential Center at 11:45AM
 - 4) Arriving at Staten Island Residential Center at 12:45PM
 - 5) Departing Staten Island Residential Center at 2:30PM
 - 6) Arriving at 150 William Street New York, NY 10038 at 3:45PM
- d. ACS is offering a site visit to the Bronx Residential Center on April 12, 2013
- 1) Departing 150 William Street New York, NY 10038 – vans will be located on Fulton Street (between William and Gold Streets) directly outside the entrance to Lots for Less at 9:30AM on April 12, 2013
 - 2) Arriving at Bronx Residential Center at 10:30AM
 - 3) Departing Bronx Residential Center at 12:15PM
 - 4) Arriving at 150 William Street New York, NY 10038 at 1:15PM
- e. For any site information the day of the visits, you may contact Lisa Crook at 646-574-5698.
- f. City-Leased Site Floor Plans are attached in Appendix 7. Photos are also available on the acs website www.nyc.gov/acs with the solicitation.
- g. ACS will not charge the Contractor rent to operate LSP Programs in the City-Leased Sites; however the Contractor shall be responsible for all ongoing operating, maintenance, fire safety and security expenses associated with the City-Leased site at no cost to ACS. Contractors operating in a City-Leased Site shall provide services and maintain and repair building systems, equipment and fixtures, including administration of all contracts for such services such as on-call building maintenance contracts at the Contractor's sole expense with the exception of Capital Work as defined herein, in accordance with the Agreement, ACS policies and all Laws, ordinances and regulations. Capital Work involves the construction, reconstruction, major renovation or replacement of systems or major portions of systems including but not limited to heating, ventilating and air conditioning (HVAC) systems, elevator replacement (when applicable), electrical and distribution system; fire alarm system exterior façade, parapet reconstruction

(including pointing), roofing systems, and major plumbing work including work such as replacement of storm drains.

- h. It is anticipated that LSP Programs in City-Leased Sites will be fully operational, including all applicable certifications, and ready to begin accepting youth, no later than October 1, 2013.

11. LSP Sites of Proposers' Choosing Located in NYC or Outside NYC within 25 miles.

- a. Proposers not proposing a City-Leased Site may propose their own sites, in or outside of New York City, as indicated above.
- b. ACS will perform a site visit of all proposed sites before an award is recommended. The Site Visit Checklist (Appendix 5) will be utilized as the standard for approval of LSP sites. In order to obtain approval, sites must either include all items on the checklist, or the Proposer's plans to add the items to the LSP Program site must be fair and reasonable as determined by ACS and within the budget and timeframe of LSP development.
- c. All LSP Program sites in this category must be fully operational, including all applicable certifications, and ready to accept youth October 1, 2013

12. LSP Sites to be Determined

- a. Proposers not proposing a City-Leased Site, or proposing their own site within or outside of New York City, may submit a proposal that does not identify a site within the five boroughs of New York City in which the LSP Program will be operated.
- b. If a proposal that does not identify a site in which the LSP Program will be operated is recommended for an award pursuant to this solicitation, the recommended awardee must submit to ACS an identified address of the intended LSP Program site within the five boroughs of New York City no later than forty-five (45) calendar days after the recommendation for award. In the event the recommended awardee of a site to be determined fails to submit an address for their intended LSP Program site within the forty-five (45) calendar day deadline, ACS at its sole discretion may withdraw the award recommendation.
- c. All proposed sites must be visited, and approved by ACS. In order to obtain approval, sites must be within the five boroughs of New York city and either include all items on the Site Visit Checklist (Appendix 5), or the Proposer's plans to add the items to the LSP Program site must be fair and reasonable as determined by ACS and within the budget and timeframe of LSP Program development.
- d. All LSP Program sites in this category must be fully operational, including all applicable certifications, and ready to accept youth, by October 1, 2013.

E. LSP Aftercare Locations

- 1. Contractors shall provide LSP Aftercare services to all youth discharged from LSP Programs in Service Options 1 – 4. In certain circumstances described in more detail in Section III(L), Contractors shall provide LSP Aftercare services to the youth being discharged from their LSP Program.
- 2. Nearly all LSP Aftercare services shall be provided in the youth's family or discharge resource's home or at locations in the community in which the youth and family or discharge resource live (e.g., the youth's school, community-based mental health clinics, community-based after-school programs, community settings, and not in the provider's program office). Contractors shall take into consideration the safety needs of families when determining if home-based services are appropriate, for example, when there is a history or evidence of domestic violence in the family, in these circumstances, it may be more appropriate to meet with the family outside of the home.
- 3. Contractors operating LSP Aftercare in Service Options 1-4 must have available to them private office

space in all five (5) boroughs to provide services in an office setting to youth and families who are unable or unwilling to receive services in their home or an alternate location in the community. If a Contractor does not have its own office space in all five (5) boroughs, it must form written linkage agreements with other organizations to enable it to have access to office space appropriate for the provision of LSP aftercare in all five (5) boroughs. LSP Aftercare office space locations may be identified by a Contractor after receiving a contract award, but must be identified at least thirty (30) days prior to the program start date.

4. All program offices, including all offices made available to Contractors via the required linkage agreements, must be readily accessible and usable by individuals with disabilities, including but not limited to, people with visual, auditory, and/or mobility disabilities.
5. All sites utilized by Contractors shall be accessible to public transportation so that youth and families may access the site for services if needed.

F. Anticipated Contract Term

1. It is anticipated that the term of the contracts awarded from this solicitation will be from July 1, 2013 to June 30, 2016, with two (2) three (3) year options to renew. Prior to the contract award, ACS reserves the right to determine the length of the initial contract term and each option to renew, if any.

G. LSP Program Site Start-Date

1. LSP Programs Sites must be, fully operational, including all applicable certifications, and ready to begin accepting youth, no later than October 1, 2013.

H. Anticipated Available Funding

1. It is anticipated that the available annual funding for all the contracts awarded from this solicitation will be \$35,219,449.20 with an additional \$3,219,300.00 available in year one for start-up costs.
2. Base Rate
 - a. The maximum Base Rate for LSP Programs is Four Hundred and Forty-three Dollars (\$443.00) per youth per day.
 - b. The Base Rate shall be used for the provision of the services outlined in this solicitation and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) including but not limited to all staffing, including educational behavioral staff to accompany youth throughout the school day (except those staff, identified below, for which ACS is providing an “Add-On Rate”) and “other than personnel services” (OTPS) items, including but not limited to supplies, transportation expenses, translation services, facility maintenance and utilities.
3. Mental Health Services Add-On Rate
 - a. Contractors receiving awards in all Service Options may receive up to the maximum Mental Health Services Add-On Rate. The Mental Health Services Add-On Rate shall be used for the provision of the mental health services outlined in this solicitation and in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). The maximum Mental Health Services Add-On Rate differs per Service Option as indicated in the chart below:

Service Option	Maximum Mental Health Add-On Rate Per Youth Per Day
General LSP	\$56.72
Youth With Intellectual/Developmental Disabilities (“IDD”)	\$69.76
Youth Who Have Demonstrated Problematic Sexual Behaviors (“PSB”)	\$65.94
Youth with Serious Emotional Disturbance Diagnosis (“SED”) and Youth Who Have Demonstrated Fire Setting Behaviors	\$70.34
Intensive Short Term Support (“IS”)	\$84.70

- b. The Mental Health Add-On Rate shall be used for the mental health and substance abuse staffing requirements outlined below. Additionally, the Mental Health Add-On Rate shall be used for the supervisory staffing requirement for the Intensive Short Term Support LSP Program site outlined in Section III Scope of Services.
4. Occupational Therapy and Fire Safety Training Add-On Rate for Service Options 2 and 4 only
 - a. The maximum Occupational Therapy and Fire Safety Training Add-On Rate is Ten Dollars and Sixteen Cents (\$10.16) per youth per day.
 - b. For Service Option 2 – Specialized LSP Program: Youth With Intellectual/Developmental Disabilities and Youth with Serious Emotional Disturbance Diagnosis may receive up to the maximum Occupational Therapy and Fire Safety Training Add-On for the six (6) IDD beds awarded in this Service Option.
 - c. For Service Option 4 - Specialized LSP Program; Youth With Intellectual/Developmental Disabilities and Youth with Serious Emotional Disturbance Diagnosis and Youth Who Have Demonstrated Fire Setting Behaviors may receive up to the maximum Occupational Therapy and Fire Safety Training Add-On Rate for the four (4) fire setting behavior beds and may receive up to the maximum Occupational Therapy and Fire Safety Training Add-On Rate for the six (6) IDD beds outlined in this solicitation and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
5. Practice Model/Approach Training and Coaching Add-On Rate
 - a. Contractors receiving awards in all Service Options may receive up to the maximum Practice Model/Approach Training and Coaching Add-On Rate.
 - b. The maximum Practice Model/Approach Training and Coaching Add-On Rate is Forty Dollars and Twenty-seven Cents (\$40.27) per youth per day. This Add-On will be available in year one, and at the sole discretion of ACS, may be decreased after year one.
 - c. The Practice Model/Approach Add-On Rate shall be used for the implementation of the proposed practice model or approach (described in detail in Section III Scope of Services). The Practice Model/Approach Training and Coaching Add-On Rate shall be used to provide training, coaching and other consultant services required to implement the Practice Model/Approach chosen by the Contractor for LSP Program staff.
6. Teacher Ratio Add-On Rate for Service Options 1-4 only in non City-Leased Sites
 - a. The maximum Teacher Ratio Add-On Rate is Seventeen Dollars and Eighty-One Cents (\$17.81) per youth per day.
 - b. The New York City Department of Education (“DOE”) will provide all LSP Contractors one (1) teacher for every twelve (12) beds. The Teacher Ratio Add-On Rate shall be used to increase the teacher to youth ratio to provide youth with appropriate educational services, so that youth who are residing together may remain together as a group, and be separated from other youth, for the

duration of the day, including during school hours.

- c. For LSP Programs that house twelve (12) to eighteen (18) youth, the maximum Teacher Ratio Add-On Rate shall be used for one (1) New York State certified teacher, which is anticipated to set the maximum student to teacher ratio at six (6) students to one (1) teacher. For LSP Programs that house up to twenty-four (24) youth, the Teacher Ratio Add-On Rate shall be used for two (2) New York State certified teachers, which is anticipated to set the maximum student to teacher ratio at six (6) students to one (1) teacher.

7. Supplemental Rental Add-On Rate

- a. The maximum Supplemental Rental Add-On Rate is Twelve Dollars (\$12.00) per youth per day.
- b. Contractors operating an LSP Program in non City-Leased Sites may receive up to the maximum Supplemental Rental Add-On Rate.
- c. The Supplemental Rental Add-On Rate shall be used for additional site rental costs, not covered in the Base Rate.
- d. The Supplemental Rental Add-On Rate proposed by the Proposer is subject to approval by ACS.

8. Control Room Staff Add-On

- a. Contractors in all Service Options may receive up to the maximum Control Room Staff Add-On Rate. The Control Room Staff Add-On rate shall be used for the required control room staffing and services outlined in Section III Scope of Services and in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). The maximum Control Room Staff Add-On Rate differs per Service Option as indicated in the chart on the next page:

Service Option	Maximum Control Room Staff Add-On Rate Per Youth Per Day
1/General LSP (City-Leased Site)	\$21.94
1/General LSP (non-City-Leased Site)	\$36.57
2/Youth With Intellectual/Developmental Disabilities (“IDD”) and Youth with Serious Emotional Disturbance Diagnosis (“SED”) (12 Bed LSP Program Site)	\$36.57
3/Youth Who Have Demonstrated Problematic Sexual Behaviors (“PSB”) (12 Bed LSP Program Site)	\$36.57
4/Youth With Intellectual/Developmental Disabilities (“IDD”) and Youth with Serious Emotional Disturbance Diagnosis (“SED”) and Youth Who Have Demonstrated Fire Setting Behaviors (18 Bed LSP Program Site)	\$24.38
5/Intensive Short Term Support (“IS”) (8 Bed LSP Program Site)	\$54.85

9. Start-Up

- a. Contractors are permitted to utilize up to two (2) months of their budget (based on youth and rates) to cover non-facility related start-up activities such as hiring and training staff. These start-up activities must take place and be completed prior to the agreed upon program start date. All expenditures are subject to ACS approval.
- b. In addition, Contractors operating LSP Programs in an other-than City-Leased Site may receive up to the maximum Start-Up Add-On Rate
 - i. The maximum Facility Start-Up Add-On Rate is Ninety Dollars (\$90.00) per youth per day.
 - ii. The Start-Up Add-On Rate is for year one only and is subject to approval by ACS.
- c. All facility related start-work/renovations for the City-Leased Sites will be completed by ACS.

10. LSP Aftercare Slot Amount for Service Options 1-4 only

- a. The maximum LSP Aftercare Amount will be calculated by multiplying the number of awarded LSP Program beds by Six Thousand Four Hundred Ninety-three Dollars and Fifty Cents (\$6493.50).
- b. Contractors for LSP Programs shall provide LSP Aftercare services. The average length of LSP Aftercare services shall be three (3) to five (5) months and the Contractor shall provide LSP Aftercare services for all youth in their LSP Program.

11. Costs Not Incurred by Contractors

- a. ACS will provide for the following services for all LSP Program sites: health services, psychiatric services, dental services, and certification of Contractor’s trainers for the crisis intervention system to be utilized in LSP.
- b. The costs for the services for which Contractors are not responsible shall not be included by Proposers in the budgets submitted as part of this solicitation.

12. The chart below summarizes the rates and add-ons for LSP Program sites described above and provides the year-one maximum annual funding for each Service Option, exclusive of LSP Aftercare. All dollar amounts are calculated per bed. If a Proposer believes that the LSP Program, including LSP Aftercare, can be provided at a lower annual amount than the maximum annual funding listed below plus the LSP Aftercare total amount for the beds proposed, the Proposer must describe in detail how this will be accomplished. In the event of a tied score between two Proposals, the Proposal proposing

the lowest cost per bed, excluding start-up, will be given preference. Proposers must indicate their proposed Total slots and Total Proposed Annual Budget (excluding Start-Up) on the Proposal Cover Form (Attachment A).

Year One - Annual Max Funding For LSP Programs (Excluding LSP Aftercare) Per LSP Youth									
Service Options	Base Rate	Mental Health Add-On	Practice Model/ Approach Training and Coaching Add-On	Occupational Therapist Add-On	Teacher Ratio Add On	Supplemental Rental Add - On	Control Room Staff Add-On	Start-Up Add-On (Year One Only)	Maximum Year One Annual Funding
1/General (City-Leased Site)	\$443.00	\$56.72	\$40.27	NA			\$21.94		\$205,104.45
1/General (non-City-Leased Site)	\$443.00	\$56.72	\$40.27		\$17.81	\$12.00	\$36.57	\$90.00	\$254,175.05
2/Specialized - IDD	\$443.00	\$69.76	\$40.27	\$10.16	\$17.81	\$12.00	\$36.57	\$90.00	\$262,643.05
2/Specialized – SED	\$443.00	\$70.34	\$40.27		\$17.81	\$12.00	\$36.57	\$90.00	\$259,146.35
3/Specialized - PSB	\$443.00	\$65.94	\$40.27		\$17.81	\$12.00	\$36.57	\$90.00	\$257,540.35
4/Specialized - IDD	\$443.00	\$69.76	\$40.27	\$10.16	\$17.81	\$12.00	\$24.38	\$90.00	\$258,193.70
4/Specialized – SED (without fire setting bed)	\$443.00	\$70.34	\$40.27		\$17.81	\$12.00	\$24.38	\$90.00	\$254,697.00
4/Specialized - SED (one fire setting bed)	\$443.00	\$70.34	\$40.27	\$10.16	\$17.81	\$12.00	\$24.38	\$90.00	\$258,405.40
5/Specialized - IS	\$443.00	\$84.70	\$40.27			\$12.00	\$54.85	\$90.00	\$264,559.30

I. Anticipated Payment Structure

1. For the first year of LSP Program and LSP Aftercare operations, it is anticipated that ACS will prorate the budget value based on the number of months the LSP Program site is in operation. ACS defines “in operation” as the time once OCFS has issued an operating certificate and ACS program development has agreed that the LSP Program site is ready to start. The budget value will be based on the rate and projected annual care days. Once prorated and approved, the year one budget value will become a set allocation allowing Contractors, upon reconciliation at year end, to invoice up to that amount for allowable expenses using their actual care days. After the agreed upon start-up period in year one, ACS reserves the right to pay the Contractor based on actual care days. During year one of LSP Program operations, ACS will determine whether payments will be based on actual care days or a set allocation in year two and beyond of LSP Program operations.
2. It is anticipated that the payment structure of LSP Aftercare will be a line item budget reimbursement. A maximum annual (or prorated) available funding for LSP Aftercare Services, including all costs associated with the services will be calculated by multiplying the number of LSP Program beds awarded by Six Thousand Four Hundred Ninety-three Dollars and Fifty Cents (\$6493.50), Proposers should therefore propose a line-item budget utilizing a maximum budget amount calculated by

multiplying the number of beds proposed by Six Thousand Four Hundred Ninety-three Dollars and Fifty Cents (\$6493.50). Proposed Aftercare budgets will be modified for Contractors who are awarded a different number of beds than proposed. The Aftercare budget includes the costs of training as well as consultation and oversight by the EBM, AEPM and PPM developer. ACS is asking for the line item budget in order to determine allowable costs. Once the line item budget has been approved it will become a set allocation and ACS will pay based on this budget. Upon audit, if expenses do not support payments ACS will recoup any disallowed cost.

3. Proposers may not propose an annual budget above the maximum annual available funding. If a Proposer believes that the services as requested can be provided at a lower annual amount than the maximum annual funding as outlined above the Proposer must describe in detail how this will be accomplished. In the event of a tied score, the Proposal proposing the lowest cost per bed, excluding start-up, will be given preference. Proposers must indicate their proposed Total slots (beds) and Total Proposed Annual Budget (excluding Start-Up) on the Proposal Cover Form (Attachment A).

J. Minimum Qualifications

1. **Failure to provide the following documents will make the Proposal non-responsive and cause the Proposal to be rejected:**
 - a. All Proposers for LSP Programs must be incorporated in New York State and must submit a copy of their current New York State Certificate of Incorporation which must be valid and in good standing.
 - b. All Proposers must be not for profit 501 c 3. The New York State Certificate of Incorporation must state that the Proposer is Not-for-Profit.
 - c. Proposers must either be approved by the New York State Office of Children and Family Services as an “authorized agency” as defined by Section 371(10) of the New York State Social Services Law;

OR

At the time of proposal, be an agency licensed by the New York State Office of Mental Health (“OMH”) to provide residential treatment facility services to youth. After contract awards, OMH licensed agencies that are not currently “authorized agencies” must go through the OCFS approval process to become an “authorized agency” prior to the LSP program start date. For reference, Appendix 6 contains the documents necessary to submit to OCFS to become an “authorized agency.”

K. Regulations and Standards

1. Contractors will be required to adhere to all relevant ACS policies and Federal, State, and local rules and regulations including, but not limited to, Title 18 of the New York Codes, Rules and Regulations, NYS Social Services Law, and the ACS Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). Additionally, as part of the Close to Home Legislation, OCFS will issue regulations governing Limited Secure Placements. Once these regulations are in effect, all Contractors will be required to adhere to said regulations.
2. Contractors will be required, as directed by ACS, to submit requests to OCFS for waivers for specific Title 18 of the New York Codes, Rules and Regulations. These will be required to comply with the provision outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).

L. Compliance with Local Law 34 of 2007

1. Pursuant to Local Law 34 of 2007, amending the City's Campaign Finance Law, the City is required to establish a computerized database containing the names of any "person" that has "business dealings with the city" as such terms are defined in the Local Law. In order for the City to obtain necessary information to establish the required database, vendors responding to this solicitation are required to complete the attached Doing Business Data Form and return it with this proposal, and must do so in a separate envelope. (If the responding vendor is a proposed joint venture, the entities that comprise the proposed joint venture must each complete a Data Form.) If the City determines that a vendor has failed to submit a Data Form or has submitted a Data Form that is not complete, the vendor will be notified by the agency and will be given four (4) calendar days from receipt of notification to cure the specified deficiencies and return a complete Data Form to the agency. Failure to do so will result in a determination that the proposal is non-responsive. Receipt of notification is defined as the day notice is e-mailed or faxed (if the vendor has provided an e-mail address or fax number), or no later than five (5) days from the date of mailing or upon delivery, if delivered.

SECTION III - SCOPE OF SERVICES

A. Agency Goals and Objectives

1. The goal of programming during and after placement is to support youth to develop to their fullest potential and become healthy, educated, and constructive members of the community with successful transitions to adulthood. Limited Secure Placement has the following goals for youth and families:
 - a. **Connection to the Youth's Community:** Youth in LSP Programs will reside in residential facilities in or close to New York City, with opportunities to take advantage of local programs and services. Discharge planning for youth will begin upon arrival into LSP Program sites and youth will participate in robust LSP Aftercare services.
 - b. **Improved Well Being of Youth:** Youth will have enhanced programming options and expanded access to mental health care and health services. Treatment planning and clinical services will be individualized to meet the unique needs of each youth in LSP Programs.
 - c. **Better Family Engagement:** New York City families will be able to maintain frequent contact with their youth in LSP Programs, and participate in their youth's rehabilitation, which will enhance the youth's likelihood of success upon release.
 - d. **Improved Educational Outcomes:** Youth will receive individualized educational services and academic credits earned during placement will count towards a high school diploma.
 - e. **Appropriate Public Safety Measures:** Public safety measures appropriate to youth in LSP will be utilized in every program site and during LSP Aftercare. While the youth reside in an LSP Program site all services must be provided directly on-site. Youth will not be permitted to engage in activities off-site except under the constant supervision of staff or in other pre-approved settings.

B. Contractor Experience

1. The contractor has demonstrated at least three years of successful experience administering residential and community-based services to adolescents involved in the juvenile justice and/or criminal justice systems.
2. The contractor has demonstrated at least three years of successful experience in serving similar populations to those described as the target population in Section II(B).
3. For LSP Aftercare services, the contractor has demonstrated experience, implementing and successfully maintaining a model compliant EBM, AEPM or PPM.

C. Organizational Capability

ACS assumes the contractor will have the organizational capability and programmatic, managerial and financial capacity to provide the work described in Section III Scope of Services. Specifically ACS assumes the contractor will have the capability to:

1. Employ and retain highly qualified staff with specific expertise in residential services to adolescents involved in the juvenile justice system.
2. To partner with EBM, AEPM or PPM developers to train and implement an LSP Aftercare model.
3. The contractor will have internal Quality Assurance systems for monitoring and reviewing program performance.
4. Conduct formal program evaluation.
5. Ensure LSP Program site(s) will be available and ready to provide services by October 1, 2013.

D. Limited Secure Placement Program Model/Approach Summary

The following section pertains to all Service Options in this solicitation. The Agency's Assumptions regarding the approach that would most likely achieve the goals and objectives set out above are:

1. Contractors must utilize a LSP practice model or approach for services that are provided in LSP Program sites. The approach or model must be supported by best practices in the field, have evidence of good outcomes in the past, reduce recidivism, utilize a clear training and coaching curriculum, include a staff accountability system that assists the provider in ensuring that staff are incorporating their training into their work with youth and families, include youth engagement strategies that have been demonstrated to work with the populations served, and includes a clearly articulated behavior management program that also supports academic success.
2. Contractors may not utilize traditional correctional service models, but instead must provide a rehabilitative and therapeutic service model that supports and supervises young people; considers youth's families to be allies and partners in achieving successful rehabilitation and reentry; assists youth to develop healthy peer relationships; and provides targeted support and programming that helps young people develop academic, pre-vocational and communication skills.
3. Contractors must provide services to youth during their placement that engage them in a range of activities which promote positive reintegration into the youth's home communities after placement.

E. Limited Secure Placement Program Model/Approach Requirements

The following section pertains to all Service Options in this solicitation.

1. Proven Approach

Contractors must utilize a practice model or approach for services provided in LSP Program sites. A practice model or approach must include, but is not limited to:

a. Practice Model or Approach

- i. Practice models or approaches are services models that have shown good results and/or outcomes in implementation that have or have not yet been replicated in a community other than the originating community, or do not have comprehensive clinical trial data supporting the model/approach. Note, the proposed practice model or approach is not authorized to engage in clinical trial(s) involving youth placed pursuant to the resulting agreement without ACS, and other appropriate oversight approvals.
- ii. Practice models or approaches are comprehensive service delivery models that utilize specific interventions to improve outcomes for youth and families involved in the juvenile justice system. All practice models or approaches proposed must provide some data that show positive outcomes achieved by the model/approach, as compared to an objective benchmark, in the areas of reducing recidivism, school achievement, and other positive outcomes for youth and families.
- iii. There can be, but it is not expected that there will be randomized clinical trial data for practice models or approaches. In the event there is not randomized clinical trial data, examples of other acceptable types of data that could support practice models or approaches include, but are not limited to, system reentry data, re-arrest self-report data, case completion data, self-assessments completed by families, and average length of service data.
- iv. Additionally, for the purposes of this solicitation, a practice model or approach is further defined as a model/approach that is designed using demonstrated best practices with the target population and supported by successful data in similar jurisdictions with a similar target population. All

practice models or approaches must also meet the goals, objectives, and requirements of this solicitation.

2. Data-Driven, Outcome-Oriented Approach

- a. Contractors shall implement a practice model or approach that is designed to promote ACS' goals and objectives with teens and families as stated in Section III (A) of this solicitation. The practice model or approach must include built-in capacity to use data to track staff performance and youth outcomes, and to use data to facilitate a continuous quality improvement process.
- b. Contractors shall have a process of systematic collection of information on youth and family characteristics, staff characteristics, and participant service experiences to ensure services are being implemented with fidelity to the practice model or approach program's intent and structure.

3. Implementation of Model/Approach

- a. Contractors shall provide intensive practice model or approach training and coaching to all staff in LSP Programs by engaging a consultant/developer to provide forty (40) to eighty (80) hours of pre-service training for all Contractor staff and ongoing on-site coaching. For the first two (2) years of an LSP Program operation, coaching must take place on-site at least three (3) weeks /fifteen days (15) per month. After the first two (2) years of initial implementation, coaching shall take place on an as needed basis or as required by ACS. If the practice model or approach utilized by the Contractor has less than the above specified training and coaching requirements, the Contractor must demonstrate to ACS how staff will learn the necessary skills to successfully implement the practice model or approach.
- b. Contractors must make accessible all documents of the model/approach training and coaching so that ACS may monitor the success of the model/approach implementation.
- c. Contractors must allow ACS access to gather information from the model/approach developer/consultant that is providing the training and coaching on the Contractors' implementation of the model/approach.
- d. ACS may require the model/approach developer/consultant to participate in implementation activities including but not limited to conference calls and meetings.

4. Practice Model or Approach Adherence

- a. Contractors must comply with the practice model or approach in connection with its provision of services. Any deviation from the proposed practice model or approach without direct approval from both ACS and the practice model or approach developer/consultant is not permissible. Adherence includes full compliance with the clinical, administrative, and monitoring requirements set forth by the practice model or approach.
- b. Model adherence requirements include but are not limited to: adherence to each practice model or approach according to the mandates of their respective interventions and quality assurance activities required by each model/approach.
- c. Quality assurance activities may include but are not limited to: input of case data into databases operated by the developers of the practice model or approach; regular and frequent supervision of direct service staff to support and guide their ongoing practice; regular and frequent consultation with therapeutic consultants selected by the practice model or approach developers/consultants; and, with the permission of the youth and his/her family, recording of therapeutic sessions to ensure adherence to the practice model or approach by staff.

5. Practice Model or Approach Critical Elements

- a. Strength-based youth development approach to LSP Program services
 - i. LSP Programs must build on the youths' existing strengths and competencies, while also meeting their developmental needs. The practice model or approach must build on youth and family strengths and work within a clear framework to promote positive change in youth. The goal of programming during and after placement is to support youth to develop to their fullest potential and become healthy, educated, and constructive members of the community with successful transitions to adulthood.
 - ii. LSP Programs shall be designed in a way that youth live with others in their age group, gender, gender identity and/or developmental stage, and/or educational level, such as youth who are twelve to fourteen (12-14) and fifteen to seventeen (15-17) years of age. (Most youth residing in LSP Program sites will be between the ages of fourteen (14) to eighteen (18), however, there may be occasions where LSP Program sites will serve older or younger youth.) Contractors must take school level, such as middle school and high school designations, into consideration when designing LSP programs. All LSP Programs, unless designated for a specialized population with intellectual disabilities, shall have the capability to serve youth with IQs of seventy-one (71) and above, and they shall be able to accept youth with lower IQs, on a case-by-case basis.
 - iii. LSP Programs shall provide youth development activities that provide opportunities for youth to develop skills and gain experience in a work environment, in building and maintaining relationships, in community involvement and service, in personal health, in education and career planning and goal setting, and in personal creative expression.
- b. Family engagement and identification of a network of support
 - i. To assist youth in achieving program goals while in placement, and to support successful reentry, Contractors shall identify family resources and/or a network of support for each youth. Engagement of and outreach to a youth's family and/or network of support must be sustained throughout a youth's placement, and should include ongoing consultation on treatment planning. Staff must reach out to family members or other discharge resources and involve them as allies in planning and partners in the treatment of youth. Youth's families and/or networks of support will also be eligible for supportive assistance.
 - ii. Contractors shall have flexible hours in the early morning, evening and/or on weekends to accommodate family members or other discharge resources who work, attend treatment or school, or are otherwise engaged in essential activities.
 - iii. Contractors shall hire a family worker to facilitate and promote family engagement, permanency planning, transition planning, and home visits as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
- c. Individualized treatment plans and goal-setting
 - i. Contractors shall determine and create a written individualized treatment plan and program focus for each youth based on the risks and needs of the individual youth. To ensure that programs are targeting youth's specific needs, Contractors are required to use validated needs assessment and re-assessment tools, subject to ACS approval.
 - ii. Once the needs of each youth are determined, Contractors shall develop and implement an individualized treatment plan that includes identified needs, emerging needs or risks, programming, and goals. The youth and family must be engaged and encouraged to participate in the treatment planning process. Individualized treatment plans shall be updated by the Contractor throughout placement, shall include identified short and long-term goals for youth, and shall include documentation of the achievement of goals during the course of placement.

Treatment goals must be measurable and where appropriate, Contractors shall use tools to measure progress towards meeting individual treatment goals.

d. Therapeutic interventions

- i. In addition to or as part of the LSP practice model or approach that is the basis for the LSP Program services, Contractors must provide specific targeted therapeutic services to youth demonstrating behavioral issues and mental health and/or substance abuse needs. These targeted services must include therapeutic interventions that are proven, through data and research, to successfully treat common behavioral issues found in youth involved in the juvenile justice system such as aggressive and assaultive behaviors and running away. These interventions must also be proven, through data and research, to successfully treat common mental health diagnoses found in youth involved in the juvenile justice system such as, but not limited to, Depression, Anxiety, Substance Abuse/Use, Post Traumatic Stress Disorder, and Conduct Disorder. Additionally, these interventions must include targeted services for youth with co-occurring diagnoses as well.

e. Peer-support and group-work/collaboration

- i. Contractors must deliver programming in small group settings (groups of ten (10) in LSP Program City-Leased Sites and ACS suggests groups of six (6) in all other LSP Program sites) to encourage positive peer relationships among youth. Small group treatment, together with direct support and supervision from staff, will prevent youth from withdrawing and will encourage group accountability for any disruptive or disrespectful behavior. The program design shall include opportunities for group discussion and reflection and promote an environment of support and encouragement for youth. Though groups will have rotating entry and exit as youth are placed and others return home, they shall remain stable and under the supervision of the same consistent group of program staff, to encourage peer-support among youth. Groups must be formed with youth of similar ages and developmental functioning.

f. Setting expectations and managing behavior

- i. As outlined in the Juvenile Justice Limited Secure Quality Assurance Standards (Appendix 1), Contractors shall design and implement a comprehensive behavior management system that adheres to all regulations and ACS policies, and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) related to behavior management systems.
- ii. Searches of LSP spaces and personal searches of youth are permitted in LSP Programs. Contractors must adhere to all regulations and ACS policies, and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) related to all personal and facility searches.
- iii. Restraints of youth are permitted in LSP Programs, Contractors must adhere to all regulations and ACS policies, and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) related to restraints.

g. Direct and close supervision

- i. To establish an environment where youth feel safe from physical or emotional abuse, and to minimize untoward incidents during placement, Contractors' staff must practice close and direct supervision. Youth must remain in direct eyesight of the staff, or where necessary for privacy of the youth, the staff must remain in direct earshot of youth at all times. Where youth are sleeping in individual bedrooms, staff must be posted in positions where they can maintain maximum eyesight and earshot of youth. This approach must emphasize observation, relationship-building, direct communication and intervention to prevent new or emerging issues or conflicts between youth. To encourage relationship building and trust, Contractors are expected to have steady

staff to supervise youth, meaning the same staff work with the groups on a regular basis. Staff shall supervise, implement group and individual treatment plans, provide group counseling and develop constructive relationship with youth. To the extent possible, staff must work with the same group of youth from admission to placement through their release.

h. Seamless transition to the community

- i. To reduce recidivism and improve short and long-term outcomes for all youth in placement, reentry planning must begin at the time of admission. As part of LSP Programs and LSP Aftercare services, and in coordination with ACS, Contractors shall develop an array of strategies, supports and tools for each youth to promote their successful reintegration into their home community post-release. The Contractor must engage and encourage the youth and family to participate in planning for the youth's reintegration. These efforts shall include family reunification and permanency planning; educational engagement; vocational and work skill-building; counseling and emotional support; and connection with community-based services for both youth and their families or other discharge resources.
- ii. During year one, Contractors are required to accept youth being transferred from OCFS into LSP Aftercare. The Contractor must fully and comprehensively plan for and provide LSP Aftercare services to these youth and families or other discharge resources.

F. Staffing Ratios During Limited Secure Placement

Contractors are required to hire staff with the experience and minimum qualifications outlined in the ACS LSP Quality Assurance Standards (Appendix 1).

1. Direct Care Staffing Ratios For All LSP Program Sites

- a. Contractors must recruit and hire appropriate and sufficient staff to meet their program's needs. The ratio of youth to direct care workers in all the Service Options in this solicitation is six (6) youth to two (2) direct care staff (or a fraction thereof). Contractor staff are not permitted to sleep during any shift. Documentation of this staffing ratio shall include the names of staff on call for each shift, hours of coverage, and written plans for providing backup staff in emergencies.
- b. A minimum of two (2) direct care staff shall be on duty at all times. LSP Program sites shall be able to access additional staff during emergencies. Contractors are required to have staff on-call and available to report to work within thirty (30) minutes if additional staffing is necessary or required by ACS.

2. Control Room Staffing

- a. Contractors must provide one (1) staff person at all times in a central control room in each LSP Program site. This position is responsible for, but not limited to, maintaining facility keys, overseeing entry to and exits from the facility, observing closed circuit camera activity and responding to any emergencies within the facility.

3. Care Coordination Services

- a. Coverage at all facilities must also include on site care coordination coverage on a full time forty (40) hours per week) basis.
- b. On-site care coordination services, outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) may be provided by the LSP Program site Caseworker or other qualified staff as part of their duties.

4. Mental Health Staffing Requirements In All LSP Program Sites

- a. At minimum, in addition to direct care staffing requirements, staffing at all LSP Program sites must

include as outlined in the ACS LSP Quality Assurance Standards (Appendix 1), for every twelve (12) youth (or fraction thereof):

- i. One (1) full time (forty (40) hours per week) on site mental health clinician,
 - ii. One (1) full time (forty (40) hours per week) on site family worker,
 - iii. One (1) supervising clinician, and
 - iv. One (1) clinical director.
- b. Contractors must provide adequate and appropriate staffing coverage. Mental health services shall be available to youth in the morning, afternoons, evenings and weekends.
 - c. Contractors shall maintain a current list of per-diem staff who meet ACS credentialing and clearance requirements available to fill in on an as-needed basis in order to fulfill adequate coverage for staff outages (e.g. vacation, holidays and illness).

5. Substance Abuse Services Staffing Requirements For All LSP Program Sites

- a. At minimum, in addition to direct care staffing requirements, substance abuse staffing at all LSP Program sites must include, for every twelve (12) youth (or fraction thereof), one (1) full time (forty (40) hours per week) on site substance abuse service provider.
- b. Substance abuse services can be integrated into the mental health services and be provided by the mental health clinician as long as the mental health clinician providing substance abuse services has the required credentials outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).

6. Additional Mental Health Staffing Requirements for Service Options 2 and 4- Youth With Intellectual/Developmental Disabilities (“IDD”)

- a. In addition to the direct care, mental health, substance abuse and care coordination staffing requirements for all LSP Program sites, Specialized IDD LSP Program sites must include speech-language pathologist on-site coverage of a minimum of two (2) hours per week per youth.

7. Additional Mental Health Staffing Requirements for Service Option 3 - Youth Who Have Demonstrated Problematic Sexual Behaviors (“PSB”)

- a. In addition to the direct care, mental health, substance abuse and care coordination staffing requirements for all LSP Program sites, Specialized LSP Program sites for youth who have demonstrated Problematic Sexual Behaviors must include for every twelve (12) youth (or fraction thereof), a minimum of:
 - i. One (1) on-site direct care staff supervisor at all times;
 - ii. Four (4) hours per week of on-site clinical psychologist coverage; and
 - iii. One (1) hour per week per youth of on-site case worker coverage.

8. Additional Mental Health Staffing Requirements for Service Option 2 – Youth with Serious Emotional Disturbance Diagnosis (“SED”) and Service Option 4 - Youth with Serious Emotional Disturbance Diagnosis (“SED”) and Youth Who Have Demonstrated Fire Setting Behaviors

- a. In addition to the direct care, mental health, substance abuse and care coordination staffing requirements for all LSP Program sites, Specialized SED LSP Program sites must, for every twelve (12) youth (or fraction thereof), have fifty-two (52) hours per week, on-site, clinical psychologist with flexible hours to accommodate school and other activities in which the youth are participating (forty (40) of the clinical psychologist hours are to replace the full time general mental health

clinician hours, and the remaining twelve (12) hours fulfill an hour per youth per week of onsite coverage).

b. The Caseworker/Social Worker must meet with each youth, on site, at least one (1) hour per week.

9. Additional Mental Health Staffing Requirement for Service Option 5 - Intensive Short Term Support (“IS”)

a. In addition to the minimum direct care, mental health, substance abuse and care coordination staff coverage for all LSP Program sites, the Specialized IS LSP Program site must have as outlined in the ACS LSP Quality Assurance Standards (Appendix 1) a minimum of:

- i. clinical psychologist on-site coverage of four (4) hours per week for every six (6) youth (or fraction thereof); and
- ii. in addition to the minimum required direct care staffing ratio, the Specialized IS LSP Program site shall have one (1) direct care staff supervisor on site at all times for every six (6) youth (or fraction thereof).

G. ACS’ Assumptions Regarding Contractor LSP Program Sites and LSP Program Services

The following section pertains to all Service Options in this solicitation.

1. LSP Program Sites

- a. Contractors shall provide physical facilities and LSP Program services that meet all requirements outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
- b. Contractors’ LSP Program sites are largely self-contained sites. The majority of services for youth and families are provided onsite. The LSP Program site must have space to support the range of services being offered, including space appropriate for outdoor recreation. The LSP Program site must also provide space so that counseling can be conducted in privacy to ensure confidentiality is maintained. Additionally, the LSP Program site must comply with all applicable health, fire and safety regulations.
 - i. When identifying and designing LSP Program sites, consideration must be given to establishing space for services to be provided onsite, including: school; routine medical, dental and mental health services; recreation (including indoor and outdoor recreation); treatment team meetings; group treatment meetings; and family visiting.
- c. Unless otherwise directed by ACS or as part of an agreed upon treatment, education, or transition plan, youth will not be permitted to engage in activities off-site except under the constant supervision of staff and after receiving approval by ACS.
- d. All LSP facilities must be designed to accommodate between six (6) and twenty-four (24) youth. LSP Program City-Leased Sites shall contain two (2) groups of ten (10) youth each. ACS suggests that all other LSP Program sites shall contain groups of six (6) youth. No group shall exceed twelve (12) youth. No LSP Program site shall exceed twenty-four (24) beds. If LSP Program sites house more than twelve (12) youth, the LSP Program site must be divided in a way to allow each group to operate independently, including, but not limited to, separate bedroom and dayroom living space, and classrooms for each group.
- e. Outdoor space must be available to provide appropriate physical recreation space for the number of youth housed in the LSP Program site. LSP facilities’ outdoor recreational space must be able to accommodate activities that require running and/or jumping, such as basketball, martial arts, aerobics, flag football and double-dutch. Additionally, the outdoor space must have shaded areas.

- f. The exterior design of LSP Program sites must comply with all regulations and requirements outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
- g. LSP Program sites must maintain full interior (in common spaces) and exterior closed circuit television (“CCTV”) monitoring with recordings saved for a minimum of ninety (90) days and should enable easy transfer of video to ACS upon request. CCTV and recordings must include video and sound.
- h. All LSP Program site doors must be fire rated steel hollow core with vision panels on all interior doors.
- i. Contractors must ensure that the LSP Program site conforms to the requirements set forth in the New York State regulations concerning child care agencies; 18 NYCRR Parts 441 through 451 and other applicable laws, including New York City Building Code (if in New York City), by the operation start date.

2. Provision of Basic Services

- a. In addition to specific program service provisions described in this solicitation and in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix1), Contractors must provide food, clothing, bedding, and other basic necessities as required by Regulation and in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix1).

3. Accessibility of Services

- a. Contracts arising out of this NA shall be subject to the provisions of the Americans with Disabilities Act (“ADA”) and regulations promulgated pursuant thereto. The Contractor shall not discriminate against an individual with a disability, as defined in the ADA, in providing services, programs, or activities pursuant to this Agreement. Furthermore, LSP Sites should be readily accessible and usable by individuals with disabilities in compliance with the ADA and regulations promulgated pursuant thereto.
- b. Contractors shall ensure that their hours of operation reflect the needs of the youth and families to be served. This strategy shall include flexible hours to accommodate school and working family members or discharge resources in a manner that is least disruptive to daily life activities, religious proscriptions, medical and health related conditions, and neighborhood safety conditions.
- c. Contractors shall assess the communication skills of each youth and family to be served and shall address identified family literacy limitations so that oral and written communications occur at an appropriate level to ensure the youth’s and family members’ full participation in and understanding of the services offered by Contractors. Contractors shall ensure that culturally and linguistically competent services are provided through staff that is representative of the population served and fluent in the languages spoken by participating youth and family members or discharge resources. If translation services are needed, Contractors shall provide the translation services at no additional cost to ACS.
- d. Contractors shall make services accessible to clients with physical disabilities by, including but not limited to, offering Telecommunication Device for the Deaf (“TDD”) services, raising staff awareness about disabilities, utilizing large print informational reading materials, and establishing referral protocols to programs serving disabled communities.

4. Length of Service

- a. The average length of stay for youth in all LSP Program sites with the exception of youth in the Intensive Short Term Support LSP Program site is seven (7) months with approximately three (3) to five (5) months of LSP Aftercare post discharge. The length of stay for individual youth while in care may be shorter or longer, depending on youth's behavior and other factors.
- b. The length of stay for youth in Intensive Short Term Support LSP Program sites is on average three (3) weeks/twenty-one (21) days.

5. Intake Referrals

- a. ACS will determine which Contractor is an appropriate match for the youth, and will notify that Contractor of the determination. Contractors may request a review of a placement determination by telephoning or emailing a designated ACS staff member, but they may not refuse to accept any youth.
- b. During the first year of implementation, youth will be transferring from OCFS both into LSP Program sites and into LSP Aftercare programs. These transfers will happen at various points of a youth's placement period. Contractors are required to accept youth transferred to the Contractor's LSP Program site or to the Contractor's LSP Aftercare program from OCFS and must fully and comprehensively provide LSP Program services or LSP Aftercare services to these youth and families or other discharge resources.
- c. In order to accommodate fluctuating utilization levels and to meet the needs of youth, General LSP Contractors shall, when appropriate and safe for the youth, staff and community, serve youth with specialized needs (such as those specialized needs outlined in Service Options 2-5) and will be reimbursed at the Base Rate. Conversely, Specialized LSP Contractors shall, when appropriate and safe for the youth, staff and community, serve youth with non-specialized needs or youth with specialized needs other than those of the particular Specialized LSP Program site and will be reimbursed at the Base Rate. In these cases, ACS will work closely with the Contractor to ensure the youth has access to necessary services.
- d. Contractors shall have staff available from 8:00 A.M. to 9:00 P.M., on all weekdays except Court holidays, to receive intake referrals from ACS. In some cases intake may need to take place outside of these hours, ACS will work with Contractors on a case by case basis to conduct necessary intake activities.

6. Case Coordination with ACS

- a. Contractors shall work with ACS designated Placement and Permanency Specialists (PPS) who oversee Contractor case planning and decision-making on individual cases.

7. Community Relations and Community-Based Services

- a. Contractors shall develop and operate Community Advisory Boards in accordance with ACS policies. These Boards will help maximize community involvement in and support for their LSP Program sites. The Community Advisory Boards shall be comprised of representatives from local non-profits, businesses, faith-based organizations and other interested community members. The Boards must meet on a quarterly basis, at minimum. The primary goal of these bodies is to help identify avenues for deepening connections between Contractors and their communities.
- b. Due to the special needs of many of the youth residing in LSP Program sites, and the specialized nature of many of these programs, concern about living in close proximity to residential care facilities has been raised at times by neighborhood residents. Therefore, Contractors shall develop a community outreach strategy to educate the community, respond to community concerns, and build community acceptance of and support for LSP Program sites, programs, and treatment models/approaches. This strategy can include but shall not be limited to regular attendance at

significant community events.

- c. Upon award recommendation, Contractors must notify the Community Board that represents the community where the LSP Program site will be located, of the intent to develop a LSP Program site in the community. This communication must include information about the youth who will be residing in the site, services offered, and safety planning.
- d. Contractors shall participate and engage with the Community Partnership Program in the Community District where the LSP Program site is situated, if any, as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). Additionally, where appropriate and safe, linkages may be formed to bring community-based programming into the LSP Program site for the benefit of the youth.

8. Transportation

- a. Contractors shall provide all transportation necessary to fulfill their duties as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
- b. Contractors shall ensure that transportation services are readily available to transport youth to the hospital, medical and mental health appointments, home visits, court, community school (part of the youth's transition process back to the community) and other subspecialty providers as necessary. Additionally, once a youth is placed with a Contractor, that Contractor is responsible for transporting the youth from detention, or other current location of the youth, to the LSP Program site.
- c. Contractors are required to have at least two staff present at all times during transportation of youth.

9. Culturally Competent Services

- a. Contractors shall ensure that LSP Program sites are operated with understanding and respect for community needs and cultures. Culturally and linguistically competent services shall be provided by a staff that is representative of the community served and fluent in the languages spoken by youth and family members.

10. Gender Specific and Gender Responsive Services

- a. Contractors must provide LSP Program services that are responsive to the unique needs of youth. Contractors will be required to serve female and male youth.
- b. Contractors must provide staff with the tools and skills to enhance their understanding of gender specific youth development, especially the impact of physical, sexual, or emotional abuse.
- c. At LSP Program sites serving females, programming and recreation must include activities that are enriching and interesting to female youth, conversely, LSP Program sites serving male youth must include activities that are enriching and interesting to male youth.
- d. Contractors must provide a comprehensive, culturally sensitive program that includes assessment of risk factors and safety issues related to sexual exploitation, if appropriate, individual, group, and family treatment focused on trauma to address the underlying causes of the youth's acts and move toward changing their behaviors. The Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) outline in further detail service requirements for commercially sexually exploited youth.

11. Services for Youth Who Identify as LGBTQ

- a. Contractors shall provide services as outlined in the Juvenile Justice Limited Secure Placements Standards (Appendix 1) that meet the wide range of needs demonstrated by youth who identify as LGBTQ.

- b. Contractors must adhere to the ACS Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System (Appendix 3).
- c. Youth who identify as LGBTQ often experience difficulties in gaining acceptance from their families for a myriad of reasons. In these circumstances, Contractors must utilize best practices in this field to facilitate positive family reunification and functioning.
- d. Contractors shall ensure that youth who identify as transgender or gender-nonconforming receive services that provide holistic support accounting for the youth's general wellbeing, including medical and mental health supports.
- e. If a youth has identified as LGBTQ with their family, Contractors shall ensure that the parent[s], family, extended family or other discharge resource is accepting of the youth and the plan to move home is safe for the youth. If the youth has not identified as LGBTQ with their family, Contractors must ensure that the youth has a safe discharge plan and will be linked to appropriate LGBTQ supports in the community.

12. Services for Parents/Guardians, Family, and Youth's Network of Support

- a. Contractors shall provide services and referrals for services for parents/guardians, family, and youth's network for support as outlined in the Juvenile Justice Limited Secure Placements Standards (Appendix 1).

13. Education

- a. Contractors shall adhere to all education requirements as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). All youth in LSP Programs are required to attend school in accordance with New York State Education Department and Local Education Agency (LEA) regulations. All educational services must be provided onsite (except when youth are transitioning back to the community, at which point youth shall attend their community school unless youth have already received a high school diploma or GED).
- b. For New York City based sites, New York City Department of Education (DOE) District 79 Passages Academy will provide the teachers necessary to support a one (1) teacher to twelve (12) student ratio and educational staff to deliver services. Educational services will be focused on youth earning high school credit in pursuit of earning a Regents diploma.
 - i. Contractors for LSP Program sites (excluding City-Leased sites) with multiple groups of youth must provide New York State certified teachers to support the ratio beyond the DOE staff to student ratio and ensure that each group of six (6) youth will be educated separately by their own teacher as detailed in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). These teachers are accountable for adhering to the DOE/District 79 developed curriculum.
- c. For school settings outside of New York City maintained by Contractors, the Contractor must demonstrate that they are in good standing with the New York State Education Department. Additionally, Contractors must demonstrate that youth will earn credits that can be transferred to New York City schools, have access to all State exams and that youth will attend school on a regular basis.
- d. As part of the youth's transition back to their community and if determined after an individual assessment to be in the best interests of the youth, the youth may attend his or her community school. Contractors are required to transport all youth in their care attending a community school to and from school every day. However, if it is decided, in conjunction with ACS, that a youth will be responsible for their own transportation to and from school, for maintaining a close relationship with the community school the Contractor shall ensure that the youth is arriving to school on time

and is attending and achieving academic and behavioral progress at the school. There will be consistent communication and planning between the Contractor, DOE, and ACS. Contractors must obtain copies of Individualized Education Plans (“IEP”) and evaluations conducted by the DOE, and incorporate the IEP goals into the youth’s overall service plan, including behavioral plans used in placement. The Contractor must work with DOE, parents or other discharge resource, and youth to ensure that key transitions in youth’s educational progress receive adequate attention. These key transitions include application to high school for eighth (8th) graders, and application to higher education or vocational training for youth leaving high school.

- e. Contractors in New York City and outside of New York City are required, within the Base Rate, to hire qualified behavioral support staff to accompany youth in school each day and support the students and teaching staff in maintaining school wide and classroom environments conducive to learning. This staff will also assist DOE staff and Contractor teachers in engaging youth in the learning process, and assist with positive behavioral interventions with individual students.
- f. Proposers shall obtain written approval from the New York City DOE for the Proposer’s education plan and include the approved plan with their proposal. To obtain approval, proposers must contact:

Timothy F. Lisante, Ph.D.,
Superintendent NYC Department of Education District 79.
90-01 Sutphin Blvd. Jamaica, NY 11435.
718-557-2540

14. Enrichment and Recreational Activities

- a. Contractors must provide recreational opportunities in accordance with the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). Youth must be provided with opportunities to go outdoors regularly, engage in physical exercise, participate in a range of recreational activities including psycho-educational programming and culturally relevant programming, and practice their religion.

15. Sexual Health Education and Services

- a. The Contractor shall assure that all youth in care aged twelve (12) years old and over, and younger children who are known to be sexually active, receive comprehensive information about family planning and sexual health issues, and have access to the full range of services including contraception (including but not limited to condoms, emergency contraception, and prescription methods), options counseling (including abortion and adoption services), and education and treatment related to sexually transmitted infections (“STIs”) and HIV/AIDS.

16. Mental Health Services

- a. Youth in LSP Program sites may not be Title IV-E eligible, therefore these youth may not be eligible for a per-diem Medicaid rate. Accordingly, all mental health services must be provided by the Contractor within the Base Rate and the designated mental health add-on rates.
- b. Contractors shall conduct all initial mental health screenings, assessments and evaluations outlined in the Juvenile Justice Limited Secure Standards (Appendix 1).
- c. Contractors shall ensure that all mental health services are delivered on site by qualified New York State-licensed/credentialed mental health providers, and that all services are documented.
- d. Mental and behavioral health services provided by Contractors shall include, at minimum, services outlined in the Juvenile Justice Limited Secure Standards (Appendix 1).
- e. Contractors shall arrange for on-call availability of key mental health staff and providers for urgent mental health services when there is no mental health clinician on-site. There must be access to

key mental health staff for urgent mental health matters twenty-four (24) hours a day, seven (7) days a week including holidays and vacations.

- f. Contractors shall develop a protocol to ensure that Contractor staff can access emergency care information to share with mental health care providers as necessary.
- g. Contractors shall train direct care and other staff, as appropriate, on strategies to employ to address a youth's mental health crisis while awaiting arrival and/or instruction of a qualified mental health professional.
- h. Contractors shall have a written suicide prevention plan that addresses training, screening and assessment at intake, communication with all levels of supervision of suicidal youth, intervention, reporting and follow-up to suicide attempts.

17. Substance Abuse Services

- a. Youth in LSP Program sites may not be Title IV-E eligible, therefore these youth may not be eligible for a per-diem Medicaid rate. All substance abuse services must be provided by the Contractor within the Base Rate and the designated mental health add-on rates.
- b. Contractors shall provide initial substance abuse screening and assessments as outlined in the Juvenile Justice Limited Secure Placements Standards (Appendix 1).
- c. Contractors shall ensure that youth who use substances receive alcohol and other drug education and counseling on-site and substance abuse interventions that are either evidence-based/evidence-informed or on the Substance Abuse and Mental Health Services Administration's (SAMHSA) approved list of modalities <http://www.nrepp.samhsa.gov>.
- d. If a youth is regularly using or abusing substances or is chemically dependent, the young person requires treatment. Contractors are required to have an OASAS certification (or become a certified satellite clinic with a certified OASAS provider) and a Credentialed Alcohol and Substance Abuse Counselor ("CASAC") to provide residential substance abuse treatment on-site.
- e. Substance abuse services and treatment shall engage youth and their families or other discharge resource, and shall address risk factors such as family histories of substance use, intergenerational trauma and co-occurring conditions.
- f. Parents, families and other discharge resources who need chemical dependency/use treatment shall also be offered services. For more information refer to the Juvenile Justice Limited Secure Standards (Appendix 1).
- g. All Contractors must provide adequate and appropriate staffing coverage. Services shall be available to youth in the morning, afternoons, evenings and weekends. The Contractor shall maintain a current list of per-diem staff who meet credentialing and clearance requirements available to fill in on as-needed basis in order to fulfill adequate coverage for staff outages (e.g. vacation and illness).

18. Health, Psychiatric, and Dental Services

- a. Youth in LSP Program sites may not be Title IV-E eligible, therefore these youth may not be eligible for a per-diem Medicaid rate.
- b. In order to provide appropriate medical, psychiatric and dental services for youth, ACS will provide medical providers for medical, dental and psychiatric services on-site at LSP Program sites. In the event that ACS is unable to provide on-site medical, dental, or psychiatric services, ACS may require the Contractor to provide these services. In such an event, ACS may modify the Contractor's budget to include reimbursement in an amount to be determined by ACS for these services.

- c. Contractors shall be the care coordinator for all health services provided to their youth, which will promote continuity of care as well as coordinated and integrated care throughout the youth's placement and in cases where the youth transfers to other contractors and/or transitions out of placement. The medical, dental and psychiatry providers will be obligated to communicate with Contractors on diagnoses, treatment plans and provided services to ensure integrated care for placed youth.
- d. Contractors must provide LSP Program site access and room space to health, dental and psychiatric service providers.
- e. Care Coordination
 - i. Contractors shall act as a single source of coordinated and integrated care.
 - ii. Contractors shall assign qualified staff to coordinate mental and behavioral health, and substance abuse services as well as information received from psychiatric and physical health services providers in order to prevent fragmented care.
 - iii. Contractors shall communicate with ACS staff and medical, dental and psychiatry service providers, and other entities in the Child Welfare and Juvenile Justice systems.
 - iv. Contractors shall see to it that access is provided to all health, dental and psychiatric service providers.
 - v. Contractors shall forge partnerships with crisis intervention programs, mentoring programs, youth and parent advocacy.
 - vi. Contractors shall see to it that psychopharmacologic services are integrated with other approaches as much as possible.
 - vii. Contractors shall secure, maintain and update health and mental health records.

19. Medication Administration

- a. Contractors must have the capacity to administer medication when medical provider is not on-site. Contractors must follow ACS policies regarding administration of medication. Additionally, all Contractor staff administering medication must be trained in medication administration.

20. Minimum Staff Qualifications

- a. Contractors shall ensure that all staff have the experience and educational qualifications outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). If proposing for a specialized population, staff must have experience and training in working with these populations as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
- b. Contractors shall have staff, professional consultants, or close linkages with resources that are qualified to address the full range of medical, clinical, and developmental needs presented by youth in LSP Program sites. Whenever possible, Contractors shall employ social work staff with at least a Bachelor of Social Welfare degree. Staff shall be skilled at engagement of youth and their families, and have a thorough understanding of child and adolescent development.
- c. Contractors shall ensure staff are committed to working with JD youth and are experienced, culturally competent and qualified to support youth to obtain the skills and resources necessary to live healthy, productive, and self-sufficient adult lives.
- d. Social work staff shall be trained in the practice and concept of family treatment, and receive training/have experience in screening for domestic violence and chemical dependency/use issues. Experience and qualifications shall include previous work experience with similar populations and credentials in the specific areas of expertise (e.g. Credentialed Alcoholism and Substance Abuse

Counselor for chemical dependency/use).

- e. Contractors shall designate a staff person to be the Domestic Violence (DV) Services Coordinator and another staff member to be LGBTQ Point Person in accordance with the Juvenile Justice Limited Secure Quality Assurance Standards (Appendix 1).
- f. Contractors shall assure that all clinical staff are licensed professionals and meet the qualifications as described in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). For those limited services that will not be provided on site, all staff and neighborhood-based medical and mental health professionals working with Contractors shall have demonstrated experience and skill with, and commitment to, the practices and concept of effective health care management, as well as knowledge and experience with issues affecting health care provision, coordination, and integration.
- g. Contractors shall be responsible for the verification of credentials and references and screening of all current and prospective employees in accordance with ACS policy and New York State Law.

21. Staff Training and Development

- a. Contractors shall continually assess the training needs of the staff based on the population of youth in the Contractor's care and tailor the training to ensure that staff receives appropriate training.
- b. Contractors shall have a written annual training plan, which describes the specific trainings and hours of each that are required of and offered to each staff level. Contractors shall be able to track and monitor staff compliance with annual training requirements. This documentation must be available to ACS.
- c. The attendance, time and substance of all pre-service and in-service training must be documented and available to ACS.
- d. Contractors shall provide comprehensive training for staff who come into contact with youth to equip them with skills to deal positively and effectively with problem behavior; assist them in meeting the needs of a diverse population of youth in their care; receive information on techniques in identifying trauma and addressing trauma triggers, understanding differences between male and female youth, understanding adolescent development, managing behavior and preventing abuse/maltreatment, and meeting the contractual requirements of the Contractor.
- e. Training for staff coming into contact with youth and the supervisors of such staff shall consist of both on-the-job and classroom training. In addition to covering the specific topics listed below, the training shall provide a common language and open communication about behavior challenges and solutions for staff – including social service staff, direct care staff, therapists, educational specialists, and, parents and youth.
- f. All training for staff coming into contact with youth and the supervisors of such staff shall be geared toward developing and understanding the needs and characteristics of the population in care and building skills to provide emotional support and care, and appropriately manage the behavior of youth in placement. Such training shall also include all skills that are identified as needing improvement in the individual staff's annual performance evaluation.
- g. Contractor staff shall receive training in the designated LSP practice model or approach as required by the model or approach and/or as designated by ACS.
- h. Contractor staff who have contact with youth, or who supervise staff that have contact with youth, shall also receive a minimum of eighty (80) hours of pre-service training in, but not limited to, the topics outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). The number of hours for each topic is at the discretion of the provider, except required Suicide and Crisis Management and Physical Restraint Intervention training.

- i. Contractor staff who have contact with youth, or who supervise staff that have contact with youth, shall also receive a minimum of thirty (30) hours of in-service training annually (forty (40) hours of in-service training for staff in specialized programs) as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). The number of hours for each topic is at the discretion of the provider, except required Suicide and Crisis Management and Physical Restraint Intervention training.
- j. Contractors shall make every effort to ensure that training incorporates and encourages the participation of community-based service providers, such as local hospitals, mental health providers and family support programs, police precincts, and drug treatment centers, as well as community residents, community leaders and community board members.
- k. Supervisors shall have the ability to assess the professional development needs of their staff, and support those needs and provide opportunities for growth. Supervisors shall conduct quality assurance case reviews with staff, and provide staff with reflective supervisory support and regular evaluations.

22. Staff Training – Providers of Health and Mental Health Services and Coordinators of Health Services

- a. In addition to clinically appropriate trainings, Contractors shall ensure that coordinators of health services and mental health services providers who are working with youth in their care receive orientation or training in issues such as the importance of a strengths based approach to assessment and treatment as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).

23. Monitoring, Evaluation and Quality Improvement for LSP Program Services and LSP Aftercare Services

- a. Contractors shall cooperate with ACS and OCFS assessment, evaluation and technical assistance systems, and must provide all information necessary to allow ACS to fulfill these responsibilities.
- b. Contractors shall maintain adequate case files and fiscal records, and ensure that staff follow appropriate record-keeping practices and procedures, in a manner which is in compliance with and supports all existing Federal, State, and City laws, rules, and regulations, and is consistent with policies, procedures, and standards promulgated by ACS, including the utilization of electronic data management systems such as the New York State systems of record including but not limited to, Connections (“CNNX”), Child Care Review Service (“CCRS”) and Automated Restraint Tracking System (“ARTS”).
- c. Contractors shall provide sufficient information to ACS and OCFS to enable data collection and monitor additional performance indicators as appropriate and as part of a full evaluation process.
- d. Contractors shall comply with any ACS and OCFS request to obtain additional data specific to the needs of this population.
- e. Contractors shall track and report quantitative and qualitative outcomes to demonstrate effectiveness throughout the contract term. Outcomes of interest include, but are not limited to: public safety, reduction in recidivism, connections to the community, and better family functioning.
- f. Contractors shall maintain internal quality assurance systems that demonstrate continuous program improvement, utilizing program specific data to inform that process.
- g. For LSP Aftercare programs, Contractors shall have access to clinical consultants who are associated with the model being provided, to provide case consultation and advice on program and clinical issues, if appropriate to the model.

- h. For LSP Aftercare programs, Contractors shall comply with the EBM, AEBM or PPM policies and procedures regarding case documentation and quality assurance measures.

24. Program Manual

- a. Contractors shall develop a comprehensive program manual in accordance with the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).

25. Documentation and Case Records

- a. Contractors shall maintain adequate case files and fiscal records, and shall ensure their staff follows appropriate record-keeping and retention practices and procedures, in a manner that is in compliance with and supports all existing federal, state and city laws, rules, and regulations, and is consistent with policies, procedures, and standards promulgated by Children's Services.

H. Additional Requirements for Service Option 2 – LSP Programs Serving Youth With Intellectual/Developmental Disabilities and Youth with Serious Emotional Disturbance Diagnosis

1. This section contains standards that are specific to LSP Program services in a twelve (12) bed LSP Program site for youth with intellectual/developmental disabilities ("IDD") and youth with a serious emotional disturbance diagnosis ("SED"). These standards apply in addition to those listed above in this solicitation and in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). In some areas, standards in this section may be more stringent than those in the main text of the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
2. Contractors may subcontract with another provider with specific expertise and experience working with youth in this Service Option.
3. This LSP Program site must be divided in a way that allows for one (1) group of six (6) youth with IDD and one (1) group of six (6) SED youth to operate independently from each other.
4. Contractors shall be prepared to serve populations with IDD Youth in this category include but are not limited to youth with:
 - a. Youth with Neurological Impairment and Severe Muscular Disorder,
 - b. Youth with Autism Spectrum Disorder,
 - c. Youth with Severe Learning Disabilities,
 - d. Youth with Intellectual Disability with an IQ below 70,
 - e. Autism Spectrum Disorder,
 - f. Cerebral Palsy,
 - g. Fetal Alcohol Spectrum Disorders ("FASD"), and
 - h. Down Syndrome.
5. Contractors shall provide youth who are served in a Specialized IDD LSP Program site with all the support, treatment, and understanding necessary to meet their broad range of physical, emotional, and developmental needs, in a manner that maximizes their chances for reunification with their families or discharge resources. When these options are not possible, Contractors must provide them with the skills necessary to live healthy, productive, and self-sufficient adult lives if possible.
6. Contractors shall educate youth about their developmental need and its various effects and lifestyle implications. Additionally, Contractors shall provide youth with information relevant to their particular medications, their effects and side effects or the use of medical equipment and other devices necessary for the treatment and maintenance of their condition.
7. Youth, their siblings, and other family members, shall be provided with ongoing counseling to increase

functioning. When indicated, youth must receive additional health care and personal hygiene information specific to their disability and/or medical condition.

8. Contractors shall supply or arrange for speech, occupational, and physical therapy as needed and when recommended by the ACS health services provider.
9. As necessary, a LSP Program site serving youth with IDD diagnoses must have access to a minimum of on-site speech and language pathology services two (2) hours per week, per youth. If a youth requires more than two (2) hours per week of speech and language pathology services, Contractors must ensure that the youth receives on-site services as required.
10. As outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1), Contractors shall develop and implement youth-specific training curricula for parent[s], family, extended family or other discharge resources along with special extended family support.
11. Contractors shall comply with the Americans with Disabilities Act and applicable state and local laws to make services and service locations accessible to youth and family members with physical disabilities including, but not limited to, making facilities wheelchair accessible, and utilizing sign language interpreters and large print informational reading materials.
12. Contractor staff shall connect the parent[s], family, extended family or other discharge resources to in-home supports that are available at the time of the youth's discharge (e.g., New York State Office of Mental Health Home (OMH) and Community Based Waiver programs, the New York State Bridges to Health Waiver program services through the New York State OMH or New York State Office of People with Developmental Disabilities (OPWDD) services.
13. In addition to required staff qualifications, trainings, and development described in Section III(G)(20-21), Contractors shall provide supplementary training to staff who care for or interact with youth with IDD to help them meet their specialized needs. The training shall take into account the individual needs of the youth served and shall be provided by either Contractors or an outside educational institution. Contractors shall provide all staff continuous and ongoing training to meet the changing needs of this population.
14. Contractors shall serve populations with SED diagnosis. Youth in this category include but are not limited to:
 - a. Youth who meet the definition of Seriously Emotional Disturbance ("SED"), as that term is defined by the New York State Office of Mental Health, at the following link: http://www.omh.ny.gov/omhweb/guidance/hcbs/html/SED_criteria.htm, and
 - b. Youth with DSM IV Axis I diagnoses that could benefit from service provision as outlined in this section.
15. Contractors shall ensure youth receive all the support, treatment, and understanding necessary to meet physical, emotional, chemical dependency/use and developmental needs, in a manner that maximizes their chances to live healthy, productive, and self-sufficient adult lives.
16. The Contractor shall meet the full range of physical, emotional, chemical dependency/use and psychological needs of the youth.
17. Contractors shall provide a comprehensive, culturally sensitive program as outlined in the Juvenile Justice Limited Secure Placements Standards (Appendix 1) that includes assessment of risk factors and safety issues related to serious emotional disturbance followed by individual, group, and family treatment.
18. Contractors must provide the additional staff training for staff working with SED and IDD youth as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).

I. Additional Requirements for Service Option 3 – LSP Programs for Youth Who Have Demonstrated Problematic Sexual Behaviors

1. This section contains those standards that are specific to LSP Program services in a twelve (12) bed LSP Program site for youth with problematic sexual behaviors. These standards apply in addition to those listed elsewhere in this solicitation and in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). In some areas, standards in this section may be more stringent than the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
2. Youth who have demonstrated problematic sexual behaviors include, but are not limited to:
 - a. Youth who have been found by Family Court to have committed what would be a crime of a sexual nature (excluding prostitution) if committed by an adult (note that not all youth adjudicated on these charges will be required to be placed in a specialized program), and
 - b. Youth who have in the past been found by a court to have committed what would be (or was) a crime of a sexual nature if committed by an adult.
3. For youth who have demonstrated problematic sexual behaviors who require limited secure juvenile justice placement, Contractors shall provide specialized treatment services in a highly structured setting that addresses the youth's needs. Through the Contractor's provision of this specialized service, the youth will learn impulse control; guidelines for appropriate sexual behavior; privacy; and respect for boundaries. The youth will be held accountable for his/her actions, and learn to fundamentally change harmful behaviors.
4. The Contractor must provide extensive treatment to address the issues which have led or contributed to the youth's offending behaviors.
5. Contractors shall establish a written safety plan for each youth to establish guidelines for interacting with peers in school, around other youth in the community or facility and interacting with staff and family members.
6. Contractors must assess and provide services to youth and families in as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
7. Contractors shall provide skill building for academic and social activities. Additional program activities will vary depending on the age of the youth. A positive and predictable environment must be established for youth via a structured behavior management system with consistent follow-through on consequences, which will provide the youth with boundaries, consistency, expectations regarding their behavior, improvement in their self-esteem, and safety for youth and staff.
8. Contractors must thoroughly train all staff and discharge resources about the behavior management system and about each youth's written safety and behavior management plans.
9. Parent/caretaker acknowledgement of the problem, buy-in, support, and active participation is paramount for the family's successful completion of the program and re-integration of youth in a stable supportive environment. Parent[s], family, extended family or other discharge resources will also address the impact of their youth's behavior on their family (particularly if the child was sexually abusive toward a sibling or other family member), and ensure that the caretaker fully understands how past abuse (if any) may have impacted his/her inappropriate/offending behavior.
10. Contractors shall ensure that special planning around interactions with victims, particularly if they are within the household to which the youth will be discharged after placement in a LSP Program site. If victims are in the household to which the youth will be discharged, the Contractor shall develop a thorough, comprehensive written safety plan to be included in the discharge plan as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1), including engaging the victim's system of care as appropriate. Additionally, Contractors shall provide or arrange

for any and all appropriate treatment and supports requested by the victim. ACS must provide prior written approval of discharge to a setting in which a victim of the youth is residing.

11. Contractor staff must receive specialized training as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).

J. Additional Requirements for Service Option 4 – LSP Programs Serving Youth With Intellectual/Developmental Disabilities and Youth with Serious Emotional Disturbance Diagnosis and Youth Who Have Demonstrated Fire Setting Behaviors

1. This section contains those standards that are specific to LSP Program services at an eighteen (18) bed LSP Program site for youth with intellectual/developmental disabilities (“IDD”), youth with serious emotional disturbance (“SED”) and youth who have demonstrated fire setting behaviors. These standards apply in addition to the general scope of services and in the Juvenile Justice Limited Secure Standards (Appendix 1). In some areas, standards in this section may be more stringent than those in the Juvenile Justice Limited Secure Placements Standards (Appendix 1).
2. Contractors may subcontract with another provider with specific expertise and experience working with youth in this service option.
3. This LSP Program site must be divided in a way that allows for one (1) group of six (6) youth with IDD and one (1) or multiple groups of youth with SED diagnoses (twelve (12) total youth with SED diagnoses – 4 of the SED beds shall be dedicated for youth who have demonstrated fire setting behaviors when needed) to operate independently from each other.
4. Contractors shall be prepared to serve populations with SED diagnosis in this category include but are not limited to youth with:
 - a. Who meet the definition of Seriously Emotional Disturbance (“SED”), as that term is defined by the New York State Office of Mental Health, at the following link:
http://www.omh.ny.gov/omhweb/guidance/hcbs/html/SED_criteria.htm
 - b. With DSM IV Axis I diagnoses that could benefit from service provision as outlined in this section.
 - c. Who have demonstrated fire setting behaviors.
5. As needed, there are four (4) designated beds within the twelve (12) bed SED LSP Program dedicated for youth who have demonstrated fire setting behaviors (these youth may or may not have an SED diagnosis). At the sole discretion of ACS, the Contractor may utilize the four (4) designated beds to serve youth who have not demonstrated fire setting behaviors.
6. Contractors shall ensure youth with SED diagnoses receive all the support, treatment, and understanding necessary to meet physical, emotional, chemical dependency/use and developmental needs, in a manner that maximizes their chances to live healthy, productive, and self-sufficient adult lives.
7. The Contractor shall meet the full range of physical, emotional, chemical dependency/use and psychological needs of the youth.
8. Contractors shall provide a comprehensive, culturally sensitive program as outlined in the Juvenile Justice Limited Secure Placements Standards (Appendix 1) that includes assessment of risk factors and safety issues related to serious emotional disturbance followed by individual, group, and family treatment.
9. Contractors must provide the additional staff training for staff working with youth with SED diagnoses and youth with IDD as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).
10. Contractors shall collaborate with a local fire department to ensure all appropriate fire safety and

prevention measures have been undertaken in the Specialized LSP Program site.

11. In addition to the required LSP staff outlined in this solicitation and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1), the following staff are required to provide services for youth who have demonstrated fire setting behaviors:
 - a. Occupational Therapist: Must have NYS License to practice Occupational Therapy, with experience working with adolescents who exhibit pervasive fire-setting behaviors.
 - b. Fire Safety Trainer: Bachelor's degree preferred in a related field, with demonstrated experience working with adolescents who exhibit pervasive fire-setting behaviors.
12. Prior to discharging youth who have demonstrated fire setting behaviors the likelihood of continued fire setting behaviors must be assessed.
13. In addition to the general discharge planning requirements, discharge planning for youth who have demonstrated fire setting behaviors must focus on safety planning with the youth and all discharge resources, as well as on relapse prevention. The discharge plan must include a comprehensive safety plan which must include a documented risk assessment.
14. Contractors shall be prepared to serve populations with Intellectual/Developmental Disabilities Youth in this category include but are not limited to youth with:
 - a. Youth with Neurological Impairment and Severe Muscular Disorder,
 - b. Youth with Autism Spectrum Disorder,
 - c. Youth with Severe Learning Disabilities,
 - d. Youth with Intellectual Disability with an IQ below 70,
 - e. Autism Spectrum Disorder,
 - f. Cerebral Palsy,
 - g. Fetal Alcohol Spectrum Disorders ("FASD"), and
 - h. Down Syndrome.
15. Contractors shall provide youth with IDD with all the support, treatment, and understanding necessary to meet their broad range of physical, emotional, and developmental needs, in a manner that maximizes their chances for reunification with their families or discharge resources. When these options are not possible, Contractors must provide them with the skills necessary to live healthy, productive, and self-sufficient adult lives if possible.
16. Contractors shall educate IDD youth about their developmental need and its various effects and lifestyle implications. Additionally, Contractors shall provide youth with information relevant to their particular medications, their effects and side effects or the use of medical equipment and other devices necessary for the treatment and maintenance of their condition.
17. Youth, their siblings, and other family members, shall be provided with ongoing counseling to increase functioning. When indicated, youth must receive additional health care and personal hygiene information specific to their disability and/or medical condition.
18. Contractors shall supply or arrange for speech, occupational, and physical therapy as needed and when recommended by the ACS health services provider.
19. As necessary, the LSP Program site serving youth with IDD diagnoses must have access to a minimum of on-site speech and language pathology services two (2) hours per week, per youth. If a youth requires more than two (2) hours per week of speech and language pathology services, Contractors must ensure that the youth receives on-site services as required.
20. As outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1), Contractors shall develop and implement youth-specific training curricula for parent[s],

family, extended family or other discharge resources along with special extended family support.

21. Contractors shall comply with the Americans with Disabilities Act and applicable state and local laws to make services and service locations accessible to youth and family members with physical disabilities including, but not limited to, making facilities wheelchair accessible, and utilizing sign language interpreters and large print informational reading materials.
22. Contractor staff shall connect the parent[s], family, extended family or other discharge resources to in-home supports that are available at the time of the youth's discharge (e.g., New York State Office of Mental Health Home (OMH) and Community Based Waiver programs, the New York State Bridges to Health Waiver program services through the New York State OMH or New York State Office of People with Developmental Disabilities (OPWDD) services.
23. In addition to required staff qualifications, trainings, and development described in Section III(G)(20-21), Contractors shall provide supplementary training to staff who care for or interact with youth with IDD to help them meet their specialized needs. The training shall take into account the individual needs of the youth served and shall be provided by either Contractors or an outside educational institution. Contractors shall provide all staff continuous and ongoing training to meet the changing needs of this population.

K. Additional Requirements for Service Option 5 - Intensive Short Term Support - LSP Programs

1. This section contains the requirements that are specific to LSP Program services for youth in need of short-term placement in an intensive support setting. These standards apply in addition to the general scope of services and in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). In some areas, standards in this section may be more stringent than those in the Juvenile Justice Limited Secure Placements Standards (Appendix 1).
2. This LSP Program site must be divided in a way that allows for two (2) groups of four (4) youth to operate independently from each other. There may be times when one (1) group of youth in this LSP Program site is female youth and one (1) group in this LSP Program site is male.
3. ACS will determine when and if a youth shall be placed in an Intensive Support LSP Program site. Request by a Contractor for a youth's placement in an Intensive Support LSP Program site will be subject to ACS approval and may be used as an intermediary step between placement options, as required.
4. Intensive Support services will be used for youth and families in need of crisis management and support during periods of time of a maximum of approximately three (3) weeks/twenty-one (21) days. Any length of stay beyond twenty-one days requires ACS approval.
5. Intensive Support services shall include assessments, treatment, medical and mental health intervention, and crisis management services for youth and families with the goal of establishing stability, identifying treatment needs and service resources for youth and families.
6. Contractors shall develop a written crisis management plan in addition to the youth's individualized treatment plans which will include the Intensive Support Contractor's assessments describing the underlying cause of the youth and family's crisis and/or need for Intensive Support services; as well as the short-term goals established to get the youth and/or family through the temporary crisis, and achievement of such goals.
7. Contractors must provide the additional staff training for this specialized placement as outlined in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1).

L. LSP Aftercare

1. Contractors of General LSP Program services, Specialized IDD LSP Program services; Specialized

PSB LSP Program services, and Specialized SED and Fire Setting Behaviors LSP Program services provide LSP Aftercare which will be used to assist in the transition of youth placed in LSP Program sites back to their home communities by providing intensive in-home services that promote behavior change in the youth's community. Contractors shall provide LSP Aftercare services through the implementation of an evidence-based model (“EBM”), an adaption of an evidence based model (“AEBM”) or a promising practice model (“PPM”) directed at reducing delinquency and recidivism, improving school attendance and achievement, and improving family functioning and relationships.

2. Due to the program design of Intensive Short Term Support LSP Programs, aftercare is not provided with these services.
3. The model used in LSP Aftercare shall provide a seamless transition for youth returning from LSP Program sites to their home communities, the model must complement the LSP practice model or approach program and behavior management approaches used in the LSP Program sites.
4. In addition to providing services directly, Contractors shall link the youth and families they serve with local social services and recreational programs, so that youth may engage in pro-social activities and families may obtain the support they need in their own communities. Pro-social activities are activities for youth, often recreational in nature, that provide positive peer-to-peer interaction for the youth. A minimum of three (3) linkage agreements with local programs that can provide pro-social activities for the youth served by the Contractor are required prior to the program start date.
5. Proven Approach

Proposers must propose an EBM, AEBM, or PPM. ACS’ definitions of EBMs, AEBMs, and PPMs are as follows:

a. Evidence-Based Model (“EBM”)

- i. EBMs are models of therapeutic services that have demonstrated, through multiple randomized clinical trials, sustained positive outcomes for the families served. The models must have demonstrated success in multiple, diverse settings, with families of wide-ranging cultural backgrounds.
- ii. More specifically, to qualify as an EBM, services must have been studied in replicated study protocols that contain clear outlines of the methodology for implementation, delivery, supervision, training, and monitoring of model adherence and fidelity. The clinical research must have delineated clear outcomes with a description of valid and reliable measures and key findings. Study data must have supported the effectiveness of all phases of the intervention, and the effectiveness of therapists and case planners trained in the delivery of the designed intervention. All quality assurance methods must demonstrate supporting evidence in the properties of the instruments and methods used in the fidelity of implementation. These models must work alongside research findings and must translate research findings and developments as they apply to clinical practice.
- iii. The clinical research that exists must be supported by replications in different settings and populations over time. The research behind the models must provide replicated evidence that the population studied in the various trials include youth with conduct disorder, delinquency, and substance abuse; as well as families involved in the child welfare system, families at risk of parental neglect and/or abuse, parent substance abuse, and parental high conflict. Studied populations must be representative of the white, black/African American, Hispanic/Latino, and race/ethnicity unspecified categories, within both the male and female gender groups, and conducted within various geographic locations to evaluate the effectiveness of interventions for the targeted population of these models. Sample sizes must be large enough to provide statistical power to detect at least moderate-sized effects.

- iv. The reliability and validity of model outcome measures and objectives must be supported by various studies, and measured by the percentage of research subjects who reported or exhibited the following data indicators: significantly reduced youth involvement in the juvenile justice system; reduced adolescent re-arrests, decreased family conflict; improved school attendance and grades; effective change of maladaptive behaviors; reduced potential of new offending by siblings of treated adolescents; reduced out of home placement; significant improvements in behavioral needs of parents as well as youth; improvement in parental monitoring, discipline, and support of appropriate youth behavior; and reduced length of service rate than comparable services.
 - v. All EBMs must have an EBM Manual which includes a detailed business process for delivering the therapeutic services; descriptions of staff qualifications, staff and supervisory caseload ratios; and the training provided to staff and supervisors. The EBM Manual must also include a detailed description of supervisory and quality assurance measures that will be utilized to ensure compliance with the model. The quality assurance activities should include, at minimum, strict adherence to a therapeutic model, collection of data to assess outcomes and create performance improvement plans, and regular review of practice to ensure model fidelity.
- b. Adaptation of an Evidence-Based Model (“AEBM”)
- i. An AEBM contains the core components of the EBM, but has been adapted for a different recipient population (including, but not limited to, geographic location), and is therefore considered “promising” or “evidence-informed” as opposed to an EBM which is considered “proven” or “evidence-based.” The AEBM must be approved by the original developer of the EBM or his/her approved designee. The AEBM must not stray far from the core components of the original EBM, but must be closely aligned with the therapeutic structure contained in the original EBM. AEBMs may or may not have undergone rigorous evaluations as to their efficacy. If rigorous evaluations such as experimental or quasi-experimental studies have not been completed, they should be planned to determine whether the model adaptation is able to sustain similar positive effects as the original EBM.
 - ii. All AEBMs must have an AEBM Manual which includes a detailed business process for delivering the therapeutic services; descriptions of staff qualifications, staff and supervisory caseload ratios; and the training provided to staff and supervisors. The AEBM Manual must also include a detailed description of supervisory and quality assurance measures that will be utilized to ensure compliance with the model. The quality assurance activities should include, at minimum, strict adherence to a therapeutic model, collection of data to assess outcomes and create performance improvement plans, and regular review of practice to ensure model fidelity.
- c. Promising Practice Model (“PPM”)
- i. PPMs are services models that do not have the quantity or quality of research that EBMs and AEBMs have to support their effectiveness. PPMs have thus shown good results and/or outcomes in implementation but have either not yet been replicated in another community other than the originating community, or do not have as comprehensive data as compared to EBMs or AEBMs.
 - ii. PPMs are comprehensive service delivery models that utilize specific interventions to improve the family’s level of functioning. All PPMs proposed must provide some data that show positive outcomes achieved by the model as compared to an objective benchmark, in the areas of reducing recidivism, reducing maltreatment, preventing foster care placements for the proposed population, and/or positive outcomes for youth and families.
 - iii. Examples of appropriate types of outcomes include, but are not limited to, case completion data, self-assessments completed from families, and average length of service data.
 - iv. Additionally, for the purposes of this NA, a PPM is further defined as a model that is designed using demonstrated best practices with the target population and supported by successful data in

similar jurisdictions with a similar target population. All PPMs must also meet the goals and objectives of this NA.

- v. All PPMs must have a PPM Manual which includes a detailed business process for delivering the therapeutic services; descriptions of staff qualifications, staff and supervisory caseload ratios; and the training provided to staff and supervisors. The PPM Manual must also include a detailed description of supervisory and quality assurance measures that will be utilized to ensure compliance with the model. The quality assurance activities should include, at minimum, strict adherence to a therapeutic model, collection of data to assess outcomes and create performance improvement plans, and regular review of practice to ensure model fidelity.
- vi. PPMs must include a supervisor level staff position to be on-call twenty-four (24) hours a day – seven (7) days a week and have safety plans for staff making home visits. The agency must also demonstrate how they will track outcomes through data collection instruments.

6. Data-Driven, Outcome-Oriented Approach

- a. Contractors shall implement an EBM, AEPM or PPM that is designed to promote ACS' goals with teens and families (listed below in item (10)). The EBM, AEPM or PPM must include built-in capacity to use data to track provider and individual staff performance and outcomes, and to use data to facilitate a continuous quality improvement process.
- b. Contractors shall have a process of systematic collection of information on youth characteristics, staff characteristics, and participant service experiences to ensure services are being implemented with fidelity to the EBM, AEPM, or PPM program intent and structure.

7. Operational Alignment

- a. Contractors shall provide aftercare for all of the youth being discharged from their LSP Program sites (excluding Service Option 4), with the necessary accommodations to support the intellectual/developmental functioning for youth with IID diagnoses.
- b. Unless otherwise directed by ACS, Contractors shall confirm the aftercare plan with the ACS Placement and Permanency Unit no later than day sixty (60) of LSP placement so that the appropriate LSP Aftercare staff can participate in discharge planning.
- c. Once the youth is discharged out of the LSP Program site and back to his/her home community, outreach by the Contractor must be swift (as described below in item (8)) and the Contractor must begin delivering aftercare services to the family immediately.
- d. Contractor's initial responsibility is to respond to the needs of the youth identified throughout LSP Program services by building on the youth's strengths. Contractors shall also assess long-term goals for the youth and develop a written plan with the youth and his/her family or discharge resource for how these goals will be achieved.

8. Swift Outreach

- a. Contractor staff will be responsible for making his or her first therapeutic contact with the family within seventy-two (72) hours of the youth's release.

9. Minimize Intervention Durations; Tailor to Immediate Needs

- a. Contractors shall provide prompt, targeted, effective, time-limited, EBM, AEPM or PPM adherent services that directly address the challenges and needs of families and youth who have been discharged from an LSP Program site. LSP Aftercare services shall be no longer than five (5) months on average (ACS approval is required when terminating LSP Aftercare services prior to five (5) months and for the continuation of LSP Aftercare services beyond five (5) months) and seek to ensure that youth and family functioning are strengthened and outcomes in key areas (including but not limited to recidivism and justice system involvement, school attendance, health, mental health, and family functioning) are improved.

10. Treatment Goals and Approaches

- a. Aftercare services shall seek to accomplish the goals set forth above in Section III Scope of Services. The services must be tailored to youth being discharged from a LSP Program site and their parents or other discharge resources, and must work to improve parenting skills of parents of teens, and thereby reduce teen maladaptive behavior and assist youth in avoiding interaction with the juvenile justice and/or criminal justice system.
- b. The services must work intensively with the family or discharge resource, and be holistic. The services must address, through therapeutic sessions conducted with the family or discharge resource by a therapist trained in the EBM, AEEM, or PPM, causes of problems within the household by drawing on the strengths of each household. Services must be able to address both relational (e.g., lack of communication between teen and parent, inability of parent to communicate with school officials) and concrete (e.g., lack of appropriate housing for the family or discharge resource, need for psychiatric services) needs of families. Services must include clinical staff interaction with the parent or other discharge resource and the youth; services that focus therapy solely on the teen without family or other discharge resource involvement are not permitted. Thus, the clinical staff must verbally interact both with parent/caregiver and youth throughout the life of the therapeutic intervention.
- c. Over the life of each case, the services must engage the family (including the youth being discharged from an LSP Program site), diagnose the problematic behaviors and focus on the strengths of the family or other discharge resource, motivate the family to change their behaviors, cause negative behaviors to change, and allow the family to practice – and sustain – behavior change on their own.
- d. The services must also be able to incorporate siblings of the youth into the intervention process as needed.
- e. The vast majority of services must be provided directly by the Contractor staff. Referrals to outside service providers must be limited only to those offering specialized services, such as those that require a special educational degree or certification (e.g., medical services, psychiatric services) or those that provide “pro-social” activities for teens as described in Section III Scope of Services (K)(12).
- f. The services must focus on the strengths of the family as a source of change. Strengths must be drawn upon in the services to effectuate positive change, to increase hope for the family, and to decrease frustration with the pace of change.
- g. The services must have a systemic method for assessing the families’ strengths and needs, and then must use the assessment to formulate therapeutic goals. Therapeutic goals must be determined in collaboration with the family or other discharge resource, Contractors, and ACS and must be clearly articulated by the Contractor staff to the family or other discharge resource. The services must include crisis intervention when needed by the family. As crises can occur at any time of the day and on any day, crisis intervention must be available twenty-four (24) hours per day, seven (7) days per week.
- h. There must be an identified caregiver for the youth prior to the youth beginning LSP Aftercare services, so parents or discharge resources must be encouraged from the beginning to be committed for the duration of treatment.

11. Therapeutic Sessions and Other Services to Be Provided by the Contractor

- a. LSP Aftercare services by the Contractor shall be primarily provided via therapeutic sessions. Therapeutic sessions are at minimum hour-long interactions provided weekly between a therapist trained in the EBM, AEEM, or PPM and the family members or discharge resources who are the primary recipients of the family therapy. If it is therapeutically appropriate the Contractor must provide sessions longer than an hour. Others may join the therapeutic sessions, such as siblings,

extended family, or staff from the school attended by the youth, when doing so would help to further the youth and family's clinical goals.

- b. Therapeutic sessions must be provided for the duration of the Contractor's involvement with the family. The Contractor must provide additional sessions when needed, and shall provide immediate attention to youth and families in crisis.
- c. Therapeutic sessions shall be home-based where possible (unless there are safety issues presented in the home that make home-based services unsafe for Contractor staff). Contractors shall provide home-based services to families, either through the use of multi-lingual staff or through interpretation services that shall be provided by Contractors at no additional cost to ACS. Therapeutic sessions may be provided in an office setting when permitted by the EBM, AEPM or PPM, and where it is more convenient for the family to do so.
- d. Services other than therapeutic sessions shall also be provided by Contractors when appropriate and warranted. Other services may include but are not limited to assistance with concrete needs of the family (e.g., housing, government benefits, and assistance with school placement of the youth or the youth's siblings). These services may be provided using various means including, but not limited to, accompanying the youth and/or family to appointments and making referrals to the youth and/or family for services with other service providers. When possible, the same staff conducting the therapeutic sessions with the youth and family shall also provide these services, so as to minimize the number of different staff members interacting with the family.

12. Linkages With and Referrals to Other Service Providers

- a. Referrals to outside service providers must be limited only to those offering specialized services, such as those that require a special educational degree or certification (e.g., medical services, psychiatric services, substance abuse rehabilitation) and those that provide "pro-social" activities for youth.
- b. Contractors shall have established linkages and referral protocols with at least three (3) community based service providers to provide individualized "pro-social" activities and support for youth which may include but are not limited to vocational counseling, academic support and tutoring, mentoring, afterschool programming, recreational and cultural programming. Within the Contractor's LSP Aftercare budget, Contractors shall pay all fees associated with participation during the period of time the family is receiving aftercare services if the family or discharge resource is unable to afford the fee.
- c. Contractors shall also establish linkages with organizations providing expert and specialized services to individuals with chronic physical, mental, developmental or intellectual disabilities, prenatal and postnatal counseling and services, and alcohol and substance abuse as appropriate to the EBM, AEPM or PPM utilized. These linkages may be among the three (3) that are required for LSP Program sites.
- d. Contractors shall build supportive services and work in partnership with other providers in the community to best meet the needs of youth and families living in the community.

13. ACS Referrals and No Reject Policy

- a. The ACS PPS Unit shall determine an aftercare plan for each youth in a LSP Program site no later than day sixty (60) of the placement. The PPS Unit provides case management of youth while they are in a LSP Program site and makes all referrals of youth to Contractors.
- b. Contractors shall primarily provide aftercare services for youth discharged from their own LSP Program sites. However, there may be instances where ACS refers a youth discharged from another LSP Program site for aftercare services. During year one, Contractors shall accept youth transferred from OCFS into LSP Aftercare.

- c. Contractors shall accept all referrals from ACS and shall have a no reject/eject policy. Contractors must provide LSP Aftercare services for all youth leaving the Contractor's LSP Program site. ACS must be the only referral source for slots awarded under this solicitation. If the Contractor believes a referral was erroneously made by ACS, a system will be put in place for Contractor to appeal the referral.

14. Coordination with the Department of Education

- a. Consistent with the goals of this solicitation, including significantly reducing truancy and improving school performance among youth served, Contractors shall coordinate with the New York City DOE regarding the educational needs of the youth. In coordination with ACS and DOE, Contractors are responsible for facilitating the youth's transition to a community based school that is appropriate for the youth and meets their needs. Additionally, for the duration of LSP Aftercare services, Contractors are responsible for working with DOE to ensure that services provided to the youth focus on ensuring school participation and strengthening the relationship between the youth, their family or discharge resource, and the school.

15. EBM/AEBM/PPM Adherence

- a. Contractors must precisely comply with the EBM, AEBM, or PPM in connection with its provision of services. Any deviation from the EBM, AEBM or PPM without direct approval from ACS and the EBM, AEBM or PPM developer is not permissible.
- b. Model adherence includes full compliance with the stringent clinical and administrative requirements set forth by the EBM, AEBM, or PPM and also includes but is not limited to: strict clinical adherence to each EBM, AEBM, or PPM according to the mandates of their respective therapeutic interventions; quality assurance activities required by each modality; attendance at required trainings; and the provision, when appropriate and, at a minimum, as required by the EBM, AEBM, or PPM, of home-based treatment. Where home-based treatment is required by the EBM, AEBM, or PPM, Contractors must be prepared to provide to clinicians appropriate technology to support such community-based work, such as laptops and cellular phones at no additional cost to ACS.
- c. Quality assurance activities may include but are not limited to: input of case data into database operated by the developers of the EBM, AEBM, or PPM; regular and frequent supervision of direct service staff to support and guide their ongoing practice; regular and frequent consultation with therapeutic consultants selected by the EBM, AEBM, or PPM developers; and, with the permission of the youth and his/her family or discharge resource, recording of therapeutic sessions to ensure model adherence by staff.

16. Staff Qualifications

- a. Staff conducting therapeutic sessions must have experience and skills commensurate with the responsibilities associated with these positions, including but not limited to the practices and concepts of child safety and risk, family mental health treatment, domestic violence issues and substance abuse issues. If proposing Service Options 2, 3, and/or 5, staff must have experience and skills working with those populations.

17. Staff Caseloads

- a. Caseloads of staff conducting therapeutic sessions shall not exceed twelve (12) families per staff member.
- b. Contractors must organize staff coverage schedules so as to minimize the risk of staff "burn out" and to appropriately meet the needs of youth and families in crisis.

18. Staff Training and Development

- a. Contractors shall ensure that all appropriate staff is trained in the use of the proposed EBM, AEEM or PPM before they begin to provide LSP Aftercare services to families.
- b. Contractors shall ensure that, prior to the provision of services; appropriate staff is trained in behavioral management techniques appropriate to the EBM, AEEM or PPM and issues specific to the target population.
- c. Contractors shall provide appropriate staff with pre-service and ongoing training about relevant child welfare and juvenile justice topics including, but not limited to, requirements of mandated reporters; recognizing, assessing and managing youth safety and risk; substance abuse; adolescent development, including adolescent brain development; psychotropic medication and medication management; working with child welfare and juvenile justice-involved families; concurrent juvenile justice and child welfare permanency planning; domestic violence; teen relationship abuse; HIV/AIDS; behavior modification and management, including the behavior management approaches described further in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1); youth development disorders; LGBTQ youth and families; gender identity and expression; sexual abuse of children/adolescents; crisis intervention; and trauma theory.
- d. Contractors for the Specialized Service Options in this solicitation shall ensure that all staff receive pre-service and ongoing training regarding issues specific to the special population of youth with which they will be working.
- e. Contractors shall ensure that all appropriate staff receive training specific to the provision of community-based services, including training on community characteristics, resources, and needs, and on how to successfully negotiate services for youth within their communities.
- f. Contractors shall ensure that training incorporates and encourages the participation of representatives from community-based service providers and those who have expertise on culturally competence, including but not limited to programs serving LGBTQ youth; local hospitals; and other community-based programs.
- g. Contractors shall provide training on how to recognize and assess the presence of domestic violence and substance abuse as well as methods for performing interventions that are appropriate to the model being utilized.
- h. Contractors shall have a strategy for guiding staff in balancing the task of delivering program content while being responsive to a family's cultural beliefs and immediate circumstances.
- i. Contractors shall provide training to all therapeutic staff and supervisors on worker safety and secondary trauma.

19. Accessibility of Services

- a. Contractors for Service Options 1-4, shall either have LSP Aftercare program sites in all five (5) boroughs or form linkages with other organizations to utilize the other organization's program sites, per Section II (E), Summary of the Negotiated Acquisition.
- b. All LSP Aftercare program sites utilized by Contractors shall be accessible to public transportation so that youth and families may access the site for services if needed.
- c. Contractors shall ensure that its hours of operation reflect the needs of the youth and families to be served. This strategy shall include flexible hours to accommodate school hours and working family members or discharge resource in a manner that is least disruptive to daily life activities, religious proscriptions, medical and health related conditions, and neighborhood safety conditions.

- d. Contractors shall assess the communication skills of each youth and family to be served and shall address identified family literacy limitations so that oral and written communications occur at an appropriate level to ensure the youth's and family members' full participation in and understanding of the services offered by Contractors. Contractors shall ensure that culturally and linguistically competent services are provided through staff that is representative of the population served and fluent in the languages spoken by participating youth and family members or discharge resource. If translation of services is needed, Contractors shall provide translation services at no additional cost to ACS.
- e. Contractors shall make services accessible to clients with physical disabilities by, including but not limited to, offering Telecommunication Device for the Deaf ("TDD") services, raising staff awareness about disabilities, utilizing large print informational reading materials, and establishing referral protocols to programs serving disabled communities.

SECTION IV - FORMAT AND CONTENT OF THE PROPOSAL

Instructions: Proposers must provide all the information requested in the format below. The proposal must be typed in a 12 point or greater font, double-spaced on both sides of white 8 1/2" X 11" paper with 1"-1.5" left and right hand margins. The City of New York requests that all proposals be submitted on paper with no less than 30% post consumer material content, i.e., the minimum recovered fiber content level for reprographic papers recommended by the United States Environmental Protection Agency (for any changes to that standard please consult: <http://www.epa.gov/cpg/products/printing.htm>). Pages must be paginated. The proposal will be evaluated on the basis of its content not length. However, it is suggested, that the program narrative, inclusive of its Table of Contents, not exceed thirty (30) pages. ACS requests that the original proposal package (i.e., the proposal and all appendices, supporting documents and related materials) and requested copies of the package **not** be bound with glue, spiral combs, tape, staples or other permanent binding materials.

A. Proposal Format

1. Proposal Cover Form

- a. The Proposal Cover Form (Attachment A) transmits the proposer's Proposal Package to ACS. It must be completed, signed and dated by an individual authorized by the Proposer to enter into a contract with the City on behalf of the proposer.

2. Acknowledgment of Addenda

- a. The Acknowledgment of Addenda form (see Attachment B) serves as the proposer's acknowledgment of the receipt of addenda to this NA that may have been distributed by ACS prior to the Proposal Due Date and Time. Contractors shall complete and submit the Acknowledgment of Addenda form (Attachment B) as part of the Proposal Package.

3. Program Proposal

The Program Proposal is a clear, concise narrative that addresses the proposer's overall program and service concepts and incorporates all relevant requirements. The Program Proposal must demonstrate that proposer has, or will have, the capacity to meet the requirements of Section III, Scope of Services and to uphold the Juvenile Justice Limited Secure Standards (Appendix 1). The program proposal narrative shall address the following:

a. Experience

- i. Describe the Proposer's prior successful experience administering residential and community-based services to adolescents involved in the juvenile justice and/or criminal justice systems, including, if applicable, the services described in the Juvenile Justice Limited Secure Quality Assurance Standards and in Section III (Scope of Services), the implementation and maintenance of a practice model or approach within a residential setting, and, if applicable, the implementation and maintenance of the practice model or approach that is being proposed for the LSP Program site(s) in the proposal.
- ii. Describe the Proposer's prior successful experience in serving similar populations to those described as the target population in Section II(B) (Summary of the Negotiated Acquisition) including number of years of experience. For those proposing for specialized competitions, describe the proposer's experience serving the specific population proposing for as described in Section III (H-K) (Scope of Services). Include outcome data showing success if available.
- iii. Attach a copy or documentation of any formal evaluation material and performance monitoring letters and reports received from ACS or other funders during the past two years for relevant service provision. If applicable, include documentation for any poor evaluations, corrective actions, neglect and abuse data, or license suspension or revocation received within the last two (2) years from other contracted or licensed services.

- iv. Attach letters of support for the proposal from at least two (2) relevant references. The letters must include the name of the reference entity, a brief statement describing the relationship between the Proposer and the reference entity, and the name, title, and telephone number of a contact person at the reference entity and for the proposer.
- v. For LSP Aftercare services, describe the Proposer's experience, if any, implementing and successfully maintaining a model compliant EBM, AEPM or PPM. Describe the population that received the EBM, AEPM or PPM services provided by the Proposer. Include data showing whether the Proposer successfully implemented and achieved successful outcomes with the model.
- vi. Describe the Proposer's experience, if any, implementing the EBM, AEPM or PPM that is being proposed for LSP Aftercare in the proposal. If applicable and available, include data showing whether the Proposer successfully implemented and achieved successful outcomes.

b. Program Approach

- i. Describe in detail the Proposer's plan to provide Limited Secure Placement and Aftercare services that will meet the goals and objectives of ACS as stated in Section II(A) (Purpose of the Negotiated Acquisition) and Section III(A) (Agency Goals and Objectives).
- ii. Describe the LSP practice model or approach that the Proposer is proposing to use in Limited Secure Placement, including how the model or approach includes the critical elements described in Section III(E)(5). Explain the reason that the Proposer chose the proposed practice model or approach. Provide data, if available, that demonstrates that providing services utilizing the proposed practice model or approach will achieve ACS' objectives for youth and families as stated in Section II(A) (Purpose of the Negotiated Acquisition) and Section III(A) (Agency Goals and Objectives).
- iii. Describe the EBM, AEPM or PPM that the Proposer is proposing to use for LSP Aftercare services. Explain the reason that the Proposer chose the proposed EBM, AEPM or PPM. Provide data, if available, that demonstrates that providing services utilizing the proposed EBM, AEPM or PPM will achieve ACS' objectives for youth and families as stated in Section II(A) (Purpose of the Negotiated Acquisition) and Section III(A) (Agency Goals and Objectives).
- iv. Describe how the Proposer will provide treatment within the LSP Program site in small groups and will also provide individualized treatment to youth, during an average length of stay in LSP of seven (7) months. Describe how the services within the LSP Program site will include opportunities for group discussion and reflection and promote an environment of support and encouragement for youth. Describe how groups will remain stable to encourage peer-support among youth.
- v. Describe how the Proposer will engage family or other discharge resources of youth, and identify a network of support for each youth, while the youth are residing in the LSP Program site.
- vi. Describe how the Proposer will provide close and direct supervision in the LSP Site, including how the minimum staff to youth ratios will be met. Describe how youth will remain in direct eyesight of the staff, or where necessary for privacy of the youth, in direct earshot of youth at all times. Describe how this approach will emphasize observation, relationship-building, direct communication and intervention to prevent new or emerging issues or conflicts between young people. Describe Proposer's plan to have the same consistent staff with each group to encourage relationship-building and trust. Describe how staff will supervise, implement group and individual treatment plans, provide group counseling and develop constructive relationship with youth. Describe staff will work with the same group of youth from their admission to placement through their release.
- vii. Describe how the Proposer will provide pre-service and in-service training to staff, including how the proposed training schedule adheres to training requirements contained in the Juvenile

Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). Describe how the Proposer will provide staff with tools and skills to enhance their understanding of gender specific youth development, especially the impact of physical, sexual, or emotional abuse. Describe how the Proposer will determine programming and recreation of interest to female youth, if asked to house female youth. Describe how the Proposer will provide a comprehensive, culturally sensitive program that includes assessment of risk factors and safety issues related to sexual exploitation.

- viii. Describe how the Proposer will ensure the safety of the youth, staff, and community both in the LSP Program Site and while the youth is participating in LSP Aftercare. Explain how the services proposed utilize best practices, proven de-escalation techniques, and a youth development approach that will ensure a safe environment both within the LSP Program site, in the community surrounding the LSP Program site, and while the youth are in LSP Aftercare.
- ix. For Proposers proposing to work with specialized populations in Service Options (2) – (5), describe how the LSP Program and LSP Aftercare services (excluding LSP Aftercare services for Intensive Support) proposed meet the needs of the specialized population to be served within each Service Option, how the services will meet the special goals and objectives for the populations to be served within each Service Option, and how any required special services will be provided.
- x. Describe the Proposer's education plan, which must be in compliance with the education standards delineated in Section III(G)(13) (Education) and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1), including:
 - a) For LSP Program sites within New York City with on-site schools and DOE for educational services, a copy of the Proposer's school plan and a letter from the DOE approving such plan. The school plan must include a description of how the Proposer will plan and provide for youth transitioning from an LSP Program school to their community school as part of his or her discharge planning process and how the Proposer will utilize behavioral support staff and additional teachers (if needed to maintain a lower student to teacher ratio);
 - b) For LSP Program sites outside of NYC and utilizing a Non-DOE school, evidence that the school is in good standing with the New York State Education Department, and a letter from DOE approving the education plan for when the program site will relocate into New York City, the approved educational plan must include a description of how Proposers will plan and provide for youth transitioning from an LSP Program school to their community school as part of his or her discharge planning process and how Proposers will utilize behavioral support staff and additional teachers (if needed to maintain a lower student to teacher ratio);
 - c) A plan to use an education based psycho-social assessment for youth and their family/guardian(s) that includes, but is not limited to, educational goals and aspirations, supports in the home to help youth achieve educational goals, historical educational behaviors, assistance the family/guardian(s) feel they and the youth need for the youth to succeed.
- xi. Describe how the Proposer will provide all mental health services outlined in Section III(G)(16) (Mental Health Services) and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) and provide all substance abuse services outlined in Section III(G)(17) (Substance Abuse Services) and the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1). Describe how the Proposer will meet the required minimum staffing outlined in Section III(F).
- xii. Describe how the Proposer will provide case coordination services and work closely with medical, dental and psychiatric service providers.

- xiii. Describe the supervisory and quality assurance measures to ensure compliance with the LSP Program site practice model or approach and LSP Aftercare model. The quality assurance activities must include, at minimum, monitoring for adherence, collecting data to assess outcomes and create performance improvement plans, and conducting a regular review of practice to ensure fidelity to the approach or model and adherence to the Juvenile Justice Limited Secure Placements Quality Assurance Standards. Describe the role of the LSP practice model or approach, EBM, AEEM, and/or PPM developer, if any, in the Proposer's operations.
- xiv. For Proposers of Service Options (1) – (4), provide the name of the EBM, AEEM or PPM being proposed for LSP Aftercare.
- xv. For Proposers of Service Options (1) – (4), describe in detail the EBM, AEEM or PPM being proposed for LSP Aftercare and demonstrate how the model meets all of the goals and objectives of the NA.
- xvi. For Proposers of Service Options (1) – (4), describe how the EBM, AEEM or PPM being proposed for LSP Aftercare meets the definitions stated in Section III Scope of Services (L)(5) above.
- xvii. For Proposers of Service Options (1) – (4), describe how the EBM, AEEM or PPM proposed for LSP Aftercare complements the LSP practice model or approach being used while the youth is in placement.
- xviii. For Proposers of Service Options (1) – (4), describe how the Proposer will engage and partner with families or other discharge resources, employ strategies that support culturally competent practice, meet the language needs of clients and engage community and neighborhood services while providing LSP Aftercare services.
- xix. For Proposers of Service Options (1) – (4), attach a manual for or a comprehensive summary of the EBM, AEEM or PPM being proposed for aftercare that includes detailed and comprehensive descriptions of the following:
 - a) The name of the model and the model developer(s);
 - b) The philosophy underlying the model;
 - c) How the model accomplishes behavior change with the families;
 - d) The business process of assessment, clinical goal setting, the provision of clinical services, and the determination to end clinical services with a family;
 - e) The model's staffing plan with caseload requirements, staff qualifications and supervisory structure;
 - f) Inclusionary and exclusionary criteria;
 - g) Guidelines for length of treatment;
 - h) Content of training provided and frequency;
 - i) How unusual incidents and/or crises will be treated;
 - j) How 24/7 Supervisor coverage will be managed;
 - k) Standards for discharge and closing of cases;
 - l) Quality assurance mechanisms and fidelity measures;
 - m) Support provided to staff working primarily out of the office (laptops, cell phones, safety planning);
 - n) If not a home-based service, how families will access services without travel hardships from a borough-wide program; and
 - o) If applicable, any other elements of the model not listed above that are important to the implementation and delivery of the model.
- xx. For Proposers proposing for Service Option 2 - Youth Who Have Intellectual/Developmental Disabilities (IDD) and Youth with Serious Emotional Disturbance (SED) Diagnosis, describe how the Proposer will provide support, assessment and treatment for both of these populations during LSP Program services and during LSP Aftercare. Describe how the Proposer will meet

the mental health and substance abuse staffing requirements in Section III (F)(4-5) and Section III (H). Describe the plan for medication management. Describe a plan for providing Occupational Therapy for IDD youth.

- xxi. For Proposers proposing for Service Option 3 - Youth Who Have Demonstrated Problematic Sexual Behaviors, describe how the Proposer will provide services to address issues which lead or contributed to the youth's offending behaviors. Describe the mental health psychological services that will be available and meet the mental health and substance abuse staffing requirements in Section III(F)(4-5) and Section III (I). Describe how the Proposer will provide support, assessment and treatment for this population during LSP Program services and during LSP Aftercare.
- xxii. For Proposers proposing for Service Option 4 – Youth with Intellectual Developmental Disabilities (IDD) and Youth with Serious Emotional Disturbance (SED) Diagnosis and Youth Who Have Demonstrated Fire Setting Behaviors, describe how Proposer will provide support, assessment and treatment for all of these populations during LSP and during aftercare. Describe how the contractor will make mental health and psychosocial services available to the youth receiving services and how the Proposer will meet the mental health and substance abuse staffing requirements in Section III (F) (4-5) and Section III (J). Describe the plan for medication management. Describe a plan for providing Occupational Therapy for IDD youth and youth who have demonstrated fire setting behaviors.
- xxiii. For Proposers proposing for Service Option 5 - Intensive Support, describe how the Proposer will provide short term, intensive crisis management and intervention to youth and families. Describe the proposer's plan to assess underlying cause of the youth and family's crisis and/or need for temporary intensive support. Describe how the Proposer will establish short-term goals to get the youth and/or family through the temporary crisis, and achievement of such goals. Describe the plan for medication management. Describe the plan to integrate structured educational programs and structured, closely supervised therapeutic recreational events into the Intensive Support program proposed. Describe how the proposer, will provide services and programming that, at times, will allow for one group of female youth and one group of male youth to independently operate. Describe how the Proposer will meet the mental health and substance abuse staffing requirements in Section III (F) (4-5) and Section III (K).

c. Organizational Capability

- i. Describe the proposer's organizational, programmatic, managerial, and financial capability to perform the services described in Section III Scope of Services.
- ii. Describe personnel who will be part of the treatment team for each youth.
- iii. Describe the steps that will be taken to ensure organizational readiness to implement the LSP practice model or approach for LSP Program services and for Service Options 1 – 4 the EBM, AEBM, or PPM for LSP Aftercare being proposed. Include a plan, with timelines, for implementation that shows how the Proposer will build capacity to meet the goals and provide model-adherent services for the first three (3) years of service. Within this plan there must be a description of how the necessary staffing and program start up activities that will take place within two (2) months prior to accepting youth. If proposing a non-City-Leased site, describe the facility start-up activities, including a detailed a timeline for all renovation activities and site inspections.
- iv. Attach an organizational chart that includes but is not limited to positions that would be key to implementation of these contracts. For Proposers of Service Options 1 – 4, the organizational chart must include staffing model for both LSP Program sites and LSP Aftercare services.
- v. Describe and demonstrate the effectiveness of Proposer's internal Quality Assurance systems for monitoring and reviewing program performance, including monitoring length of stay and designing and implementing improvement strategies. Describe the Proposer's Quality Assurance

staffing structure including functions and quality assurance skills of Quality Assurance staff. For Proposers of Service Options 1 – 4, the Quality Assurance plan must describe Quality Assurance for both LSP and Aftercare services.

- vi. For Proposers of Service Options 1 – 4, describe the capability of the person or entity who will train the Proposer's staff in the LSP Aftercare model.
- vii. Demonstrate that the proposed LSP Program site will be available and ready to provide services by October 1, 2013. If the Proposer is proposing a site that is accessible to and useable by individuals with disabilities, the start-up plan must include how the facility is already accessible to and useable by individuals with disabilities or will be accessible to and useable by individuals with disabilities between by October 1, 2013.

d. LSP Program Site

- i. If proposing to provide services in one of the City-Leased sites listed in Section II (D)(10), Proposer must provide proof that they have visited the program site prior to submission. Please provide a signed attestation from ACS which includes the date and time of the visit.
- ii. If proposing to provide services at a Non-City-Leased site, ACS will do a site visit to confirm that the program site is appropriate for LSP. ACS staff will complete a checklist which is attached as Appendix 5.

e. Price Proposal

- i. For each proposed LPS Program site, please submit a separate budget for the Base Rate and each Add-On rate for both year one and on-going. Proposers are required to use the templates provided by ACS. In addition, provide a narrative that describes the cost effectiveness of the proposed budget, and include a justification for any proposed Start-Up costs.

4. Minimum Qualification Documentation

a. Failure to provide the following documents will make the Proposal non-responsive and cause the Proposal to be rejected:

- i. All proposers must provide a copy of the proposer's current New York State Certificate of Incorporation.
- ii. All proposers must be a Not-for-Profit organization and the proposers' New York State Certificate of Incorporation must state that the proposer is a Not-for-Profit.
- iii. Proposers must either submit proof that they are currently approved as an "authorized agency" by OCFS;

OR

a copy of their current licensure from OMH, which must be valid and in good standing.

5. Doing Business Data Form

Pursuant to Local Law 34 of 2007, amending the City's Campaign Finance Law, the City is required to establish a computerized database containing the names of any "person" that has "business dealings with the city" as such terms are defined in the Local Law. In order for the City to obtain necessary information to establish the required database, vendors responding to this solicitation are required to complete the attached Doing Business Data Form.

B. Proposal Package Contents (“Checklist”)

The Proposal Package must contain the following materials. Proposers must utilize this section as a “checklist” to assure completeness prior to submitting their proposal to ACS.

1. A separate sealed inner envelope labeled “Program Proposal,” containing one original set and seven (7) duplicate sets of the documents (please do not bind with glue, spiral combs, tape, staples or use other permanent binding materials) listed below in the following order:
 - a. Proposal Cover Form (submit as Attachment A)
 - b. Acknowledgment of Addenda Form (submit as Attachment B)
 - c. Program Proposal Narrative (submit as Attachment C)
 - d. Documentation of Educational Plan (submit as Attachment D)
 - e. Letter of Support from the program developer of the model being proposed (submit as Attachment E)
 - f. Organization Chart (submit Attachment F)
 - g. Audit Report(s) or Certified Financial Statement(s) (submit as Attachment G)
 - h. Performance Evaluations on relevant services for the past two (2) years (submits as Attachment H)
 - i. First Year Budget (submit as Attachment I)
 - j. Annual On-going Budget (submit as Attachment J)
2. Minimum Qualification Documents (submit as Attachment K – submit only one (1) copy, separated into its own envelope). **Failure to provide these documents will make the Proposal non-responsive and cause the Proposal to be rejected.**
 - a. Provide a copy of the Proposer’s current New York State Certificate of Incorporation.
 - Not-for-Profit Status must be documented on the New York State Certificate of Incorporation.
 - b. Proposers must either submit proof that they are currently approved as an “authorized agency” by OCFS

OR

a copy of their current licensure from OMH, which must be valid and in good standing.
3. “Doing Business Data Form” containing an original, completed Doing Business Data Form (submit only one (1) copy in its own envelope as Attachment L).
4. A sealed outer envelope, enclosing the three sealed inner envelopes. The sealed outer envelope must be labeled with the following information:
 - a. The proposer’s name and address, the Title and PIN of this NA and the name and telephone number of the Proposer’s Contact Person
 - b. The name, title and address of the Authorized Proposer Contact Person.
 - c. The Service option being proposed

SECTION V - PROPOSAL EVALUATION AND CONTRACT AWARD PROCEDURES

A. Evaluation Procedures

1. All proposals accepted by ACS will be reviewed to determine whether they are responsive or non-responsive to the requisites of this NA. Proposals that are determined by ACS to be non-responsive will be rejected. ACS' Evaluation Committee will evaluate and rate all remaining proposals based on the Evaluation Criteria prescribed below.
2. ACS will conduct site visits on all identified sites for proposals deemed responsive. In the event that a proposed site is deemed inappropriate or unacceptable after the site visit, the proposed program site will be considered for award with other program sites classified as to be determined as described in Section II (D) (12) LSP Program Sites to be Determined. **All proposed sites must be identified on the Proposal Cover Form Attachment A. Failure to identify a site on the Proposal Cover Form, Attachment A, will be considered as a not identified proposed site as described in Section II (D)(12) LSP Program Sites to be Determined.**
3. In addition, ACS reserves the right to conduct interviews and/or to request that proposers make presentations and/or demonstrations, as ACS deems applicable and appropriate.
4. ACS reserves the right to conduct additional site visits and/or interviews, as ACS deems applicable and appropriate. Although discussion may be conducted with Proposers submitting acceptable applications, ACS reserves the right to award contracts on the basis of initial proposals received, without discussion; therefore, the Proposers' initial application should contain its best pricing and programmatic terms.

B. Evaluation Criteria

Demonstrated Quantity and Quality of Successful Relevant Experience	30 %
Demonstrated Organizational Capability	30 %
Quality of Program Approach	40 %

C. Basis for Contract Award

1. Contracts will be awarded to the responsible proposer(s) whose proposal(s) (is)(are) determined to be the most advantageous to the City, taking into consideration the price and such other factors or criteria which are set forth in this NA, as further described below. Proposals determined non-responsive will not be considered for contract award.
2. All responsive proposals will be ranked in order of technical score within the proposed service option. Proposals that are within the technically viable range or above the natural break that adhere to the solicitation's stated maximum annual funding will be considered viable for award. Proposals deemed as not technically viable will not be considered further.

3. Once all proposals are scored and ranked, awards will be determined as follows:

a. Service Option 1 – General LSP – City-Leased Sites

- i. ACS will recommend awards first to those technically viable Proposers proposing LSP Program sites at one of the City-Leased sites listed in Section II (D)(10) based on ranking of their technical score.
- ii. If there are no technically viable proposals proposing for City-Leased sites ACS may then recommend an award for available City-Leased sites to Proposers who have not indicated a specific site within the City of New York as part of their proposal. To be considered for these sites, Proposers must indicate on the proposal cover form (Attachment A) their willingness to move their program to a City-Leased Site.
- iii. If there still remains an insufficient number of Proposers, ACS may consider, at its own discretion, to offer an award for available City-Leased sites to Proposers proposing LSP sites located up to twenty-five (25) miles outside of New York City. To be considered for these sites, Proposers must indicate on the proposal cover form (Attachment A) their willingness to move their program to a City-Leased Site.
- iv. In the event that there are still insufficient proposers proposing for one of the City-Leased sites, ACS may consider, at its own discretion to recommend an award for available City-Leased sites to technically viable Proposers proposing other LSP sites located within in New York City. To be considered for these sites, Proposers must indicate on the proposal cover form (Attachment A) their willingness to move their program to a City-Leased Site.

b. Service Option 1 –General LSP – Non City-Leased Sites

- i. Site Specific Award Based on Accessibility by Individuals with Disabilities:
 - (a) After the City-Leased sites are awarded, ACS will recommend a site specific award to the proposer with the highest scoring technically viable proposal with a site identified as readily accessible to and useable by individuals with disabilities, and located within New York City.
 - (b) In the event that there are no technically viable proposals which contain an identified site in New York City that is readily accessible to and useable by individuals with disabilities, ACS will recommend a site specific award to the proposer with the highest scoring technically viable proposal identifying a site located in New York City which will be readily accessible to and useable by individuals with disabilities after renovations within the maximum Facility Start-Up Add-On Rate and be ready to accept youth by October 1, 2013.
 - (c) In the event there are no technically viable sites identified which are readily accessible to and useable by individuals with disabilities then ACS will consider making a recommendation for award to the highest scoring proposer who has not yet identified a site, but plans on identifying a site located in New York City that is readily accessible to and useable by individuals with disabilities (or will be after renovations within the maximum Facility Start-Up Add-On Rate) site within New York City within forty-five (45) days from the recommendation for award.
- ii. Remaining General LSP Awards
 - (a) ACS will then make award recommendations for the remaining General LSP beds to general LSP proposers, based on their technical score, first to proposers proposing acceptable LSP Program sites located within New York City.

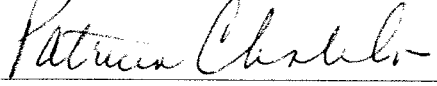
- (b) In the event that there are no technically viable proposals which contain an identified site in New York City, ACS will consider making a recommendation for award to the highest scoring proposer who has not yet identified a site, but plans on identifying a site located in New York City. This shall include proposals that proposed a City-Leased site, but were not awarded a City-Leased site and that identified on their Proposal Cover Form (Attachment A) their willingness to find a site after award recommendations if not selected for a City-Leased site.
- (c) In the event that there still remain an insufficient number of technically viable proposals for General LSP programs, ACS may consider, in its sole discretion, offering awards to those proposing acceptable sites up to twenty-five (25) miles of New York City. Proposers proposing LSP Program sites outside of New York City must submit a plan to move to a site within the five (5) boroughs of New York City within two (2) years of the effective date of the OCFS approved Close to Home LSP Plan for New York City.

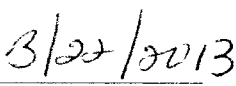
c. Specialized Service Options 2, 3, 4, 5

- i. For each of the Specialized Service Options 2, 3, 4 and 5, ACS will make award recommendations based on technical score within each service option, first to proposers proposing acceptable LSP Program sites within New York City.
 - ii. In the event that there are no technically viable proposals within a service option which contain an identified sites in New York City, ACS will consider making a recommendation for award to the highest technical scoring proposer in the service option who has not yet identified a site, but plans on identifying a site located in New York City.
 - iii. In the event that there still remain an insufficient number of technically viable proposals within a service option, ACS may consider, in its sole discretion, offering awards to those proposing acceptable sites up to twenty-five (25) miles outside of New York City. Proposers proposing LSP Program sites outside of New York City must submit a plan to move to a site within the five (5) boroughs of New York City within two (2) years of the effective date of the OCFS approved Close to Home LSP Plan for New York City.
4. In the event of a tied score between two Proposals within a service option, the Proposal proposing the lower cost will be given preference. Proposers must indicate their proposed Total slots and Total Proposed Annual Budget (excluding Start-Up) on the Proposal Cover Form (Attachment A).

SECTION VI - GENERAL INFORMATION TO PROPOSERS

- A. Complaints.** The New York City Comptroller is charged with the audit of contracts in New York City. Any proposer who believes that there has been unfairness, favoritism or impropriety in the proposal process should inform the Comptroller, Office of Contract Administration, 1 Centre Street, Room 835, New York, NY 10007; the telephone number is (212) 669-3000. In addition, the New York City Department of Investigation should be informed of such complaints at its Investigations Division, 80 Maiden Lane, New York, NY 10038; the telephone number is (212) 825-5959.
- B. Applicable Laws.** This Request for Proposals and the resulting contract award(s), if any, unless otherwise stated, are subject to all applicable provisions of New York State Law, the New York City Administrative Code, New York City Charter and New York City Procurement Policy Board (PPB) Rules. A copy of the PPB Rules may be obtained by contacting the PPB at (212) 788-7820.
- C. General Contract Provisions.** Contracts shall be subject to New York City's general contract provisions, in substantially the form that they appear in "Appendix A—General Provisions Governing Contracts for Consultants, Professional and Technical Services" or, if the Agency utilizes other than the formal Appendix A, in substantially the form that they appear in the Agency's general contract provisions. A copy of the applicable document is available through the Authorized Agency Contact Person.
- D. Contract Award.** Contract award is subject to each of the following applicable conditions and any others that may apply: New York City Fair Share Criteria; New York City MacBride Principles Law; submission by the proposer of the requisite New York City Department of Business Services/Division of Labor Services Employment Report and certification by that office; submission by the proposer of the requisite VENDEX Questionnaires/Affidavits of No Change and review of the information contained therein by the New York City Department of Investigation; all other required oversight approvals; applicable provisions of federal, state and local laws and executive orders requiring affirmative action and equal employment opportunity; and Section 6-108.1 of the New York City Administrative Code relating to the Local Based Enterprises program and its implementation rules.
- E. Proposer Appeal Rights.** Pursuant to New York City's Procurement Policy Board Rules, proposers have the right to appeal Agency non-responsiveness determinations and Agency non-responsibility determinations and to protest an Agency's determination regarding the solicitation or award of a contract.
- F. Multi-Year Contracts.** Multi-year contracts are subject to modification or cancellation if adequate funds are not appropriated to the Agency to support continuation of performance in any City fiscal year succeeding the first fiscal year and/or if the contractor's performance is not satisfactory. The Agency will notify the contractor as soon as is practicable that the funds are, or are not, available for the continuation of the multi-year contract for each succeeding City fiscal year. In the event of cancellation, the contractor will be reimbursed for those costs, if any, which are so provided for in the contract.
- G. Prompt Payment Policy.** Pursuant to the New York City's Procurement Policy Board Rules, it is the policy of the City to process contract payments efficiently and expeditiously.
- H. Prices Irrevocable.** Prices proposed by the proposer shall be irrevocable until contract award, unless the proposal is withdrawn. Proposals may only be withdrawn by submitting a written request to the Agency prior to contract award but after the expiration of 90 days after the opening of proposals. This shall not limit the discretion of the Agency to request proposers to revise proposed prices through the submission of best and final offers and/or the conduct of negotiations.
- I. Confidential, Proprietary Information or Trade Secrets.** Proposers should give specific attention to the identification of those portions of their proposals that they deem to be confidential, proprietary information or trade secrets and provide any justification of why such materials, upon request, should not be disclosed by the City. Such information must be easily separable from the non-confidential sections of the proposal. All information not so identified may be disclosed by the City.
- J. RFP Postponement/Cancellation.** The Agency reserves the right to postpone or cancel this RFP, in whole or in part, and to reject all proposals.
- K. Proposer Costs.** Proposers will not be reimbursed for any costs incurred to prepare proposals.
- L. Vendex Fees.** Pursuant to PPB Rule 2-08(f)(2), the contractor will be charged a fee for the administration of the Vendex system, including the Vendor Name Check Process, if a Vendor Name Check review is required to be conducted by the Department of Investigation. The contractor shall also be required to pay the applicable fees for any of its subcontractors for which Vendor Name Check reviews are required. The fee(s) will be deducted from payments made to the contractor under the contract. For contracts with an estimated value of less than or equal to \$1,000,000, the fee will be \$175. For contracts with an estimated value of greater than \$1,000,000, the fee will be \$350. The estimated value for each contract resulting from this RFP is estimated to be (less than or equal to \$1million) (above \$1million).


(Commissioner) (Agency Chief Contracting Officer)


Date

Message from the New York City Vendor Enrollment Center
Get on mailing lists for New York City contract opportunities!
Submit a NYC-FMS Vendor Application - Call 212/857-1680

ATTACHMENT A

PROPOSAL COVER FORM

ATTACHMENT A – PROPOSAL COVER FORM

Limited Secure Placement Services Negotiated Acquisition

PIN:06813N0004

A. Proposer Information

Proposer Name: _____

Address: _____

Tax Identification #: _____

Is the response printed on both sides, on recycled paper containing the minimum percentage of recovered fiber content as requested by the City in the instructions to this solicitation? ☐ Yes ☐ No

Proposer's Contact Person: (Please list the official contact person ACS should contact with any questions regarding the proposal)

Name: _____

Title: _____

Telephone #: _____ **E-mail:** _____

Proposer's Authorized Representative: (Please list the official authorized to enter into a contract with ACS)

Name: _____

Title: _____

Telephone #: _____ **E-mail:** _____

Signature: _____ **Date:** _____

B. Service Option Proposed: (check only one (1), each Service Option must be submitted as a separate proposal)

☐ Service Option 1 - General LSP (General LSP)

☐ Service Option 2 - Specialized LSP: Youth with Intellectual/Developmental Disabilities (IDD) and Youth with Serious Emotional Disturbance (SED)

☐ Service Option 3 - Specialized LSP: Youth who Have Demonstrated Problematic Sexual Behaviors (PSB)

☐ Service Option 4 - Specialized LSP: Youth with Intellectual/Developmental Disabilities (IDD) and Youth with Serious Emotional Disturbance (SED) and Youth Who Have Demonstrated Fire Setting Behaviors

☐ Service Option 5 - Specialized LSP: Intensive Short Term Support (IS)

Total Proposed Slots _____ **Proposed Total Annual Budget (excluding Start-Up)** _____

ATTACHMENT A – PROPOSAL COVER FORM

C. Site Information: (List all sites being proposed for this service option indicating site name and address as indicated below, if more space is needed make additional copies of this page.)

Site Name: _____

Address: _____

- ☐ **Proposed Site is currently a site accessible to individuals with disabilities**
☐ **Proposed Site will be made a site accessible to individuals with disabilities**

Total # of Slots _____ **Group Size** _____ **Number of Groups within Program Site** _____

Preferred Gender for Site: ☐ **Female** ☐ **Male** **Preferred Age Range** _____

Please check if interested:

- ☐ If proposed City-Leased site is not available, would be willing to provide services at another City-Leased Site
☐ If proposing a City-Leased site, but are not recommended for an award in a City-Leased site, willing to find a non-City-Leased LSP Program site after award recommendation

Site Name: _____

Address: _____

- ☐ **Proposed Site is currently a site accessible to individuals with disabilities**
☐ **Proposed Site will be made a site accessible to individuals with disabilities**

Total # of Slots _____ **Group Size** _____ **Number of Groups within Program Site** _____

Preferred Gender for Site: ☐ **Female** ☐ **Male** **Preferred Age Range** _____

Please check if interested:

- ☐ If proposed City-Leased site is not available, would be willing to provide services at another City-Leased Site
☐ If proposing a City-Leased site, but are not recommended for an award in a City-Leased site, willing to find a non-City-Leased LSP Program site after award recommendation

Site Name: _____

Address: _____

- ☐ **Proposed Site is currently a site accessible to individuals with disabilities**
☐ **Proposed Site will be made a site accessible to individuals with disabilities**

Total # of Slots _____ **Group Size** _____ **Number of Groups within Program Site** _____

Preferred Gender for Site: ☐ **Female** ☐ **Male** **Preferred Age Range** _____

Please check if interested:

- ☐ If proposed City-Leased site is not available, would be willing to provide services at another City-Leased Site
☐ If proposing a City-Leased site, but are not recommended for an award in a City-Leased site, willing to find a non-City-Leased LSP Program site after award recommendation

ATTACHMENT B

ACKNOWLEDGEMENT OF ADDENDA

ATTACHMENT B – ACKNOWLEDGEMENT OF ADDENDA

Limited Secure Placement Services Negotiated Acquisition

PIN: 06813N0004

DIRECTIONS: COMPLETE PART I OR PART II, WHICHEVER IS APPLICABLE.

PART I: LISTED BELOW ARE THE DATES OF ISSUE FOR EACH ADDENDUM RECEIVED IN CONNECTION WITH THIS SOLICITATION:

ADDENDUM # 1, DATED _____, 2013

ADDENDUM # 2, DATED _____, 2013

ADDENDUM # 3, DATED _____, 2013

ADDENDUM # 4, DATED _____, 2013

ADDENDUM # 5, DATED _____, 2013

ADDENDUM # 6, DATED _____, 2013

ADDENDUM # 7, DATED _____, 2013

ADDENDUM # 8, DATED _____, 2013

ADDENDUM # 9, DATED _____, 2013

ADDENDUM #10, DATED _____, 2013

PART II: _____ NO ADDENDUM WAS RECEIVED IN CONNECTION WITH THIS SOLICITATION.

NAME OF ORGANIZATION:_____

SIGNATURE:_____ **TITLE:**_____

DATE:____/____/____

ATTACHMENT C

BUDGET TEMPLATE INSTRUCTIONS

ATTACHMENT C – LSP BUDGET TEMPLATE INSTRUCTIONS

Start Up: Contractors are permitted to utilize up to two (2) months of their budget (based on youth and rates) to cover non-facility related start-up activities such as hiring and training staff. These start-up activities must take place and be completed prior to the agreed upon program start date. All expenditures are subject to ACS approval. You cannot exceed the 12 month awarded budget value. **PLEASE USE THE BASE RATE, MENTAL HEALTH, TEACHERS, TRAINING COACHING, and/ or AFTERCARE BUDGET TEMPLATES FOR THIS PORTION OF YOUR START UP EXPENSES.**

In addition, Contractors operating LSP Programs in an other-than City-Leased Site may receive up to the maximum Start-Up Add-On Rate – **PLEASE USE THE SEPARATE START UP BUDGET TEMPLATE FOR THIS PORTION OF YOUR START UP EXPENSES.**

- i. The maximum Facility Start-Up Add-On Rate is Ninety Dollars (\$90.00) per youth per day.
- ii. The Start-Up Add-On Rate is for year one only and is subject to approval by ACS.

All facility related start-work/renovations for the City-Leased Sites will be completed by ACS.

Fringe Benefits: Fringe rates should not exceed 26%. If the rate exceeds 26%, please provide supporting documentation as to the increase. NYC Children's Services expects agencies to make the required payments for: employee pension contributions, unemployment insurance, disability insurance, worker's compensation, health insurance, and payroll tax.

Consultants: Other staff who are not Full Time Equivalent (FTE).

Administrative Overhead: The costs necessary for operations but not directly associated with the services to the client. Examples of this are: allocable salaries/wages/fringe benefits of any administrative support staff employed by the program, but not specifically identified in the program and/or the cost of routine maintenance and support not identified in the budget. Administrative overhead can not exceed 10% of an agency's PS and OTPS subtotal.

Other Than Personnel Services (OTPS): These are expenses that are necessary for the direct operation of the program; this does not include overhead expenses. Please include breakdown of these expenditures, such as liability insurance, equipment, etc, on the appropriate back-up forms.

The following is a list of non allowable OTPS items:

- Any services not necessarily and actually incurred in the performance of the program.
- Purchase of real property.
- Cost of meals, except in travel status.
- Payment to any profit-making firm, company, association, corporation or organization in which a member of the Contractor's Board of Directors or a member of his immediate family has any ownership or control or financial interest. For the purposes of this paragraph "ownership" means ownership of more than 3% of the assets, stocks, bonds or other dividend or interest-bearing securities and "control" means as a member of the Board of Directors or other governing body, or as an officer.
- Payment to a member of the Board of Directors or other governing body of the Contractor of any

ATTACHMENT C – LSP BUDGET TEMPLATE INSTRUCTIONS

fee, remuneration, salary or stipend for employment or services payable from funds received under this Agreement, except direct and ordinary expenses incurred in attending meetings of the Board of Directors or other governing Boards and a nominal stipend may be paid in accordance with regulations established by NYC Children's Services.

- Any travel expenses not related to this program.
- Costs incurred in fundraising.
- Capital item purchases, where the purchase of such items would be less economical or cost beneficial than leasing or rental of such equipment. All equipment purchased with NYC Children's Services funds is the property of the City of New York.
- Debts, including legal costs.
- Donations to others.
- Interest costs.
- Depreciation/ Amortization.
- Any expense which violates any provision of the proposal.

Cost Allocation

Agencies must allocate their costs to the appropriate NYC Children's Services and non-NYC Children's Services programs using a fair and accurate allocation methodology. The allocation methodology must be based on expense type, i.e.: square footage for space costs, full time equivalent (FTE) or working hours for personnel costs, etc. The method must be developed in accordance with generally acceptable accounting principles and applicable laws, regulations and policies.

ATTACHMENT D

YEAR ONE BUDGET TEMPLATES

- D1 – Year One Startup
- D2 – Year One w/start-up Base Rate
- D3 – Year One w/start-up Mental Health Add-on
- D4 – Year One w/start-up Teacher Add-On
- D5 – Year One w/start-up Training & Coaching Add-on
- D6 – Year One w/start-up Supplemental Rental Add-on
- D7 – Year One w/start-up Control Room Add-on
- D8 – Year One w/start-up Aftercare

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget - Start Up
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Start Up cost per slot:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES
SALARY		
FRINGE BENEFITS		#DIV/0!
PS SUBTOTAL	\$ -	
CONSULTANT		
FACILITY		
OTHER OTPS		
OTPS SUBTOTAL	\$ -	
PS & OTPS SUBTOTAL	\$ -	
OVERHEAD		#DIV/0!
GRAND TOTAL	\$ -	

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

Indicate "D" for Direct Staff and "I" for Indirect Staff	TITLE	NUMBER OF INDIVIDUALS IN TITLE	FULL TIME EQUIVALENT POSITION	ANNUAL SALARY	ACS PROGRAM BUDGET AMOUNT
	TOTAL - SALARY BY TITLE			\$0	\$0

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

[illegible]

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL
NAME			
TOTAL - CONSULTANTS			

Attachment D1 - LSP year one Budget Template start up CONSULTANTS

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Start Up
FACILITY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL: YES NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Start Up
OTPS

AGENCY: _____
PROGRAM NAME: _____
FACILITY NAME: _____
MAILING ADDRESS: _____

CATEGORY	ACS PROGRAM BUDGET AMOUNT
AUDIT FEES	
OTHER INSURANCE	
EQUIPMENT	
SERVICES TO YOUTH: (Itemize)	
OTHER OTPS:	
TOTAL	

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Start Up
START UP

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget with Start Up - Base Rate
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Base Program Rate		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES	START UP	Annual Budget with out Start Up
SALARY				
FRINGE BENEFITS		#DIV/0!		
PS SUBTOTAL	\$ -			
CONSULTANT				
FACILITY				
OTHER OTPS				
OTPS SUBTOTAL	\$ -			
PS & OTPS SUBTOTAL	\$ -			
OVERHEAD		#DIV/0!		
GRAND TOTAL	\$ -			

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

[illegible]

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

[illegible]

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Base Rate
CONSULTANTS**

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME				

TOTAL - CONSULTANTS				

Names of Consultants are required.

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Base Rate
FACILITY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL: YES NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Base Rate
OTPS

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
AUDIT FEES		
OTHER INSURANCE		
EQUIPMENT		
SERVICES TO YOUTH: (Itemize)		
OTHER OTPS:		
TOTAL		

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Base Rate
OVERHEAD

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT	START UP BUDGET VALUE
TOTAL		

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Base Rate
START UP

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget with Start Up - Mental Health
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Mental Health Rate: (with OT if necessary)		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES	START UP	Annual Budget with out Start Up
SALARY				
FRINGE BENEFITS		#DIV/0!		
PS SUBTOTAL	\$ -			
CONSULTANT				
FACILITY				
OTHER OTPS				
OTPS SUBTOTAL	\$ -			
PS & OTPS SUBTOTAL	\$ -			
OVERHEAD		#DIV/0!		
GRAND TOTAL	\$ -			

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

[illegible]

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

[illegible]

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget -Mental Health
CONSULTANTS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME				

TOTAL - CONSULTANTS				

Names of Consultants are required.

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Mental Health
FACILITY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL:	YES	NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Mental Health
OTPS

AGENCY:**PROGRAM NAME:****FACILITY NAME:****MAILING ADDRESS:**

CATEGORY	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
AUDIT FEES		
OTHER INSURANCE		
EQUIPMENT		
SERVICES TO YOUTH: (Itemize)		
OTHER OTPS:		
TOTAL		

MAILING ADDRESS:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Mental Health
START UP

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget with Start Up - Teachers
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Teachers Ratio rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES	START UP	Annual Budget with out Start Up
SALARY				
FRINGE BENEFITS		#DIV/0!		
PS SUBTOTAL	\$ -			
CONSULTANT				
OTHER OTPS				
OTPS SUBTOTAL	\$ -			
PS & OTPS SUBTOTAL	\$ -			
OVERHEAD		#DIV/0!		
GRAND TOTAL	\$ -			

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

[illegible]

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
TOTAL - FRINGE BENEFITS	0.00%		\$0.00	\$0.00

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget -Teachers
CONSULTANTS

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

TOTAL - CONSULTANTS				

Names of Consultants are required.

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Teachers
OTPS

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
AUDIT FEES		
OTHER INSURANCE		
EQUIPMENT		
SERVICES TO YOUTH: (Itemize)		
OTHER OTPS:		
TOTAL		

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Teachers
OVERHEAD

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT	START UP BUDGET VALUE
TOTAL		

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Teachers
START UP

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget with Start Up - Training/ Coaching
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Training/ Coaching rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES	START UP	Annual Budget with out Start Up
SALARY				
FRINGE BENEFITS		#DIV/0!		
PS SUBTOTAL	\$ -			
CONSULTANT				
FACILITY				
OTHER OTPS				
OTPS SUBTOTAL	\$ -			
PS & OTPS SUBTOTAL	\$ -			
OVERHEAD		#DIV/0!		
GRAND TOTAL	\$ -			

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

[illegible]

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
TOTAL - FRINGE BENEFITS	0.00%		\$0.00	\$0.00

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Training/ Coaching
CONSULTANTS

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME				

TOTAL - CONSULTANTS				

Names of Consultants are required.

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Training/ Coaching
FACILITY

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL:	YES	NO

FLOOR AND ROOM NUMBER:	
COST PER SQ. FT.:	
LANDLORD'S NAME:	
LANDLORD'S ADDRESS:	

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Training/ Coaching
OTPS

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
AUDIT FEES		
OTHER INSURANCE		
EQUIPMENT		
SERVICES TO YOUTH: (Itemize)		
OTHER OTPS:		
TOTAL		

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget -Training/ Coaching
OVERHEAD**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT	START UP BUDGET VALUE
TOTAL		

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Training/ Coaching
START UP

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget with Start Up - Supplemental Rental add on
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Facility Maintenance Rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES	START UP	Annual Budget with out Start Up
FACILITY				
GRAND TOTAL	\$ -			

Description/ Comments: (please attach additional sheets if necessary)

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Supplemental Rental add on
FACILITY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL: YES NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Supplemental Rental add on
START UP

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget with Start Up - Control Room
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Control Room rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES	START UP	Annual Budget with out Start Up
SALARY				
FRINGE BENEFITS		#DIV/0!		
GRAND TOTAL	#REF!			

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

[illegible]

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
TOTAL - FRINGE BENEFITS	0.00%		\$0.00	\$0.00

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Training/ Coaching
START UP

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 YEAR ONE LSP Program Budget - Aftercare
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:				
AGENCY ADDRESS:				
PROGRAM NAME:				
PROGRAM TYPE:				
BUDGET PERIOD:				
Aftercare (cost per slot):		Census:	Value:	

CATEGORY	ACS ANNUAL PROGRAM BUDGET AMOUNT	PERCENTAGES	START UP	Annual Budget with out Start Up
SALARY				
FRINGE BENEFITS		#DIV/0!		
PS SUBTOTAL	\$ -			
CONSULTANT				
FACILITY				
OTHER OTPS				
OTPS SUBTOTAL	\$ -			
PS & OTPS SUBTOTAL	\$ -			
OVERHEAD		#DIV/0!		
GRAND TOTAL	\$ -			

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

Indicate "D" for Direct Staff and "I" for Indirect Staff	TITLE	NUMBER OF INDIVIDUALS IN TITLE	FULL TIME EQUIVALENT POSITION	ANNUAL SALARY	ACS PROGRAM BUDGET AMOUNT
	TOTAL - SALARY BY TITLE			\$0	\$0

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
TOTAL - FRINGE BENEFITS	0.00%		\$0.00	\$0.00

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Aftercare
CONSULTANTS

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME			

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL	Start Up Budget Value
NAME				

TOTAL - CONSULTANTS				

Names of Consultants are required.

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Aftercare
FACILITY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL:	YES	NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Aftercare
OTPS

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT	Start Up Budget Value
AUDIT FEES		
OTHER INSURANCE		
EQUIPMENT		
SERVICES TO YOUTH: (Itemize)		
OTHER OTPS:		
TOTAL		

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
YEAR ONE LSP Program Budget - Aftercare
START UP**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

Please explain your Start Up Budget Plan:

ATTACHMENT E

ON-GOING BUDGET TEMPLATES

- E1 – On Going Base Rate
- E2 – On Going Mental Health Add-on
- E3 – On Going Teacher Add-on
- E4 – On Going Training & Coaching Add-on
- E5 – On Going Supplemental Rental Add-on
- E6 – On Going Control Room Add-on
- E7 – On Going Aftercare

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 ON GOING LSP Program Budget - Base Rate
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Base Program Rate		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

	ACS PROGRAM BUDGET AMOUNT	PERCENTAGES
CATEGORY		
SALARY		
FRINGE BENEFITS		#DIV/0!
PS SUBTOTAL	\$ -	
CONSULTANT		
FACILITY		
OTHER OTPS		
OTPS SUBTOTAL	\$ -	
PS & OTPS SUBTOTAL	\$ -	
OVERHEAD		#DIV/0!
GRAND TOTAL	\$ -	

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT
TOTAL - FRINGE BENEFITS	0.00%		\$0.00

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget - Base Rate
CONSULTANTS**

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL
NAME			

TOTAL - CONSULTANTS			\$0.00

Names of Consultants are required.

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget - Base Rate
FACILITY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL: YES NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget- Base Rate
OTPS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT
AUDIT FEES	
OTHER INSURANCE	
EQUIPMENT	
SERVICES TO YOUTH: (Itemize)	
OTHER OTPS:	
TOTAL	

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget- Base Rate
OVERHEAD**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 ON GOING LSP Program Budget -Mental Health
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Mental Health Rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

	ACS PROGRAM BUDGET AMOUNT	PERCENTAGES
CATEGORY		
SALARY		
FRINGE BENEFITS		#DIV/0!
PS SUBTOTAL	\$ -	
CONSULTANT		
FACILITY		
OTHER OTPS		
OTPS SUBTOTAL	\$ -	
PS & OTPS SUBTOTAL	\$ -	
OVERHEAD		#DIV/0!
GRAND TOTAL	\$ -	

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT
TOTAL - FRINGE BENEFITS	0.00%		\$0.00

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget - Mental Health
CONSULTANTS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL
NAME			

TOTAL - CONSULTANTS			\$0.00

Names of Consultants are required.

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget -Mental Health
FACILITY**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL:	YES	NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget- Mental Health
OTPS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT
AUDIT FEES	
OTHER INSURANCE	
EQUIPMENT	
SERVICES TO YOUTH: (Itemize)	
OTHER OTPS:	
TOTAL	

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 ON GOING LSP Program Budget -Teachers
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Teachers Ratio rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

	ACS PROGRAM BUDGET AMOUNT	PERCENTAGES
CATEGORY		
SALARY		
FRINGE BENEFITS		#DIV/0!
PS SUBTOTAL	\$ -	
CONSULTANT		
OTHER OTPS		
OTPS SUBTOTAL	\$ -	
PS & OTPS SUBTOTAL	\$ -	
OVERHEAD		#DIV/0!
GRAND TOTAL	\$ -	

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

Attachment E3 - LSP On Going Budget Template teachers TITLE Page 2 of 6

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

Page 3 of 6

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget -Teachers
CONSULTANTS

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

TOTAL - CONSULTANTS			#REF!

Names of Consultants are required.

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget-Teachers
OTPS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT
AUDIT FEES	
OTHER INSURANCE	
EQUIPMENT	
SERVICES TO YOUTH: (Itemize)	
OTHER OTPS:	
TOTAL	

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 ON GOING LSP Program Budget -Training/ Coaching
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Training/ Coaching rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

	ACS PROGRAM BUDGET AMOUNT	PERCENTAGES
CATEGORY		
SALARY		
FRINGE BENEFITS		#DIV/0!
PS SUBTOTAL	\$ -	
CONSULTANT		
FACILITY		
OTHER OTPS		
OTPS SUBTOTAL	\$ -	
PS & OTPS SUBTOTAL	\$ -	
OVERHEAD		#DIV/0!
GRAND TOTAL	\$ -	

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT
TOTAL - FRINGE BENEFITS	0.00%		\$0.00

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget -Training/ Coaching
CONSULTANTS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL
NAME			

TOTAL - CONSULTANTS			\$0.00

Names of Consultants are required.

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget -Training/ Coaching
FACILITY**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL: YES NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget-Training/ Coaching
OTPS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT
AUDIT FEES	
OTHER INSURANCE	
EQUIPMENT	
SERVICES TO YOUTH: (Itemize)	
OTHER OTPS:	
TOTAL	

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 ON GOING LSP Program Budget - Supplemental Rental add on
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Facility Maintenance Rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

	ACS PROGRAM BUDGET AMOUNT	PERCENTAGES
CATEGORY		
FACILITY		
GRAND TOTAL	\$ -	

Description/ Comments: (please attach additional sheets if necessary)

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget - Supplemental Rental add on
FACILITY

AGENCY:

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL: ☐ YES ☐ NO

FLOOR AND ROOM NUMBER:	
COST PER SQ. FT.:	
LANDLORD'S NAME:	
LANDLORD'S ADDRESS:	

[illegible]

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 ON GOING LSP Program Budget -Control Room
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Control Room rate:		Census:	Value:
Total ACS Revenue:		Total Revenue (Including Other Funding):	

	ACS PROGRAM BUDGET AMOUNT	PERCENTAGES
CATEGORY		
SALARY		
FRINGE BENEFITS		#DIV/0!
GRAND TOTAL	#REF!	

Description/ Comments: (please attach additional sheets if necessary)

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget -Control Room
SALARY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TITLE	NUMBER OF INDIVIDUALS IN TITLE	FULL TIME EQUIVALEN T POSITION	ANNUAL SALARY	ACS PROGRAM BUDGET AMOUNT
TOTAL - SALARY BY TITLE			\$0	\$0

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

DESCRIPTION	RATE	TOTAL SALARIES	ACS PROGRAM BUDGET AMOUNT
TOTAL - FRINGE BENEFITS	0.00%		\$0.00

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
 ON GOING LSP Program Budget -Aftercare
 BUDGET SUMMARY PAGE
ONE FACILITY PER BUDGET

AGENCY NAME:			
AGENCY ADDRESS:			
PROGRAM NAME:			
PROGRAM TYPE:			
BUDGET PERIOD:			
Aftercare (cost per slot):		Census:	Value:

	ACS PROGRAM BUDGET AMOUNT	PERCENTAGES
CATEGORY		
SALARY		
FRINGE BENEFITS		#DIV/0!
PS SUBTOTAL	\$ -	
CONSULTANT		
FACILITY		
OTHER OTPS		
OTPS SUBTOTAL	\$ -	
PS & OTPS SUBTOTAL	\$ -	
OVERHEAD		#DIV/0!
GRAND TOTAL	\$ -	

Description/ Comments: (please attach additional sheets if necessary)

AGENCY:	
PROGRAM NAME:	
FACILITY NAME:	
MAILING ADDRESS:	

		# of Staff	Total Annual Salaries	Total ACS Program Budgeted	Percentage of ACS Program Budgeted
Total Direct Salaries					#DIV/0!
Total Indirect Salaries					#DIV/0!
Grand Total		0	\$0.00	\$0.00	#DIV/0!

AGENCY:
PROGRAM NAME:
FACILITY NAME:
MAILING ADDRESS:

[illegible]

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget -Aftercare
CONSULTANTS**

AGENCY: _____

PROGRAM NAME: _____

FACILITY NAME: _____

MAILING ADDRESS: _____

PSYCHIATRISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

PSYCHOLOGISTS

PROGRAM	AMOUNT PER HOUR	TOTAL
NAME		

OTHER (SPECIFY)

PROGRAM	TOTAL NUMBER OF PERSONS	AMOUNT PER HOUR	TOTAL
NAME			

TOTAL - CONSULTANTS			\$0.00

Names of Consultants are required.

NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget -Aftercare
FACILITY

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

TERM OF LEASE:

LEASE RENEWAL: YES NO

FLOOR AND ROOM NUMBER:
COST PER SQ. FT.:
LANDLORD'S NAME:
LANDLORD'S ADDRESS:

[illegible]

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget-Aftercare
OTPS**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

CATEGORY	ACS PROGRAM BUDGET AMOUNT
AUDIT FEES	
OTHER INSURANCE	
EQUIPMENT	
SERVICES TO YOUTH: (Itemize)	
OTHER OTPS:	
TOTAL	

**NYC ADMINISTRATION FOR CHILDREN'S SERVICES
ON GOING LSP Program Budget-Aftercare
OVERHEAD**

AGENCY:

PROGRAM NAME:

FACILITY NAME:

MAILING ADDRESS:

[illegible]

ATTACHMENT F

DOING BUSINESS DATA FORM & INSTRUCTIONS

DOING BUSINESS ACCOUNTABILITY PROJECT

QUESTIONS AND ANSWERS ABOUT THE DOING BUSINESS DATA FORM**What is the purpose of this *Data Form*?**

To collect accurate, up-to-date identification information about organizations that have business dealings with the City of New York in order to comply with Local Law 34 of 2007 (LL 34), a campaign finance reform law. LL 34 limits municipal campaign contributions from principal officers, owners and senior managers of entities doing business with the City and mandates the creation of a *Doing Business Database* to allow the City to enforce the law. The information requested in this *Data Form* must be provided, regardless of whether the organization or the people associated with it make or intend to make campaign contributions. No sensitive personal information collected will be disclosed to the public.

Why have I received this *Data Form*?

The contract, franchise, concession, grant or economic development agreement you are proposing on, applying for or have already been awarded is considered a business dealing with the City under LL 34. No proposal or application will be considered and no award will be made unless this *Data Form* is completed. Most transactions valued at more than \$5,000 are considered business dealings and require completion of the *Data Form*. Exceptions include transactions awarded on an emergency basis or by "conventional" competitive sealed bid (i.e. bids that do not use a prequalified list or "Best Value" selection criteria.) Other types of transactions that are considered business dealings include real property and land use actions with the City.

What individuals will be included in the *Doing Business Database*?

The principal officers, owners and certain senior managers of organizations listed in the *Doing Business Database* are themselves considered to be doing business with the City and will also be included in the *Database*.

- **Principal Officers** are the Chief Executive Officer (CEO), Chief Financial Officer (CFO) and Chief Operating Officer (COO), or their functional equivalents. See the *Data Form* for examples of titles that apply.
- **Principal Owners** are individuals who own or control 10% or more of the organization. This includes stockholders, partners and anyone else with an ownership or controlling interest in the entity.
- **Senior Managers** include anyone who, either by job title or actual duties, has substantial discretion and high-level oversight regarding the solicitation, letting or administration of any contract, concession, franchise, grant or economic development agreement with the City. At least one Senior Manager must be listed or the *Data Form* will be considered incomplete.

I have already completed a *Doing Business Data Form*; do I have to submit another one?

Yes. An organization is required to submit a *Doing Business Data Form* each time it enters into a transaction considered a business dealing with the City, including contract, concession and franchise proposals. However, the *Data Form* has both a Change option, which requires only information that has changed since the last *Data Form* was filed, and a No Change option. No organization should have to fill out the entire *Data Form* more than once.

If you have already submitted a *Data Form* for one transaction type (such as a contract), and this is the first time you are completing a *Data Form* for a different transaction type (such as a grant), please select the Change option and complete Section 4 (Senior Managers) for the new transaction type.

Will the personal information on this *Data Form* be available to the public?

No. The names and titles of the officers, owners and senior managers reported on the *Data Form* will be made available to the public, as will information about the organization itself. However, personal identifying information, such as home address, home phone and date of birth, will not be disclosed to the public, and home address and phone number information will not be used for communication purposes.



I provided some of this information on the VENDEX Questionnaire; do I have to provide it again?

Yes. Although the *Doing Business Data Form* and the VENDEX Questionnaire request some of the same information, they serve entirely different purposes. In addition, the *Data Form* requests information concerning senior managers, which is not part of the VENDEX Questionnaire.

What organizations will be included in the *Doing Business Database*?

Organizations that hold \$100,000 or more in grants, contracts for goods or services, franchises or concessions (\$500,000 for construction contracts), or that hold any economic development agreement or pension fund investment contract, are considered to be doing business with the City for the purposes of LL 34. Because all of the business that an organization does or proposes to do with the City will be added together, the *Data Form* must be completed for all transactions valued at more than \$5,000 even if the organization doesn't currently do enough business with the City to be listed in the *Database*.

No one in my organization plans to contribute to a candidate; do I have to fill out this *Data Form*?

Yes. All organizations are required to return this *Data Form* with complete and accurate information, regardless of the history or intention of the entity or its officers, owners or senior managers to make campaign contributions. The *Doing Business Database* must be complete so that the Campaign Finance Board can verify whether future contributions are in compliance with the law.

My organization is proposing on a contract with another firm as a Joint Venture that does not exist yet; how should the *Data Form* be completed?

A joint venture that does not yet exist must submit a *Data Form* for each of its component firms. If the joint venture receives the award, it must then complete a form in the name of the joint venture.

How long will an organization and its officers, owners and senior managers remain listed on the *Doing Business Database*?

- **Contract, Concession and Economic Development Agreement holders:** generally for the term of the transaction, plus one year.
 - **Franchise and Grant holders:** from the commencement or renewal of the transaction, plus one year.
 - **Pension investment contracts:** from the time of presentation on an investment opportunity or the submission of a proposal, whichever is earlier, until the end of the contract, plus one year.
 - **Line item and discretionary appropriations:** from the date of budget adoption until the end of the contract, plus one year.
 - **Contract proposers:** for one year from the proposal date or date of public advertisement of the solicitation, whichever is later.
 - **Franchise and Concession proposers:** for one year from the proposal submission date.
- For information on other transaction types, contact the Doing Business Accountability Project.

How does a person remove him/herself from the *Doing Business Database*?

When an organization stops doing business with the City, the people associated with it are removed from the *Database* automatically. However, any person who believes that s/he should not be listed may apply for removal. Reasons that a person would be removed include his/her no longer being the principal officer, owner or senior manager of the organization. Organizations may also update their database information by submitting an update form. Removal Request and Update forms are available online at www.nyc.gov/mocs (once there, click MOCS Programs) or by calling 212-788-8104.

What are the new campaign contribution limits for people doing business with the City?

Contributions to City Council candidates are limited to \$250 per election cycle; \$320 to Borough President candidates; and \$400 to candidates for citywide office. Please contact the NYC Campaign Finance Board for more information at www.nycffb.info, or 212-306-7100.

The *Data Form* is to be returned to the City office that issued it.

If you have any questions about the *Data Form* please contact the Doing Business Accountability Project at 212-788-8104 or DoingBusiness@cityhall.nyc.gov.



Doing Business Data Form

To be completed by the City agency prior to distribution			
Agency: _____		Transaction ID: _____	
Check One:	Transaction Type (check one):		
☐ Proposal	☐ Concession	☐ Contract	☐ Economic Development Agreement
☐ Award	☐ Franchise	☐ Grant	☐ Pension Investment Contract

Any entity receiving, applying for or proposing on an award or agreement must complete a Doing Business Data Form (see Q&A sheet for more information). Please either type responses directly into this fillable form or print answers by hand in black ink, and be sure to fill out the certification box on the last page. **Submission of a complete and accurate form is required for a proposal to be considered responsive or for any entity to receive an award or enter into an agreement.**

This Data Form requires information to be provided on principal officers, owners and senior managers. The name, employer and title of each person identified on the Data Form will be included in a public database of people who do business with the City of New York; no other information reported on this form will be disclosed to the public. **This Data Form is not related to the City's VENDEX requirements.**

Please return the completed Data Form to the City office that supplied it. Please contact the Doing Business Accountability Project at DoingBusiness@cityhall.nyc.gov or 212-788-8104 with any questions regarding this Data Form. Thank you for your cooperation.

Section 1: Entity Information

Entity Name: _____

Entity EIN/TIN: _____

Entity Filing Status (select one):

- ☐ Entity has never completed a Doing Business Data Form. *Fill out the entire form.*
- ☐ Change from previous Data Form dated _____. *Fill out only those sections that have changed, and indicate the name of the persons who no longer hold positions with the entity.*
- ☐ No Change from previous Data Form dated _____. *Skip to the bottom of the last page.*

Entity is a Non-Profit: ☐ Yes ☐ No

Entity Type: ☐ Corporation (any type) ☐ Joint Venture ☐ LLC ☐ Partnership (any type)
☐ Sole Proprietor ☐ Other (specify): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone : _____ Fax : _____

E-mail: _____

Provide your e-mail address and/or fax number in order to receive notices regarding this form by e-mail or fax.

Section 2: Principal Officers

Please fill in the required identification information for each officer listed below. If the entity has no such officer or its equivalent, please check "This position does not exist." If the entity is filing a Change Form and the person listed is replacing someone who was previously disclosed, please check "This person replaced..." and fill in the name of the person being replaced so his/her name can be removed from the *Doing Business Database*, and indicate the date that the change became effective.

Chief Executive Officer (CEO) or equivalent officer☐ This position does not exist

The highest ranking officer or manager, such as the President, Executive Director, Sole Proprietor or Chairperson of the Board.

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

☐ This person replaced former CEO: _____ on date: _____

Chief Financial Officer (CFO) or equivalent officer☐ This position does not exist

The highest ranking financial officer, such as the Treasurer, Comptroller, Financial Director or VP for Finance.

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

☐ This person replaced former CFO: _____ on date: _____

Chief Operating Officer (COO) or equivalent officer☐ This position does not exist

The highest ranking operational officer, such as the Chief Planning Officer, Director of Operations or VP for Operations.

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

☐ This person replaced former COO: _____ on date: _____

Section 3: Principal Owners

Please fill in the required identification information for all individuals who, through stock shares, partnership agreements or other means, **own or control 10% or more of the entity**. If no individual owners exist, please check the appropriate box to indicate why and skip to the next page. If the entity is owned by other companies, those companies do **not** need to be listed. If an owner was identified on the previous page, fill in his/her name and write "See above." If the entity is filing a Change Form, list any individuals who are no longer owners at the bottom of this page. If more space is needed, attach additional pages labeled "Additional Owners."

There are no owners listed because (select one):

- ☐ The entity is not-for-profit ☐ There are no individual owners ☐ No individual owner holds 10% or more shares in the entity
☐ Other (explain): _____

Principal Owners (who own or control 10% or more of the entity):

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

Remove the following previously-reported Principal Owners:

Name: _____ Removal Date: _____

Name: _____ Removal Date: _____

Name: _____ Removal Date: _____

Section 4: Senior Managers

Please fill in the required identification information for all senior managers who oversee any of the entity's relevant transactions with the City (e.g., contract managers if this form is for a contract award/proposal, grant managers if for a grant, etc.). Senior managers include anyone who, either by title or duties, has substantial discretion and high-level oversight regarding the solicitation, letting or administration of any transaction with the City. **At least one senior manager must be listed, or the Data Form will be considered incomplete.** If a senior manager has been identified on a previous page, fill in his/her name and write "See above." If the entity is filing a Change Form, list individuals who are no longer senior managers at the bottom of this section. If more space is needed, attach additional pages labeled "Additional Senior Managers."

Senior Managers:

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

First Name: _____ MI: _____ Last: _____

Office Title: _____

Employer (if not employed by entity): _____

Birth Date (mm/dd/yy): _____ Home Phone #: _____

Home Address: _____

Remove the following previously-reported Senior Managers:

Name: _____ Removal Date: _____

Name: _____ Removal Date: _____

Certification

I certify that the information submitted on these four pages and _____ additional pages is accurate and complete. I understand that willful or fraudulent submission of a materially false statement may result in the entity being found non-responsible and therefore denied future City awards.

Name: _____

Signature: _____ Date: _____

Entity Name: _____

Title: _____ Work Phone #: _____

Please return this form to the City agency that supplied it to you, not to the Doing Business Accountability Project.

For information or assistance, call the Doing Business Accountability Project at 212-788-8104.



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ATTACHMENT G
IRAN DIVESTMENT ACT

**IRAN DIVESTMENT ACT COMPLIANCE RIDER FOR
NEW YORK CITY CONTRACTORS**

The Iran Divestment Act of 2012, effective as of April 12, 2012, is codified at State Finance Law ("SFL") §165-a and General Municipal Law ("GML") §103-g. The Iran Divestment Act, with certain exceptions, prohibits municipalities, including the City, from entering into contracts with persons engaged in investment activities in the energy sector of Iran. Pursuant to the terms set forth in SFL §165-a and GML §103-g, a person engages in investment activities in the energy sector of Iran if:

(a) the person provides goods or services of twenty million dollars or more in the energy sector of Iran, including a person that provides oil or liquefied natural gas tankers, or products used to construct or maintain pipelines used to transport oil or liquefied natural gas, for the energy sector of Iran; or

(b) The person is a financial institution that extends twenty million dollars or more in credit to another person, for forty-five days or more, if that person will use the credit to provide goods or services in the energy sector in Iran and is identified on a list created pursuant to paragraph (b) of subdivision three of Section 165-a of the State Finance Law and maintained by the Commissioner of the Office of General Services.

A bid or proposal shall not be considered for award nor shall any award be made where the bidder or proposer fails to submit a signed and verified bidder's certification.

Each bidder or proposer must certify that it is not on the list of entities engaged in investment activities in Iran created pursuant to paragraph (b) of subdivision 3 of Section 165-a of the State Finance Law. In any case where the bidder or proposer cannot certify that they are not on such list, the bidder or proposer shall so state and shall furnish with the bid or proposal a signed statement which sets forth in detail the reasons why such statement cannot be made. The City of New York may award a bid to a bidder who cannot make the certification on a case by case basis if:

(1) The investment activities in Iran were made before the effective date of this section (i.e., April 12, 2012), the investment activities in Iran have not been expanded or renewed after the effective date of this section and the person has adopted, publicized and is implementing a formal plan to cease the investment activities in Iran and to refrain from engaging in any new investments in Iran: or

(2) The City makes a determination that the goods or services are necessary for the City to perform its functions and that, absent such an exemption, the City would be unable to obtain the goods or services for which the contract is offered. Such determination shall be made in writing and shall be a public document.

**BIDDER'S CERTIFICATION OF COMPLIANCE WITH
IRAN DIVESTMENT ACT**

Pursuant to General Municipal Law §103-g, which generally prohibits the City from entering into contracts with persons engaged in investment activities in the energy sector of Iran, the bidder/proposer submits the following certification:

[Please Check One]

BIDDER'S CERTIFICATION

- ☐ By submission of this bid or proposal, each bidder/proposer and each person signing on behalf of any bidder/proposer certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief, that each bidder/proposer is not on the list created pursuant to paragraph (b) of subdivision 3 of Section 165-a of the State Finance Law.
- ☐ I am unable to certify that my name and the name of the bidder/proposer does not appear on the list created pursuant to paragraph (b) of subdivision 3 of Section 165-a of the State Finance Law. I have attached a signed statement setting forth in detail why I cannot so certify.

Dated: _____, New York
_____, 20__

SIGNATURE

PRINTED NAME

TITLE

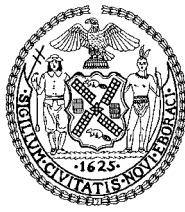
Sworn to before me this
____ da y of _____, 20__

Notary Public

Dated:

ATTACHMENT G

ATTACHMENT H
WHISTLEBLOWER PROTECTION EXPANSIOIN ACT



MICHAEL A. CARDOZO
Corporation Counsel

**THE CITY OF NEW YORK
LAW DEPARTMENT**

100 CHURCH STREET
NEW YORK, NY 10007

STEVEN STEIN CUSHMAN
Chief, Contracts and Real Estate
(212) 788-0730
(212) 788-0902
scushman@law.nyc.gov

MEMORANDUM

TO: AGENCY GENERAL COUNSELS
AGENCY CHIEF CONTRACTING OFFICERS

FROM: STEVEN STEIN CUSHMAN

DATE: SEPTEMBER 18, 2012

SUBJECT: LOCAL LAW NOS. 30-2012 AND 33-2012

Local Law No. 33-2012, the Whistleblower Protection Expansion Act (“WPEA”), prohibits a contractor or its subcontractor from taking an adverse personnel action against an employee or officer for whistleblower activity in connection with a City contract; requires that City contracts contain a provision to that effect; and provides that a contractor or subcontractor may be subject to penalties and injunctive relief if a court finds that it retaliated in violation of the WPEA. The WPEA is effective on September 18, 2012, and is codified at Section 12-113 of the Administrative Code. It applies to a contract or subcontract for goods or services if it meets the following criteria: (a) it is valued in excess of \$100,000; (b) it is solicited or renewed on or after September 18, 2012; and (c) it is not an emergency procurement or a government-to-government procurement.

Local Law No. 30-2012 requires a contractor to prominently post information explaining how its employees can report allegations of fraud, false claims, criminality, or corruption in connection with a City contract to City officials and the rights and remedies afforded to employees for whistleblowing activity. Local Law No. 30-2012 is codified at Section 6-132 of the Administrative Code and it is effective on October 18, 2012. It applies to a contract or subcontract for goods or services if it meets the following criteria: (a) it is valued in excess of \$100,000; (b) it is first solicited on or after October 18, 2012; and (c) it is not a government-to-government procurement.

Attached to this memo is a rider and a notice for use in all contracts for goods and services solicited or renewed on or after September 18, 2012 that are valued in excess of \$100,000 and are not government-to-government procurements.

Attachments

WHISTLEBLOWER PROTECTION EXPANSION ACT RIDER

1. In accordance with Local Law Nos. 30-2012 and 33-2012, codified at sections 6-132 and 12-113 of the New York City Administrative Code, respectively,

- (a) Contractor shall not take an adverse personnel action with respect to an officer or employee in retaliation for such officer or employee making a report of information concerning conduct which such officer or employee knows or reasonably believes to involve corruption, criminal activity, conflict of interest, gross mismanagement or abuse of authority by any officer or employee relating to this Contract to (i) the Commissioner of the Department of Investigation, (ii) a member of the New York City Council, the Public Advocate, or the Comptroller, or (iii) the City Chief Procurement Officer, ACCO, Agency head, or Commissioner.
- (b) If any of Contractor's officers or employees believes that he or she has been the subject of an adverse personnel action in violation of subparagraph (a) of paragraph 1 of this rider, he or she shall be entitled to bring a cause of action against Contractor to recover all relief necessary to make him or her whole. Such relief may include but is not limited to: (i) an injunction to restrain continued retaliation, (ii) reinstatement to the position such employee would have had but for the retaliation or to an equivalent position, (iii) reinstatement of full fringe benefits and seniority rights, (iv) payment of two times back pay, plus interest, and (v) compensation for any special damages sustained as a result of the retaliation, including litigation costs and reasonable attorney's fees.
- (c) Contractor shall post a notice provided by the City in a prominent and accessible place on any site where work pursuant to the Contract is performed that contains information about:
 - (i) how its employees can report to the New York City Department of Investigation allegations of fraud, false claims, criminality or corruption arising out of or in connection with the Contract; and
 - (ii) the rights and remedies afforded to its employees under New York City Administrative Code sections 7-805 (the New York City False Claims Act) and 12-113 (the Whistleblower Protection Expansion Act) for lawful acts taken in connection with the reporting of allegations of fraud, false claims, criminality or corruption in connection with the Contract.
- (d) For the purposes of this rider, "adverse personnel action" includes dismissal, demotion, suspension, disciplinary action, negative performance evaluation, any action resulting in loss of staff, office space, equipment or other benefit, failure to appoint, failure to promote, or any transfer or assignment or failure to transfer or assign against the wishes of the affected officer or employee.

- (e) This rider is applicable to all of Contractor's subcontractors having subcontracts with a value in excess of \$100,000; accordingly, Contractor shall include this rider in all subcontracts with a value a value in excess of \$100,000.

2. Paragraph 1 is not applicable to this Contract if it is valued at \$100,000 or less. Subparagraphs (a), (b), (d), and (e) of paragraph 1 are not applicable to this Contract if it was solicited pursuant to a finding of an emergency. Subparagraph (c) of paragraph 1 is neither applicable to this Contract if it was solicited prior to October 18, 2012 nor if it is a renewal of a contract executed prior to October 18, 2012.

NOTICE TO BIDDERS, PROPOSERS, CONTRACTORS, AND RENEWAL CONTRACTORS

This contract includes a provision concerning the protection of employees for whistleblowing activity, pursuant to New York City Local Law Nos. 30-2012 and 33-2012, effective October 18, 2012 and September 18, 2012, respectively. The provisions apply to contracts with a value in excess of \$100,000.

Local Law No. 33-2012, the Whistleblower Protection Expansion Act (“WPEA”), prohibits a contractor or its subcontractor from taking an adverse personnel action against an employee or officer for whistleblower activity in connection with a City contract; requires that certain City contracts include a provision to that effect; and provides that a contractor or subcontractor may be subject to penalties and injunctive relief if a court finds that it retaliated in violation of the WPEA. The WPEA is codified at Section 12-113 of the New York City Administrative Code.

Local Law No. 30-2012 requires a contractor to prominently post information explaining how its employees can report allegations of fraud, false claims, criminality, or corruption in connection with a City contract to City officials and the rights and remedies afforded to employees for whistleblowing activity. Local Law No. 30-2012 is codified at Section 6-132 of the New York City Administrative Code.

Local Law 30-2012

By Council Members Garodnick, Barron, Brewer, Chin, Dromm, Ferreras, Fidler, Gennaro, Gentile, Jackson, James, Koppell, Lander, Mark-Viverito, Mealy, Mendez, Palma, Rose, Seabrook, Vann, Williams, Nelson, Foster, Van Bramer, Halloran and Koo

A Local Law to amend the administrative code of the city of New York, in relation to requiring city contractors and subcontractors to post information concerning their employees' reporting of fraud, false claims, criminality or corruption and their whistleblower protection rights.

Be it enacted by the Council as follows:

Section 1. Title 6 of the administrative code of the city of New York is amended by adding a new section 6-132 to read as follows:

§6-132. Posting of notice of whistleblower protection rights.

a. Definitions. For the purposes of this section, the following terms shall have the following meanings:

(1) "Contract" shall mean any written agreement, purchase order or instrument valued in excess of one hundred thousand dollars or more pursuant to which a contracting agency is committed to expend or does expend funds in return for work, labor, services, supplies, equipment, materials, or any combination of the foregoing, and shall include a subcontract between a contractor and a subcontractor.

(2) "Contracting agency" shall mean a city, county, borough, or other office, position, administration, department, division, bureau, board or commission, or a corporation, institution or agency of government, the expenses of which are paid in whole or in part from the city treasury.

(3) "Contractor" shall mean a person or business entity who is a party to a contract with a contracting agency valued in excess of one hundred thousand dollars, and "subcontractor" shall mean a person or entity who is a party to a contract with a contractor valued in excess of one hundred thousand dollars.

b. Posting of information about reporting fraud, false claims, criminality or corruption.

Every contractor or subcontractor having a contract valued in excess of one hundred thousand dollars or more shall post a notice, in a prominent and accessible place on any site where work pursuant to such contract or subcontract is performed, containing information about

(1) how its employees can report to the New York city department of investigation allegations of fraud, false claims, criminality or corruption arising out of or in connection with such contract or subcontract, and

(2) the rights and remedies afforded to its employees under sections 7-805 and 12-113 of the administrative code for lawful acts taken in connection with the reporting of allegations of fraud, false claims, criminality or corruption in connection with such contract or subcontract.

c. Contract provisions. Every city contract or subcontract valued in excess of one hundred thousand dollars shall contain a provision detailing the requirements of this section. If a contracting agency determines that there has been a violation of this section, it shall take such action it deems appropriate consistent with the remedies available under the contract or subcontract.

d. Nothing in this section shall be construed to limit an agency's authority to cancel or terminate a contract, issue a non-responsibility finding, issue a non-responsiveness finding, deny a person or entity pre-qualification, or otherwise deny a contractor city business.

§2. This local law shall take effect 120 days after its enactment into law and shall apply to contracts and subcontracts for which bids or proposals are first solicited after such effective date; provided, however, that the commissioner of investigation and the city's chief procurement officer shall take such measures as are necessary for its implementation, including the promulgation of rules, prior to such effective date.

Local Law 33-2012

By Council Members Garodnick, Halloran, Dromm, Barron, Brewer, Ferreras, Fidler, Gentile, Jackson, James, Koo, Koppell, Lander, Levin, Mark-Viverito, Palma, Rose, Sanders Jr., Seabrook, Van Bramer, Vann, Williams, Rivera, Rodriguez, Foster, Chin, Mealy, Gennaro and Ulrich

A Local Law to amend the administrative code of the city of New York, in relation to extending whistleblower protection for officers and employees of city contractors and subcontractors.

Be it enacted by the Council as follows:

Section 1. This bill shall be known and may be cited as the "Whistleblower Protection Expansion Act."

§ 2. Section 12-113 of the administrative code of the city of New York, as amended by local law number 10 for the year 2003, paragraphs 4, 5 and 6 of subdivision a and paragraph 3 of subdivision b as added by local law number 25 for the year 2007, and subdivision f as amended by local law number 25 for the year 2007, is amended to read as follows:

§ 12-113 Protection of sources of information. a. Definitions. For purposes of this section:

1. "Adverse personnel action" shall include dismissal, demotion, suspension, disciplinary action, negative performance evaluation, any action resulting in loss of staff, office space or equipment or other benefit, failure to appoint, failure to promote, or any transfer or assignment or failure to transfer or assign against the wishes of the affected officer or employee.

2. "Remedial action" means an appropriate action to restore the officer or employee to his or her former status, which may include one or more of the following:

(i) reinstatement of the officer or employee to a position the same as or comparable to the position the officer or employee held or would have held if not for the adverse personnel action, or, as appropriate, to an equivalent position;

(ii) reinstatement of full seniority rights;

(iii) payment of lost compensation; and

(iv) other measures necessary to address the effects of the adverse personnel action.

3. "Commissioner" shall mean the commissioner of investigation.

4. "Child" shall mean any person under the age of nineteen, or any person ages nineteen through twenty-one if such person receives instruction pursuant to an individualized education plan.

5. "Educational welfare" shall mean any aspect of a child's education or educational environment that significantly impacts upon such child's ability to receive appropriate instruction, as mandated by any relevant law, rule, regulation or sound educational practice.

6. "Superior officer" shall mean an agency head, deputy agency head or other person designated by the head of the agency to receive a report pursuant to this section, who is employed in the agency in which the conduct described in such report occurred.

7. "Contract" shall mean any written agreement, purchase order or instrument having a value in excess of one hundred thousand dollars pursuant to which a contracting agency is committed to expend or does expend funds in return for work, labor, services, supplies, equipment, materials, or any combination of the foregoing, and shall include a subcontract between a covered contractor and a covered subcontractor. Such term shall not include contracts or subcontracts resulting from emergency procurements or that are government-to-government procurements.

8. "Contracting agency" shall mean a city, county, borough, or other office, position, administration, department, division, bureau, board or commission, or a corporation, institution or agency of government, the expenses of which are paid in whole or in part from the city treasury.

9. "Covered contractor" shall mean a person or business entity who is a party or a proposed party to a contract with a contracting agency valued in excess of one hundred thousand dollars, and "covered subcontractor" shall mean a person or entity who is a party or a proposed party to a contract with a covered contractor valued in excess of one hundred thousand dollars.

10. "Officers or employees of an agency of the city" shall be deemed to include officers or employees of local development corporations or other not-for-profit corporations that are parties to contracts with contracting agencies and the governing boards of which include city officials acting in their official capacity or appointees of city officials. Such officers and employees shall not be deemed to be officers or employees of a covered contractor or covered subcontractor.

b. 1. No officer or employee of an agency of the city shall take an adverse personnel action with respect to another officer or employee in retaliation for his or her making a report of information concerning conduct which he or she knows or reasonably believes to involve corruption, criminal activity, conflict of interest, gross mismanagement or abuse of authority by another city officer or employee, which concerns his or her office or employment, or by persons dealing with the city, which concerns their dealings with the city, (i) to the commissioner, or (ii) to a council member, the public advocate or the comptroller, who shall refer such report to the commissioner. For purposes of this subdivision, an agency of the city shall be deemed to include, but not be limited to, an agency the head or members of which are appointed by one or more city officers, and the offices of elected city officers.

2. No officer or employee of a covered contractor or covered subcontractor shall take an adverse personnel action with respect to another officer or employee of such contractor or subcontractor in retaliation for such officer or employee making a report of information concerning conduct which such officer or employee knows or reasonably believes to involve

corruption, criminal activity, conflict of interest, gross mismanagement or abuse of authority by any officer or employee of such contractor or subcontractor, which concerns a contract with a contracting agency, (i) to the commissioner, (ii) to a council member, the public advocate or the comptroller, who shall refer such report to the commissioner, or (iii) to the city chief procurement officer, agency chief contracting officer, or agency head or commissioner of the contracting agency, who shall refer such report to the commissioner.

3. Every contract or subcontract in excess of one hundred thousand dollars shall contain a provision detailing the provisions of paragraph two of this subdivision and of paragraph two of subdivision e of this section.

[2.] 4. Upon request, the commissioner, council member, public advocate or comptroller receiving the report of alleged adverse personnel action shall make reasonable efforts to protect the anonymity and confidentiality of the officer or employee making such report.

[3.] 5. No officer or employee of an agency of the city shall take an adverse personnel action with respect to another officer or employee in retaliation for his or her making a report of information concerning conduct which he or she knows or reasonably believes to present a substantial and specific risk of harm to the health, safety or educational welfare of a child by another city officer or employee, which concerns his or her office or employment, or by persons dealing with the city, which concerns their dealings with the city, (i) to the commissioner, (ii) to a council member, the public advocate, the comptroller or the mayor, or (iii) to any superior officer.

c. An officer or employee (i) of an agency of the city, or (ii) of a public agency or public entity subject to the jurisdiction of the commissioner pursuant to chapter thirty-four of the charter who believes that another officer or employee has taken an adverse personnel action in violation of subdivision b of this section may report such action to the commissioner.

d. 1. Upon receipt of a report made pursuant to subdivision c of this section, the commissioner shall conduct an inquiry to determine whether retaliatory adverse personnel action has been taken.

2. Within fifteen days after receipt of an allegation pursuant to subdivision c of this section of a prohibited adverse personnel action, the commissioner shall provide written notice to the officer or employee making the allegation that the allegation has been received by the commissioner. Such notice shall include the name of the person in the department of investigation who shall serve as a contact with the officer or employee making the allegation.

3. Upon the completion of an investigation initiated under subdivision c of this section, the commissioner shall provide a written statement of the final determination to the officer or employee who complained of the retaliatory adverse personnel action. The statement shall include the commissioner's recommendations, if any, for remedial action, or shall state the commissioner has determined to dismiss the complaint and terminate the investigation.

e. 1. Upon a determination that a retaliatory adverse personnel action has been taken with respect to an officer or employee of an agency of the city in violation of paragraph one or five of subdivision b of this section, the commissioner shall without undue delay report his or her findings and, if appropriate, recommendations to the head of the appropriate agency or entity, who (i) shall determine whether to take remedial action and (ii) shall report such determination to the commissioner in writing. Upon a determination that the agency or entity head has failed to take appropriate remedial action, the commissioner shall consult with the agency or entity head and afford the agency or entity head reasonable opportunity to take such action. If such action is not taken, the commissioner shall report his or her findings and the response of the agency or entity head (i) if the complainant was employed by an agency the head or members of which are appointed by the mayor, to the mayor, (ii) if the complainant was employed by a non-mayoral

agency of the city, to the city officer or officers who appointed the agency head, or (iii) if the complainant was employed by a public agency or other public entity not covered by the preceding categories but subject to the jurisdiction of the commissioner pursuant to chapter thirty-four of the charter, to the officer or officers who appointed the head of the public agency or public entity, who shall take such action as is deemed appropriate.

2. Any officer or employee of a covered contractor or covered subcontractor who believes that he or she has been the subject of an adverse personnel action in violation of paragraph two of subdivision b shall be entitled to bring a cause of action against such covered contractor or covered subcontractor to recover all relief necessary to make him or her whole. Such relief may include but shall not be limited to: (i) an injunction to restrain continued retaliation, (ii) reinstatement to the position such employee would have had but for the retaliation or to an equivalent position, (iii) reinstatement of full fringe benefits and seniority rights, (iv) payment of two times back pay, plus interest, and (v) compensation for any special damages sustained as a result of the retaliation, including litigation costs and reasonable attorneys' fees. An officer or employee described in this paragraph may bring an action in any court of competent jurisdiction for such relief. An officer or employee who brings a cause of action pursuant to this paragraph shall notify the agency chief contracting officer or agency head or commissioner of the contracting agency of such action; provided, however, that failure to provide such notice shall not be a jurisdictional defect, and shall not be a defense to an action brought pursuant to this paragraph. This paragraph shall not be deemed to create a right of action against the city, any public agency or other public entity, or local development corporations or not-for-profit corporations the governing boards of which include city officials acting in their official capacity or appointees of city officials, nor shall any such public agency, entity or corporation be made a party to an action brought pursuant to this subdivision.

f. Nothing in this section shall be construed to limit the rights of any officer or employee with regard to any administrative procedure or judicial review, nor shall anything in this section be construed to diminish or impair the rights of a public employee or employer under any law, rule, regulation or collective bargaining agreement or to prohibit any personnel action which otherwise would have been taken regardless of any report of information made pursuant to this section.

g. Violation of this section may constitute cause for administrative penalties.

h. The commissioner shall conduct ongoing public education efforts as necessary to inform employees and officers of covered agencies and contractors of their rights and responsibilities under this section.

i. Not later than October thirty-first of each year, the commissioner shall prepare and forward to the mayor and the council a report on the complaints governed by this section during the preceding fiscal year. The report shall include, but not be limited to, the number of complaints received pursuant to this section, and the disposition of such complaints.

§ 3. This local law shall take effect ninety days after its enactment into law; provided, however, that the provisions of this local law shall apply only to contracts or subcontracts solicited or renewed on or after such effective date.

**New York City Administrative Code section 7-805
Remedies of employees.**

a. (1) Any officer or employee of the city of New York who believes that he or she has been the subject of an adverse personnel action, as such term is defined in paragraph one of subdivision a of section 12-113 of the administrative code of the city of New York; or

(2) any officer or employee of the city or state of New York, who believes that he or she has been the subject of a retaliatory action, as defined by section seventy-five-b of the civil service law; or

(3) any non-public employee who believes that he or she has been the subject of a retaliatory action by his or her employer, as defined by section seven hundred forty of the labor law because of lawful acts of such employee in furtherance of a civil enforcement action brought under this section, including the investigation, initiation, testimony, or assistance in connection with, a civil enforcement action commenced or to be commenced under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include but not be limited to: (i) an injunction to restrain continued discrimination, (ii) reinstatement to the position such employee would have had but for the discrimination or to an equivalent position, (iii) reinstatement of full fringe benefits and seniority rights, (iv) payment of two times back pay, plus interest, and (v) compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

b. An employee described in subdivision a of this section may bring an action in any court of competent jurisdiction for the relief provided in this section.

APPENDIX 1

JUVENILE JUSTICE LIMITED SECURE PLACEMENTS QUALITY ASSURANCE STANDARDS



**Juvenile Justice
Limited Secure Placements Quality Assurance Standards
2013**

Ronald E. Richter, Commissioner

Effective March 13, 2013

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DEFINITIONS & ACRONYMS

Definitions

- 1) Whenever the following terms and phrases are used in these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*, they shall have the following meanings, unless it is expressly indicated that such term or phrase is to have a different or additional meaning. All such other terms and phrases that shall not be specifically defined in this Part shall have the meaning ascribed to it by law, or, in the event that such term or phrase is not described in the law, it shall have the meaning as is commonly ascribed to it.
- 2) "ACS Policies" shall mean all applicable ACS policies, procedures guidelines, bulletins and standards as amended.
- 3) "Administrator" or "Commissioner" or "Agency Head" shall mean the Commissioner of the ACS or her/his duly authorized representative. The term "duly authorized representative" shall include any person or persons acting within the limits of her/his authority.
- 4) "Case Planner" shall mean the caseworker with the primary responsibility for providing or coordinating and evaluating the provision of services to the family as defined in 18 NYCRR 428.2(c).
- 5) "City" shall mean the corporation of the City of New York, its departments and political subdivisions.
- 6) "Community" for shall be considered both the neighborhood the site is located within, whether in New York City or beyond, as well as the home neighborhood(s) of the children who will be receiving services.
- 7) "CONNECTIONS" or "CNNX" means the New York State automated system designed to create a single integrated statement system for collecting and recording child protective, preventive, foster care and adoption services information.
- 8) "Day" shall mean a calendar day unless otherwise specified in these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*.
- 9) "Days of Care" shall mean the number of days in which a youth placed in, and physically present at, a facility operated by the Contractor, plus the number of days of allowable absences during the time in which the youth is in placement in such program.

- 10) “Juvenile Justice Youth” are youth adjudicated delinquent by the Court and placed in and receiving services from an ACS contractor pursuant to ACS policies and the law. Generally, these youth meet the following criteria:
- a) The youth is between the ages of seven (7) and eighteen (18).
 - b) The youth’s care and custody has been transferred to the Administration for Children’s Services pursuant to Article 3 of the Family Court Act.
- 11) “Law(s)” shall mean all applicable federal, state and city laws, regulations, ordinances and rules and any successor and any amendments thereto including but not limited to the New York City Charter, the New York City Administrative Code, a local law of the City of New York, and any ordinance, rule or regulation having the force of law and including any waivers issued by OCFS.
- 12) “LSP Facility” shall mean a licensed facility operated and staffed by an authorized agency for the care and maintenance of youth placed with ACS by the Family Court on juvenile delinquency cases pursuant to Article 3 of the Family Court Act.
- 13) “LSP contractor” shall mean the agency that is contracted by ACS to operate a NSP facility.
- 14) “Office of Children and Family Services” or “OCFS” shall mean the New York State Office of Children and Family Services which is responsible for, among other things, regulating and monitoring child welfare and juvenile justice services in New York State.
- 15) “Residential Care Facility” shall mean a congregate care facility. Such facilities include:
- a) “Group Home” shall mean a licensed family-type home operated and staffed by an authorized agency for the care and maintenance of seven (7) to twelve (12) youth.
 - b) “Group Residence” shall mean a licensed institution operated and staffed by an authorized agency for the care and maintenance of up to twenty five (25) youth.
 - c) “Institution”, locally referred to as “Residential Center” shall mean a licensed facility operated and staffed by an authorized agency for the care and maintenance of thirteen (13) or more youth.
- 16) “State” shall mean the State of New York.
- 17) “Suspended Payment” shall mean the cessation of payments by the City to the contractor when a youth placed with the contractor is not physically present and is not on an allowable absence.

- 18) "Tuition" shall mean the per pupil cost of all instructional services, supplies and equipment, and the operation of instructional facilities as determined by ACS. Approved tuition shall be computed from expenditures for which no revenue has been received from the following sources:
- a) Receipts from the federal government;
 - b) Any cash receipts which reduce the cost of an item applied against the item there for, except gifts, donations and earned interest; and
 - c) Any refunds made or any apportionment or payment received from the State.
- 19) "Written approval" or "approval" shall refer to paper or electronic correspondence, unless otherwise stated, and shall be rendered within thirty (30) days of receipt unless another date is agreed upon by the parties.

Acronyms

Whenever the following acronyms are used in these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*, they shall have the following meanings, unless it is expressly indicated that such acronym is to have a different or additional meaning.

ACS	New York City Administration for Children's Services or "Children's Services"
AIDS	Acquired Immune Deficiency Syndrome
APA	Agency Program Assistance
APPLA+	Another Planned Permanency Living Arrangement
ARTS	Automated Restraint Tracking System
AWOL	Absent Without Leave
CASAC	Credentialed Alcohol and Substance Abuse Counselor
CCRS	Child Care Review Service
CIN	Client Identification Number
CJC	Office of the Criminal Justice Coordinator
CNNX	CONNECTIONS
CPP	Community Partnership Program
CPS	Child Protective Services
CTHP	Child/Teen Health Plan
DCP	Division of Child Protection
DCJS	Division of Criminal Justice Services
DOE	Department of Education
DYFJ	Division of Youth and Family Justice
EOP	Extension of Placement
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FASD	Fetal Alcohol Spectrum Disorders
FCLS	Family Court Legal Services
FTC	Family Team Conference
GED	General Equivalency Diploma
HIV	Human Immune-deficiency Disease
JD	Juvenile Delinquent
JJPM	Juvenile Justice Planning and Measurement Unit
IEP	Individualized Education Plan
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Questioning
LSP	Limited Secure Placement
LTS	Legal Tracking System
MOU	Memorandum of Understanding
NSP	Non-Secure Placement or Non-Secure Juvenile Justice Placement
NYCRR	New York Codes, Rules and Regulations
OASAS	Office of Alcoholism and Substance Abuse Services
OCFS	Office of Children and Family Services
OCP	Office of Community Partnerships
OMH	Office of Mental Health

OPWDD	Office for People With Developmental Disabilities
OYFD	Office of Youth and Family Development
PINS	Person In Need of Supervision
PYA	Preparing Youth for Adulthood
PAMS	Provider Agency Measurement System
STI	Sexually Transmitted Infection
SCR	Statewide Central Register of Child Abuse and Maltreatment
SSPS	Statewide Service Payment System
TGNC	Transgender and Gender Non-Conforming

PART I: CHILDREN'S SERVICES' MISSION AND GOALS

A. Mission Statement

1. On January 10, 1996, the New York City Administration for Children's Services (Children's Services or ACS) was created as the first New York City agency devoted solely to serving children and their families. Children's Services' mission is to ensure the safety and well-being of New York City children.
2. In January 2010, Children's Services assumed responsibility of the City's Department of Juvenile Justice (DJJ). DJJ has now been fully integrated into Children's Services as part of the Division of Youth and Family Justice (DYFJ). DYFJ provides secure and non-secure detention (NSD) for alleged juvenile delinquents and secure detention for alleged juvenile offenders whose cases are pending, along with post-adjudicated juveniles awaiting transfer to state facilities. DYFJ will oversee the new continuum of juvenile justice placements and aftercare. Additionally, DYFJ provides community-based programming for youth involved in the juvenile justice and PINS systems. In keeping with the agency's overarching goals, the mission of DYFJ is to promote public safety and improve the lives of youth, families, and communities by providing services that are child-centered and family-focused.

B. Limited Secure Placement Goals and Objectives

The goal of programming during and after placement is to support youth to develop to their fullest potential and become healthy, educated, and constructive members of the community with successful transitions to adulthood.

1. **Connection to the Youth's Community:** Youth in LSP Programs will reside in residential facilities in or close to New York City, with opportunities to take advantage of local programs and services. Discharge planning for youth will begin upon arrival into LSP Program sites and youth will participate in robust LSP Aftercare services.
2. **Improved Well Being of Youth:** Youth will have enhanced programming options and expanded access to mental health care and health services. Treatment planning and clinical services will be individualized to meet the unique needs of each youth in LSP Programs.
3. **Better Family Engagement:** New York City families will be able to maintain frequent contact with their youth in LSP Programs, and participate in their youth's rehabilitation, which will enhance the youth's likelihood of success upon release.

4. **Improved Educational Outcomes:** Youth will receive individualized educational services and academic credits earned during placement will count towards a high school diploma.
5. **Appropriate Public Safety Measures:** Public safety measures appropriate to youth in LSP will be utilized in every program site and during LSP Aftercare. While the youth reside in an LSP Program site all services must be provided directly on-site. Youth will not be permitted to engage in activities off-site except under the constant supervision of staff or in other pre-approved settings.

PART II: CONTRACT AGENCY ADMINISTRATION AND ORGANIZATION

A. Limited Secure Placement Contractor Mission and Purpose

1. The Limited Secure Placement (LSP) contractor's clearly stated mission and purpose shall reflect a commitment to serve youth and their families, and shall be consistent with the mission and objectives of NYC Children's Services.
2. The contractor's mission statement shall reflect a commitment to respect and respond to the diversity of the ethnic, cultural, religious and sexual orientation groups it serves, while fostering a community-based, family-focused approach through its linkages, community involvement and integration of the family.
3. Every effort shall be made to ensure adequate representation among the contractor's board and staff of the ethnic groups in the client population, and staff shall be educated in cultural and religious factors and practices of the populations served, with particular reference to ways in which culture or religion may impact on the treatment service process.
4. There shall be programs and activities designed to foster the cultural (ethnic/religious/sexual) awareness and identity of the children in care, and to continue a seamless connection with their community of origin.
5. The LSP contractor shall make an effort to utilize contributions from the community and family in their policy-making process, and involve them in service planning. They shall actively seek the involvement of present and former family members' and foster-family members' as well as former juvenile justice system involved youth to ensure continuity of these principles.
6. Quality assurance shall form an integral part of the contractor's limited secure operations, such that process and outcomes are being regularly measured and used to inform improvement strategies and plans.

B. LSP Contractor Program Goals, Policies and Procedures

1. The LSP contractor shall maintain a LSP Program Manual. The Table of the Contents of the Program Manual shall be determined by ACS. The Program Manual shall be kept up-to-date with current information regarding the LSP contractor's operations, policies, and procedures. ACS shall approve the initial Program Manual in the program development

phase of start-up. Thereafter, the LSP contractor's Program Manual shall be provided to ACS on an annual basis, or more frequently if requested by ACS.

2. The LSP contractor shall have clearly identified programs and services that include written goals and objectives. The LSP contractor shall have a written plan that includes resources and programs for the provision of services, which is supported by a financial plan. These shall be reviewed periodically and updated as necessary.
3. The LSP contractor's philosophy shall be reflected in its goals, objectives, policies, procedures, and in the implementation of programs and services.
4. The LSP contractor shall have a written plan, which allocates resources to programs for the provision of services, which is supported by a financial plan. These shall be reviewed periodically and updated as necessary.
5. The LSP contractor shall have a long-range program plan, which covers a minimum of three (3) years. This shall be reviewed periodically and updated as necessary.
6. The LSP contractor's program mission, policies, and procedures shall be disseminated to, and reviewed and implemented by, appropriate staff. Additionally, they must be distributed to parent[s], family, extended family or other discharge resources, as appropriate and necessary for effective treatment during placement and discharge planning.
7. The LSP contractor shall have program procedures and goals that promote provision of services and allow for stable placement experiences by youth in the most family-like and least restrictive settings as possible; for populations served – by age, gender, and need.
8. The LSP contractor shall provide services to its target population within its service communities that will ensure the safety of youth and address the needs of the target group as a whole. Intervention must occur as early as possible to provide the greatest benefit and most timely resolution of presenting needs.
9. The LSP contractor shall develop a practice model that follows a team focused, decision-making approach, in service delivery and planning, and in accountability/self-evaluation.
10. The LSP contractor shall design a plan to ensure regular meetings of a team inclusive of administrative and direct care staff, parents/guardians, foster parents, youth, and community service providers. The team shall seek to ensure and provide feedback that the stated goals of the program and Children's Services are being met effectively.
11. The LSP contractor must have a quality assurance plan in place describing how it shall provide ongoing quality assurance. The LSP contractor shall assign designated staff to oversee a formal quality assurance system of services and outcomes in consultation

with direct services staff, youth, and family members served. The quality assurance format shall include a review of goal achievement (family and program) and a review to ensure compliance with OCFS, NYC Children's Services and other promulgated administrative standards.

12. The LSP contractor shall seek to maintain an appropriate cultural, ethnic, gender responsive and developmental environment that is both aesthetically pleasing and appropriate for the populations served. The contractor must formulate written policies for the interaction of staff with the service populations in the various planning environments (families, other resources, organizations or community service providers, and Family Court).

C. Community Advisory Boards

1. LSP contractors who receive funding from Children's Services shall make best efforts to encourage members of the communities they serve have the opportunity to contribute to and be informed about policy-making and program development processes. In doing so, they shall actively solicit family members' involvement in services provided to their children.
2. LSP contractors shall develop and operate Community Advisory Boards (CABs). These Boards will help maximize community involvement in and support for their NSP facilities. The Community Advisory Boards shall be comprised of representatives from local non-profits, businesses, mental health service providers, education providers and/or advocates, local arts groups, faith-based organizations and other interested community members. Providers are encouraged to seek the membership of a youth (and/or his or her parent/guardian) with past involvement in the juvenile justice system, and/or a parent advocate.
3. LSP contractors are encouraged to have a Community Advisory Board for each facility they operate. However, due to feasibility, providers may choose to have one CAB per borough as long as at least one representative from each neighborhood in which the agency operates is included.
4. Community Advisory Boards shall meet on a quarterly basis, at minimum, and will help to identify avenues for deepening connections between LSP facilities and their communities. The roles and responsibilities of Community Advisory Board may include some of the following:
 - a) Community Relations and Advocacy: to provide advocacy and education about issues affecting at-risk youth and act as a liaison between the NSP facility and community;

- b) Community Resources: to identify and develop community resources to enhance NSP programming both in- and outside of the facility, such as cultural, educational, and vocational experiences to foster long-term growth;
 - c) Financial Support and Development: to organize fundraising activities to purchase items for the facility or programs to enhance youths' experience in LSP; and
 - d) Program Development: to inform the LSP about community issues and concerns and participate in program events that provide positive experiences for youth and their families, such as open houses, family days, etc.
5. LSP contractors are required to interface with their local Community Advisory Boards and local police precincts prior to opening their facilities and on an ongoing basis. Providers shall develop relationships with the precincts' Community Relations Officers to inform them of the facility and develop an ongoing process to maintain communication about how the officers can provide support to the providers when necessary. Having a Community Advisory Board Public Safety Committee is another avenue through which the providers can develop partnerships and maintain transparency with the community about their work.
 6. Conflicts of Interest: All Community Advisory Board members must disclose to the LSP contractor any personal, business, and/or familial relationships with LSP staff or other advisory board members to prevent conflicts of interest.
 7. Confidentiality: All Community Advisory Board members must sign an agreement to maintain the confidentiality of information concerning youth in non-secure placement.

D. Participation in Community Partnership Program

1. Community Partnerships will work to develop and support holistic, seamless local networks of service providers, community members, families, and other stakeholders with the goal of assisting families and offering safety and support where they reside. Community Partnerships will identify community needs and draw upon community resources to address those needs and will work to identify and overcome obstacles to child welfare system success. Relationships and partnerships formed within the Community Partnerships will significantly impact core child welfare outcomes of safety, permanency, and well-being. The Partnership will seek to close the divisions between Children's Services, contract providers, other neighborhood organizations, and residents of neighboring communities.
2. LSP contractors shall participate in local Community Partnerships if one exists in their local community. The purpose of the involvement will be to receive feedback about the operation of the facility in the community and to encourage community involvement in the services offered by the LSP contractor. LSP contractors shall participate in the

Community Partnership nearest to their residential facility. LSP contractors are encouraged to connect discharged youth and their families to a Partnership if one exists in the community to which the youth is returning.

E. Board of Directors – Community and Client Participation

1. LSP contractors who receive funding from Children’s Services shall ensure that members of the communities they serve have the opportunity to contribute to and be informed about policy-making processes. In doing so, they shall actively solicit family members' involvement in services provided to their children. Contractors shall ensure that appropriate members of the socio-economic communities served by the LSP contractor's Children’s Services-funded programs have the opportunity to contribute to and be informed about policy-making processes. In doing so, they shall actively solicit family members' involvement in services provided to their children. LSP contractors shall have community members serve on their Board of Directors, on advisory panels, or on committees of the Board of Directors.

F. Neighborhood-Based Service Provision

1. When neighborhood placement is not possible, due to the specialized nature of the program model, site location issues, or any other reasons deemed appropriate and/or in the best interest of the child, then the LSP contractor as part of transition planning for each youth, shall establish relationships and linkages with the youth's home community and/or with the community the youth will be residing in upon discharge, if known. The LSP contractor shall facilitate and promote the child's relationship with her/his home community and facilitate visiting in that community.

G. Interagency and Community Relations

1. Upon award notification, the LSP contractor must notify the Community Board that represents the community where the LSP facility will be located, of the intent to develop a LSP facility in the community. This communication must include information about the youth who will be residing in the site and services offered.
2. The LSP contractor shall provide services which offer children the full range of services that they need to achieve placement stability and permanency goals in the least restrictive setting as possible. If the LSP contractor does not have the expertise or capacity to directly provide all services necessary to assist and support clients, the LSP contractor shall meet the full range of service through the establishment of formal linkages with other social services and community-based organizations. In that instance, the contractor shall establish linkages including but not limited to service provider contracts, formal service agreements, “letters of linkage,” and “memoranda of understanding.” It is expected that the LSP contractor will also support and develop

linkages in the child and family's community of origin and/or residence, since all services are to be community-based.

H. Non-Discrimination Policy

1. All discrimination including, but not limited to, discrimination based on an individual's actual or perceived sex, and discrimination based on an individual's gender identity, self-image, appearance, behavior or expression, or an individual's sexual orientation constitutes a violation of the City's Human Rights law, as well as New York State Human Rights Law. Moreover, New York State Social Services regulations prohibit any act by Children's Services or contractor staff that would be detrimental to any child in care.

PART III: LIMITED SECURE PLACEMENT OPERATIONS

A. Program Site

1. Physical Facilities and Equipment

- e) The physical plant and equipment shall meet the specifications as established by OCFS, ACS and all applicable State and local ordinances. The LSP contractor's physical facilities shall be clean, the appearance of the interior and exterior of the building shall be maintained, and the physical facilities shall reflect the mission of the LSP contractor and program.

2. Furnishings and Environment

- a) All LSP facilities must be designed to give an overall impression of a homelike setting.
- b) The furnishings contained in an LSP facility shall accommodate the characteristics of the population and where appropriate provide a "homelike" living environment. Furniture and furnishings shall be clean and in good condition, and shall be arranged for the safety of the population. Each youth shall have a separate bed, chair, dresser or other storage space and a closet or locker for jackets, coats and other outerwear. The furniture must be designed in a way to limit the storage or hiding of contraband.
- c) Private offices as well as common areas shall be clean, well lit, and appropriately furnished.
- d) The site shall be decorated with posters/works of art that reflect the culture of the client population to be served.

3. Accessibility

- a) The building housing the program site shall be clearly numbered. Within the program site, there shall be a reception area where family members are greeted and space for family visits.
- b) Accessibility – Americans with Disabilities Act
 - i. LSP contractor sites must make best efforts to make LSP facilities compliant with the Americans with Disabilities Act (ADA) and applicable state and local laws to make services and service locations accessible to family members with physical

disabilities; including, but not limited to, developing plans for making facilities wheelchair accessible and utilizing sign language interpreters and large print informational reading materials. If LSP facilities are not ADA compliant, LSP contractors shall provide for visitation with any visitors not able to access the site for this reason by transporting the youth to the visitor for regular visitation.

- ii. To further facilitate family access to appropriate services, the LSP contractor shall establish referral protocols to programs serving distinct disabled communities.

4. Hours of Operation

- a) LSP contractors must have flexible hours for all programming involving family and other discharge resources, including in the early morning, evening and/or on weekends to accommodate family members who work, attend treatment or school, or are otherwise engaged in essential activities.

5. LSP Facility Space and Design

- a) The LSP facility is largely a self-contained site, meaning the majority of services for youth and families are provided onsite. The LSP facility must have space to support the range of services being offered, including space appropriate for outdoor recreation. The LSP facility must also provide space so that counseling can be conducted in privacy to ensure confidentiality is maintained. Additionally, the LSP facility must comply with all applicable health, fire and safety regulations.
 - i. Services to be provided onsite include but are not limited to, daily school; routine medical, dental and mental health services; recreation (including indoor and outdoor recreation); treatment team meetings; group treatment meetings; and family visiting.
 - ii. Medical exam rooms must have a sink.
 - iii. All LSP facilities must have a library for youth onsite.
 - iv. All LSP facilities must have food preparation and food storage onsite.
 - v. All LSP facilities must have space for family visiting, including a space for visitors to secure their belongings during visits.
 - vi. All LSP facilities must have a central control room with access to monitor the CCTV system throughout the facility.

- b) All LSP facilities must be designed to accommodate between 6 – 24 youth (for ACS sites groups will be 10 youth, for all non-ACS sites, ACS suggests groups of 6 youth). No group shall exceed twelve youth. If non-ACS LSP sites house over 12 youth, the facility must be divided in a way to allow each group of youth to independently operate, including separate bedroom and dayroom living space and classrooms for each group.
- c) Outdoor Space: Outdoor space must be able to provide appropriate physical recreation space for the number of youth served (or number of youth in individual groups served if site serves more than one group of 6). LSP facilities' outdoor recreational space must be able to accommodate activities that require running and/or jumping, such as basketball, martial arts, aerobics, flag football and double-dutch. Additionally, the outdoor space must have shaded areas.
- d) Indoor Recreation Space: All LSP facilities must have onsite or access to indoor activity space that allows for 100 square feet of unencumbered space per youth, for large muscle activities.
- e) All LSP facilities must be wired for internet.
- f) All LSP facilities must have storage space including but not limited to a janitorial closet.
- g) If planned usage of the contractor site changes during the contract, the contractor must notify Children's Services in writing at least 90 days prior to the proposed change and must receive written approval from ACS prior to changing the space.
- h) Each Living Unit (10 youth for ACS leased sites and 12 youth maximum per unit for non-ACS leased sites) must contain the following:
 - i. Sleeping Area
 - (a) Youth must sleep in individual bedrooms. To foster the group dynamic, LSP providers may request from OCFS and ACS to allow for dormitory style sleeping areas.
 - (b) If requesting dormitory style sleeping areas, there must be a clear line of sight to maintain eyes-on supervision of youth
 - (c) Direct sunlight
 - (d) Desk and chair in room
 - (e) Storage space for youth's personal belongings
 - (f) 35 square feet of unencumbered space per room (per youth if in dormitory area)
 - ii. Dayroom
 - (a) Each living unit must have a dayroom in close proximity to unit sleeping area.

- (b) Direct sunlight
 - (c) Seating for every youth and staff member
 - (d) 35 square feet of unencumbered space per youth
 - iii. Bathrooms
 - (a) Each living unit must contain a minimum of 2 sinks, 2 toilets, and 2 individual showers for use by youth in the unit.
 - iv. Clinical Space
 - (a) Each living unit must have private clinical space.
 - v. Suicide Resistant Design Features
 - (a) Bathrooms and bedrooms must be suicide resistant.
 - (b) Bedrooms and bathrooms must not have anchor points.
 - (c) Doorknobs must be suicide resistant.
 - i) Exterior
 - i. Motion activated perimeter lighting must be maintained to alert LSP staff of any movement on or near the premises at night.
 - ii. CCTV must monitor the perimeter, including but not limited to facility entry and exit points.
 - iii. There must be designated entry and exit points.
 - iv. Fencing surrounding the LSP facility and outdoor space is permissible in an effort to keep unwanted persons from entering the LSP property area. Barbed wire and razor wire are prohibited.
 - v. All exterior building doors must remain locked at all times.
 - j) LSP facilities must maintain sufficient interior (in common spaces) and exterior CCTV monitoring with recordings saved for a minimum of 90 days and must enable easy transfer of video to ACS and OCFS upon request. CCTV and recordings must include video and sound.
 - k) All doors must be fire rated steel hollow core with vision panels on all interior doors.
 - l) LSP facilities shall provide fully functioning heating, cooling, lighting and ventilation systems adequate for the square footage of the facility.
6. Health and Safety: LSP facilities must be free of hazards, including but not limited to the following conditions:

- a) peeling paint, cracked plaster, water stains, and holes in walls, doors or ceilings;
 - b) unlighted stairways, halls or entrance areas;
 - c) cracked or broken windows;
 - d) frayed or exposed electrical wiring;
 - e) improperly stored combustible materials or poisonous substances;
 - f) excessive litter or soil;
 - g) signs of rodent infestation or vermin;
 - h) unsanitary or unusable bathroom facilities;
 - i) lack of operative charged and inspected fire extinguishers;
 - j) inoperative smoke and/or fire alarms;
 - k) uncapped electrical outlets;
 - l) extension cords;
 - m) torn carpeting or unsecured rugs/runners, holes in flooring, missing/ broken tiles;
and
 - n) infestations of Insects and/or rodents.
- i. LSP facilities must have in place facility protocols to prevent, manage, and contain the spread of bed bugs. If staff finds evidence of bed bugs (e.g. bites on a youth), he or she shall immediately alert the facility director. The facility director shall then notify the designated ACS Director of Placement and Permanency within one day of the discovery and shall provide the ACS Director with a written action plan to confirm the presence of bed bugs and address the problem within two days of the discovery. For more information about identifying and controlling bed bugs, see the NYC Department of Health and Mental Hygiene's website - www.nyc.gov/html/doh/html/vector/vector-faq1.shtml.

7. All sites must have:

- a) All LSP facilities must have a generator (located in a safe location in the facility) that will maintain routine program operations when power is down;
- b) All floors used by youth must be separated from each other by a smoke stop separation and have alternate means of egress remotely located from each other and accessible to the occupants;
- c) A minimum of two means of egress from each floor by way of a door at floor level;
- d) All doors and means of egress must swing in the direction of exit and conform to the New York Stat Uniform Fire Prevention and Building Code requirements for panic hardware and self-closing mechanisms;
- e) All stairs and ramps from such exits must terminate at ground level;
- f) Windows as means of egress must be at least 30 inches in its smallest dimension with the bottom of the window no higher than three feet six inches above the floor unless acceptable access is provided by steps or furniture fixed in place;

- g) An upper level window as a means of egress must also have a platform outside the window and a stair, permanently affixed to the building, leading to ground level;
- h) All exit doors and means of egress, halls and stairs must be well lighted and kept clean, free of obstruction and ready at all time for immediate use;
- i) Illuminated exit and directional exit signs and battery-operated or generated-powered emergency lighting units or systems must be provided and maintained in accordance with the New York State Uniform Fire Prevention and Building Code;
- j) Doors used as smoke stop separations must be equipped with self-closing devices and magnetic hold-open devices;
- k) A plan for building evacuation; printed procedures to follow in case of fire conspicuously posted in all halls and reception areas; regularly held fire drills (at least once every 30 days);
- l) Annual FDNY inspection report;
- m) Appropriate current Certificate of Occupancy; and
- n) Adult supervision for all youth's activities with required ratios of adults to children.

8. Physical Protection

- a) The physical environment of the facility must provide for the safety of all the persons on the premises from physical harm, drugs, and criminal activity.
- b) All LSP facilities must have key control procedures.
- c) The LSP contractor shall have a security plan which includes: precautions to be used when dealing with individuals who may be dangerous; actions to be taken when dangerous or potentially dangerous incidents occur; the circumstances under which the police are to be called; and maintaining good relationships with the local police and the precinct community relations officer. This includes the maintenance of a 24/7 staffed facility control center that manages a secure key management system, the CCTV system and the entry and exit of staff, youth, and visitors (visitors must enter through a secure entry lobby).
- d) All staff shall have the local precinct's phone number readily available for emergency use.
- e) Only Fire Department approved gates shall be used on windows that are potentially accessible from outside.
- f) Air Vents must have gaps less than 1/16 of an inch.

B. Continuity of Operations Plan

1. The LSP contractor continuity of operations plans shall be in compliance with 18 NYCRR 441.16 (a), or any successor or amended regulation, and incorporate general continuity of operations planning information; detail the procedures to be followed in caring for youth and families in the event of a disaster or emergency; and focus on planning and procedures for the continued care and supervision of all youth in the contractor's care, both during and after a disaster or emergency.
2. Families receiving in-home services, including families of youth in out-of-home placement, shall also be encouraged to develop and update family disaster plans. LSP contractors shall provide such families with emergency preparedness information and emergency contact numbers to call and check on the safety and status of their children/youth following a disaster or evacuation.
3. LSP contractor continuity of operations plans shall include, but not be limited to, the following information and planned activities:
 - a) encouraging staff to develop personal disaster plans and keep them updated;
 - b) requiring staff to check in after disasters and provide information on how to do so;
 - c) plans for maintaining the required staff to youth ratio;
 - d) plans for alternate sites if the LSP facility must be evacuated, including plans for the safe transportation of youth and supplies;
 - e) plans for ongoing communication to families;
 - f) keeping a backup generator on-site;
 - g) keeping emergency supplies in the office (including satellite offices);
 - h) training all staff on the contractor disaster plan and having them participate in drills;
 - i) establishing personal and professional support services for staff;
 - j) the protection of vital records; establishing off-site backup for information systems with case and client records;
 - k) protecting data and equipment from environmental factors (for example, covering/bagging computers and office equipment, installing surge protectors);
 - l) assessing the critical nature of paper records, prior to a disaster, and then determining what steps may be necessary to protect such records from potential damage in a disaster (for example, use of fire-safe metal filing cabinets); and
 - m) the prior establishment of disaster planning agreements with organizations in neighboring counties and states that would likely be involved in running emergency shelters to help locate displaced children/youth and families following a disaster.
4. LSP contractors shall share an initial continuity of operations plan with ACS for approval and shall share, annually, any revisions the LSP contractor has made to the plan.

C. Staff Workload Ratios and Coverage

1. LSP contractors must recruit and hire appropriate and sufficient staff to meet their program's needs. The ratio of youth to direct care workers in all types of general and specialized LSP residential settings shall be six (6) youth to two (2) direct care staff.
2. A minimum of two (2) direct care staff shall be on duty at all times. LSP facilities shall be able to access additional staff during emergencies.
3. Staff are not permitted to sleep during any shift. LSP contractors are required to have staff on-call and available to report to work within 30 minutes if additional staffing is necessary or required by ACS. Documentation of this staffing ratio shall include the names of staff on call for each shift, hours of coverage, and plans for providing backup staff in emergencies.
4. All LSP facilities must have one staff person at all times in a central control room in each LSP Program site. This position is responsible for, but not limited to, maintaining facility keys, overseeing entry to and exits from the facility, observing closed circuit camera activity and responding to any emergencies within the facility.
5. Care Coordination Services
 - a) Coverage at all facilities must also include on site care coordination coverage on a full time (forty (40) hours per week) basis.
 - b) These services (outlined further in this document) may be provided by the LSP Program site Caseworker or other qualified staff as part of their duties.
6. Mental Health Staffing Requirements In All LSP Program Sites
 - a) At minimum, staffing at all LSP Program sites must include, for every twelve (12) youth (or fraction thereof):
 - i. One (1) full time (forty (40) hours per week) on site mental health clinician,
 - ii. One (1) full time (forty (40) hours per week) on site family worker,
 - iii. One (1) supervising clinician, and
 - iv. One (1) clinical director.
 - b) LSP providers must provide adequate and appropriate staffing coverage. Services shall be available to youth in the morning, afternoons, evenings and weekends.
 - c) LSP providers shall maintain a current list of per-diem staff who meet ACS credentialing and clearance requirements available to fill in on an as-needed basis in

order to fulfill adequate coverage for staff outages (e.g. vacation, holidays and illness).

7. Substance Abuse Services Staffing Requirements For All LSP Program Sites

- a) At minimum, substance abuse staffing at all LSP Program sites must include, for every twelve (12) youth (or fraction thereof), full time (forty (40) hours per week) on site substance abuse service provider.
- b) These services can be integrated into the mental health services and be provided by the mental health clinician as long as the mental health clinician providing the services has the required credentials outlined these Standards.

D. Confidentiality/Clients' Rights

- 1. Youth in LSP facilities shall be permitted reasonable access to a telephone to call to their attorneys upon request. LSP contractors must enable the youth to speak to his/her attorney privately, without staff hearing the dialogue, during these calls. Calls to a youth's attorney will not count against any limit on phone calls. Further, letters to and from attorneys may be examined for contraband, but only in a manner that ensures that the letter's contents are not read and remain confidential (e.g., the letter may be opened by the youth in front of the contractor staff).
- 2. While a child is in care, it is important for the LSP contractor to ensure the protection of the rights of both the parent or caretaker and child. The Parents' and Children's Rights Unit within the Children's Services Office of Advocacy provides a forum to which parent(s) or caretaker(s) and relatives, youth and others may bring their concerns and complaints.
- 3. The LSP contractor must adhere to the Children's Rights of Privacy Standards.
- 4. When domestic violence is present and a parent[s], family, extended family or other discharge resource is residing in a domestic violence shelter, references in the case record shall be made to the business address (often designated as a Post Office (P.O.) box number or a P.O. station) of the shelter and not to the street address of the shelter. The actual street address of the shelter shall never be documented in a system of record or court report or given to anyone directly or indirectly, particularly the abusive partner (see *Title 18 NYCRR Part 452.10*).
- 5. All information pertaining to domestic violence safety planning (e.g. a shelter's business address or an actual address of a survivor of domestic violence) shall be clearly and boldly identified in the case record by contractor staff as "Confidential Information Due To Domestic Violence, Do Not Share".

E. Referral, Intake and Placement

1. Placement: A youth is deemed to have been placed with the LSP contractor the day on which the youth enters the LSP facility pursuant to the approval of ACS.
2. The LSP contractor shall accept all youth placed by the New York City Family Court in its care in accordance with these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*.
3. Intake Process and Admissions
 - a) After a child is placed in limited secure placement with ACS, ACS will determine which LSP facility is an appropriate match for the youth, and will notify the LSP facility of the determination. Once the determination is made, a case conference with ACS and the LSP facility will be arranged and an information packet regarding the youth will be sent to the LSP contractor. The packet will be sent before the youth arrives at the LSP facility. Children's Services will then arrange with the LSP contractor to have the youth transported to the facility. The LSP contractor must transport the youth to the LSP facility.
 - b) During year one, youth will be transferring from OCFS both into LSP Program sites and into LSP Aftercare programs. These transfers will happen at various points of a youth's placement period. Contractors are required to accept youth being transferred to the LSP contractor's LSP Program site or to the LSP contractor's LSP Aftercare program and must fully and comprehensively provide LSP Program services or LSP Aftercare services to these youth and families or other discharge resources.
 - c) LSP contractors may not refuse to accept a youth. The LSP contractor may request a review of the decision by Children's Services to place a youth in its LSP facility by telephoning or emailing a designated Children's Services staff member. This staff member will be identified when the LSP contracts commence.
 - d) LSP contractors are required to have staff available from 8:00 A.M. to 9:00 P.M., on all weekdays except Court holidays, to receive intake referrals from Children's Services. Two administrative staff persons, one (1) primary and a back-up, who can make intake decisions, shall be available during the timeframe described above. In some cases intake may need to take place outside of these hours, ACS will work with the LSP contractor on a case by case basis to ensure necessary intake activities will take place.
 - e) Children's Services shall assign an identification number to each youth in care, document eligibility requirements and placement/payment information in a system

of record, and document other required systems to support payment to the contractor within three (3) business days of placement.

- f) The LSP contractor shall verify the information in the system of record. The contractor shall maintain a Uniform Case Record in accordance with *Title 18 NYCRR Part 428*. The contractor shall have specified procedures for obtaining admission information on youth, including receiving information from Children's Services and integrating it into the treatment plan, that demonstrates a direct relationship between the plan goal and the needs of the youth.
- g) In order to accommodate fluctuating utilization levels and to meet the needs of youth, General LSP contractors shall be expected, when appropriate and safe for the youth, staff and community, to admit youth with specialized needs. Conversely, the Specialized LSP contractors shall be expected, when appropriate and safe for the youth, staff and community, to admit youth with non-specialized needs or youth with specialized needs other than those of the particular Specialized LSP Program site. In these cases, ACS will work closely with the LSP contractor to ensure the youth has access to necessary services.

F. Census Reporting

1. The LSP contractor shall report its current census, capacity, and placement vacancies to Children's Services as follows:
 - a) Capacity: The LSP contractor shall accurately report its census daily.
 - i. Census must be called into MCCU two times a day:
 - (a) Morning Census – Report to MCCU between 6:30AM – 7:00AM
 - (b) Evening Census – Report to MCCU between 10:00PM – 10:30PM
 - ii. Evening Rosters to be faxed or emailed to MCCU daily between 7:00PM – 8:00PM
 - iii. Notification of new admissions: Each time a newly admitted youth arrives to the LSP facility, the LSP contractor must call MCCU to alert ACS of the change in the facility's census. This is in addition to the regular census and roster reporting requirements outlined above.
 - b) Back-up Staff: The LSP contractor shall designate one (1) staff person and one (1) additional back-up staff person from its intake section as a liaison who will report census to ACS.
 - c) The LSP contractor's failure to report census in accordance with this section shall trigger an immediate review of LSP contractor's census reporting process and may result in the suspension of LSP contractor's intake.

G. Provision of Basic Services

1. Contractors must provide food, clothing, bedding, and other basic necessities.
2. The LSP contractor shall serve food, beverages and snacks of good quality and sufficient quantity, appropriate for the physical needs and medical conditions of the youth in care, providing suitable and sufficient nutrients and calories for each child in accordance with the provisions of *Title 18 NYCRR Part 442.22* or any successor or amended regulation.
3. Contractors must adhere to New York City guidelines for food procurement, preparation, and service as outlined by the *Mayor's Executive Order #122*. Contractors are expected to follow the standards described in each of three sections:
 - a) Standards for Purchased Food: Addresses food items purchased by contractors and gives specific standards by food category.
 - b) Standards for Meals and Snacks Served: Addresses the overall nutrient requirements that should be achieved based on the number of meals and snacks served and describes standards for snacks and special occasions.
 - c) Contractor and Population-Specific Standards and Exceptions: Describes standards for specific populations (e.g. children).

H. AWOLS, Warrants and Transportation Arrangements for Return to Program

1. The LSP contractor must follow ACS policies related to AWOLs.

I. Arrests

1. LSP contractors must follow ACS policies related to arrests of youth and reporting arrests of youth.

J. Transfers to Another LSP Facility

1. A lateral transfer involves the transfer of a youth from one LSP facility to another. All LSP contractors are required to adhere to ACS policy regarding transfers to another LSP facility.

K. Modifications

1. An order of placement entered pursuant to FCA § 353.3 may be modified when there has been a showing of a substantial change in circumstances. See FCA § 355.1. There

are a number of factual scenarios that may result in a modification application. All LSP contractors are required to adhere to ACS policy regarding modifications of placement.

L. Length of Stay Waivers

1. The average length of stay for each youth is seven (7) months. Length of stay is calculated by adding the length of stay plus ten (10) days from the date of the placement order. LSP contractors are required to submit a waiver request to the ACS Placement and Permanency Specialist if they wish to extend the length of stay for a youth beyond seven months from the date of placement. Extension requests may be for a maximum of two (2) months at a time. Only youth who meet the following criteria will be considered for a waiver:
 - a) Youth who display physically threatening, destructive, or dangerous behaviors;
 - b) Youth who exhibit behaviors that suggest that they are actively suicidal, homicidal, or psychotic and are will not be able to be discharged to the community;
 - c) Youth whose time has been tolled as a result of an AWOL, and additional time in placement is necessary to address threatening, destructive or dangerous behaviors;
 - d) Youth who lose their identified release resource and, while a Family Court order to place the youth in foster care is being pursued, no other appropriate release resource can be identified and assessed;
 - e) Youth whose identified release resource becomes temporarily unable to support the youth due to a situation that is likely to be resolved within a reasonable time.
2. The following information must be included in the waiver request:
 - a) A thorough explanation for why a waiver is being requested;
 - b) A detailed action plan for how the additional time will be used to address the problem requiring continuing the placement;
 - c) Why the problem cannot be safely addressed while the youth is residing in the community; and
 - d) Any other reports as supporting documentation.
3. Children's Services will review the waiver and make a decision within five (5) business days to either:

- a) **Approve:** If the decision is to approve the waiver, the LSP contractor's action plan for the youth's continued time in placement will be reviewed and modified as appropriate and subsequently reviewed on a continuing basis by the ACS Placement and Permanency Specialist.
 - b) **Disapprove:** If the waiver is disapproved, the seven month case management and transition plan for the youth/family will remain the same and the LSP contractor will maintain responsibility for transition planning to ensure the youth is ready for release within seven months.
- 4. If the LSP contractor requests a case conference to discuss the reason for the waiver application or to grieve the decision to deny the waiver, the request for a case conference will be granted and a case conference will be arranged by the ACS Placement and Permanency Specialist.
 - 5. If the LSP contractor wishes to extend a placement beyond the time granted in a waiver, a new waiver must be submitted, per the protocols below.

M. Extension of Placement

- 1. Family Court Act Article 3, section 355.3 provides for the placement of juvenile delinquents to be extended beyond the original date of expiration. This includes consideration of detention time spent in connection with the placement and previous local district placements. ACS must file a petition in court at least sixty (60) days prior to the placement expiration date. Generally, when an extension of placement (EOP) is requested, an extension of placement petition (OCA form 3-38) will be filed. If the petition is not filed within the mandated timeframes but is filed within 60 days before the placement expiration date, the petitioner must show **good cause** for such lateness. If the court makes a determination that there was not good cause to file late, the court must dismiss the petition. In no case can the petition be filed after the placement expiration date.
- 2. The court may grant successive extensions of placement. However, no placement may be continued beyond the placed youth's eighteenth birthday without the youth's consent. No placement can be extended past the youth's twenty-first birthday.
- 3. Procedures for filing extension of placement petitions
 - a) All EOP petitions will be developed in conjunction with ACS, and ACS will approve their content and submission to the court.
 - b) When petitions must be filed:

- i. Extension of placement petitions: The EOP petition must be prepared by the ACS Placement and Permanency Specialist ninety (90) days in advance of the expiration date and must be filed with the Family Court at least sixty (60) days prior to the placement expiration date. The initial placement expiration date appears on the Youth Fact Sheet provided by ACS. All subsequent expiration dates appear on the extension of placement orders.
- c) When submissions must be made in support of petitions:
 - i. The LSP case planner must provide the ACS Placement and Permanency Specialist with the necessary supporting documentation to file an EOP petition. Such documentation must be submitted to the ACS Placement and Permanency Specialist at least 90 days prior to the placement expiration date. In the event that a late EOP must be filed, the supporting documentation must be submitted as soon as possible, and must include information pertaining to the reason for the late submission.
 - d) Late Filing: Where an extension of placement petition is filed within 60 days of the placement expiration date, the ACS Placement and Permanency Specialist must submit an affidavit outlining good cause for the late filing. For example, good cause may be found where the youth's behavior deteriorates and is, as a result, a threat to public safety within sixty (60) days of the expiration date.
- e) Submission of petitions
 - i. After reviewing the documentation and preparing the petition, the ACS Placement and Permanency Specialist will be responsible for seeing that the petition is completed and filed by Intake staff or the FCLS Court Liaison, as applicable. The FCLS Court Liaison or the ACS Placement and Permanency Specialist will inform the LSP case planner of the scheduled court hearing date.
 - ii. Upon notification of the hearing date, ACS in conjunction with the LSP contractor will arrange for personal service of the petition and the date and time and location of the appearance upon the youth and his/her parent/guardian, attorney and the presentment agency.
 - iii. The LSP case planner must provide an updated court report to the ACS Placement and Permanency Specialist at least 15 days before the court appearance. The ACS Placement and Permanency Specialist will provide the updated report to the FCLS Court Liaison, if available, or the appropriate Intake Office for filing with the court. Copies will be provided to those who must be served with the petition.

- iv. The LSP contractor is required to permit ACS placed youth receiving a copy of a petition reasonable access to contact their attorneys and the ACS/DYFJ Office of the Ombudsman, upon the youths' requests.
 - v. On the court date, the LSP contractor must timely produce the youth in court. A representative of the LSP contractor who is capable of giving testimony about the youth must be present in court. The ACS Placement and Permanency Specialist will be present or make arrangements for another ACS professional staff to be present.
 - vi. LSP contractor employees, counselors, and mental health staff should refer any calls or communications from legal representatives concerning ACS youth to the ACS Placement and Permanency Specialist. The ACS Placement and Permanency Specialist may then refer the legal representative to FCLS for a response.
- f) If the petition is not contested:
- i. If the matter is not contested, the FCLS representative will ask the court to accept the petition with attachments and updated report into the record and be prepared to discuss plans for further service. The FCLS representative will ask the court to make findings on the record that:
 - (a) The steps that must be taken to implement the plan for release or conditional release including school enrollment or vocational planning;
 - (b) The period of extension of placement.
 - ii. If the matter is not contested and there is an extension of placement order submitted with the petition, the FCLS representative shall bring a copy of the order to court, be sure that the order is properly completed. If circumstances have changed substantially, a new order should be drafted. The FCLS representative shall fill in or correct any information which must be changed in the order and ask the judge to initial the changes. The changes will likely include, but may not be limited to:
 - (a) The date of the appearance in court. This is inserted in the paragraph above the caption on the first page.
 - (b) The date by which the next petition for an extension of placement petition must be filed (i.e. sixty [60] days before the next placement expiration date).

(c) The persons who appeared at the hearing.

(d) Any adjustments to the placement extension period based on settlement.

g) If the petition is contested:

- i. If the matter is contested and the next scheduled date is after the expiration of the placement, the ACS representative must ask the court to order a temporary extension of the placement to accommodate the next date, which must be within 30 days of the expiration of the placement. If necessary, the representative shall advise the court that the placement cannot go beyond 45 days after the expiration of the placement. The FCLS representative shall also notify all necessary parties of what occurred in court.
- ii. The LSP contractor is required to provide another updated report to the ACS Placement and Permanency Specialist at least 15 days before the hearing date. The report will be provided to all parties and FCLS.
- iii. The LSP contractor shall provide an appropriate witness to testify at the hearing who will arrive in a timely manner. The LSP contractor shall see that the youth is produced at court in a timely manner.
- iv. The FCLS Court Liaison shall forward a copy of any order resulting from the hearing to the ACS Placement and Permanency Specialist and LSP contractor case planner as soon as it becomes available.

N. Planned Release Out-of-State

1. Planning for out-of-state release for a youth with an active court placement is coordinated between the LSP case planner and the ACS Placement and Permanency Specialist.

a) Release to Parent or Legal Guardian

- v. At least sixty (60) days (and preferably more) before the anticipated release date, the NSP case planner complete and have the youth sign Interstate Compact for Juveniles (NY CLS Exec. 501-e) Form 1A and Form VI. Three copies of the completed Form 1A and Form VI and a recent progress report shall then sent to the ACS Placement and Permanency Specialist. The ACS Placement and Permanency Specialist will complete Juvenile Interstate Compact Form IV, including the recent progress report and other appropriate case material (see Form IV) and send three copies of all the material to the OCFS Juvenile Interstate Compact Coordinator at the OCFS Office in Rensselaer.

- vi. The OCFS Juvenile Interstate Compact Coordinator will send this information to the Interstate Compact Coordinator of the receiving state. The receiving state will conduct an investigation of the parent or legal guardian's home and will send its report and findings along with recommendations concerning the home environment, to the OCFS Juvenile Interstate Compact Coordinator. The Interstate Compact Coordinator, in turn, will send this information to the ACS Placement and Permanency Specialist. The ACS Placement and Permanency Specialist will forward a copy of this information to the NSP case planner. If the release to out-of-state is approved, the ACS Placement and Permanency Specialist and the LSP case planner shall make the necessary arrangements.
 - vii. Although a receiving state may recommend that a youth not be released to that state, a receiving state cannot refuse to accept supervision of a youth if a youth's parents or legal guardian reside in the receiving state.
 - viii. If problems arise while the youth is residing in the supervising state, that state may request that the youth be returned to New York where alternate case planning will be made for the youth. However, the decision to allow a youth to return is at the discretion of ACS.
- b) Release to Person Other than Parent or Legal Guardian
- i. At least sixty (60) days (and preferably more) before the anticipated release date, the LSP case planner complete and have the youth sign Interstate Compact Form 1A and Form VI, and should obtain a recent progress report.
 - ii. Three copies of the completed Form 1A and Form VI and the progress report must be sent to the ACS Placement and Permanency Specialist. The ACS Placement and Permanency Specialist will complete Interstate Compact Form IV and obtain a consent form signed by the youth's parent or legal guardian giving permission for the youth to reside with the prospective release resource. Three copies of these forms, along with the progress report on the youth's adjustment at the LSP facility and other appropriate case material (see Form IV), must be sent to the OCFS Interstate Compact Coordinator in Rensselaer. If more appropriate, the consent form can be signed by the parent in the presence of the LSP case planner and sent to the ACS Placement and Permanency Specialist.
 - iii. The OCFS Interstate Compact Coordinator will send this information to the Interstate Compact Coordinator of the receiving state. The receiving state will conduct an investigation of the prospective release resource's home and will send to the OCFS Interstate Compact Coordinator its findings, along with recommendations concerning the home environment and a statement indicating whether or not they will accept supervision of the youth. The OCFS Interstate Compact Coordinator, in turn, will send this information to the ACS Placement

and Permanency Specialist, who forwards a copy of this information to the LSP case planner. Appropriate next steps will take place between the ACS Placement and Permanency Specialist and the LSP case planner to carry out plans for the youth.

- iv. Should the receiving state agree to supervise the youth and should the youth not make a satisfactory adjustment while under supervision, the supervising state may contact the OCFS Interstate Compact Coordinator and request that the youth be returned to New York State. The OCFS Interstate Compact Coordinator will then make arrangements after discussion with the ACS Placement and Permanency Specialist for the youth to return to New York where alternate plans will be made for the youth.
- c) Youth in the custody of a local social services district
 - i. Where a youth has also been placed in the care and custody of ACS on a matter other than a delinquency proceeding, there must also be approval for the out of state placement under the Interstate Compact on the Placement of Children (*Social Services Law, section 374-a*). In such a case, the ACS Placement and Permanency Specialist must coordinate internally with appropriate staff. The ACS Central Office of Interjurisdictional Placements must be contacted for instructions as to how to proceed.

O. Case Closing Criteria and Procedures

1. General Requirements of the LSP Contractor

- a) The LSP contractor is responsible for ensuring safe, timely, and appropriate discharges of youth from care and adhering to an average length of stay of seven (7) months. When youth are being returned to their families, the contractor is responsible for determining that the parent will be able to provide a safe home for the youth prior to discharge. LSP contractors shall link youth and families to community-based services such as school and after school programs, child care, support groups, in-home supports (e.g., New York State Office of Mental Health Home (OMH) and Community Based Waiver program, the New York State Bridges to Health Waiver program, services through the New York State OMH or New York State Office of People With Developmental Disabilities (OPWDD) services, case management services, school-based services, alcohol and other drug prevention services, and preventive services).
- b) For young people who will require clinical supports as adults, LSP contractors are responsible for guiding them through the application process for supportive housing

or other services available through adult social service, health, and mental health systems.

P. Discharge Planning and Aftercare

1. Comprehensive discharge planning must begin upon admission to an LSP facility. Upon release from an LSP facility, youth will transition to aftercare. Details pertaining to aftercare services are described later in these Quality Assurance Standards.
2. LSP contractors are responsible for facilitating the youth's enrollment in Medicaid, Social Security, and other government assistance programs as early as possible/appropriate.
3. Discharge Planning – Health
 - a) The LSP contractor shall ensure that all youths' health care is up-to-date and all referrals are followed up prior to release, including filing all paperwork for transitioning into community Medicaid or private insurance. The LSP contractor shall provide all youth with a medical exam at discharge pursuant to the provisions of *Title 18 NYCRR 441.22 (n) and (o)* or any successor or amended regulation. The LSP contractor shall ensure that health services are available to all children/youth released from placement and help children/youth obtain medical coverage by assisting with the Medicaid application process or linking the child to low-premium health insurance options, such as Child or Family Health Plus. The contractor shall ensure that health records are up-to-date and all records are transferred to the discharge resource person and the post-discharge health services provider at no cost, as appropriate, pursuant to the provisions of *Title 18 NYCRR 441.22(n) and (o)* or any successor or amended regulation.
 - b) The LSP contractor shall work with the discharge resource person and/or the youth, as age appropriate, to identify and establish a linkage with the youth's post-discharge primary care provider and mental health provider, if indicated. Where appropriate and available, the post-discharge provider shall be located in the child's discharge neighborhood.
4. Discharge to APPLA+
 - a) When youth are being discharged to APPLA+, the LSP contractor is responsible for providing a transition plan per Title 18 NYCRR 430.12(j) or any successor or amended regulation; the standards for preparation for discharge set forth in Title 18 NYCRR 430.12 (f)(2)(i)(a) or any successor or amended regulation; the stipend standards in 43012 (f)(2)(i)(b) or any successor or amended regulation; the issuance of consumer reports as required by Title 18 NYCRR 430.12(k) or any successor or amended regulation; and the following actions:

- i. Commencing planning for that discharge at or before the youth's sixteenth (16th) birthday;
- ii. Referring the youth to a facility and/or program that will be able to begin serving him/her upon discharge; and
- iii. Making and documenting best efforts to identify and connect the youth to a caring adult who is willing to make a commitment to the young person's future well-being beyond the age of 21 (twenty-one), even though the youth will not be living in their home.

Q. Prison Rape Elimination Act (PREA)

- 1. All LSP contractors are required to comply with applicable federal Prison Rape Elimination Act (PREA) requirements.¹

R. Provision of Services

- 1. All LSP providers must have the ability to house and appropriately serve youth who are eligible for specialized and specialty services.

¹ <http://www.prearesourcecenter.org/sites/default/files/library/preafinalstandardstype-juveniles.pdf>

PART IV: PROGRAM APPROACH AND COMPONENTS

The program services outlined in this section are in addition to the to the services that must be provided to youth as delineated in Part III of these *Juvenile Justice Limited Secure Placements Quality Assurance Standards* and all services must seamlessly integrate.

A. Program Approach

ACS's approach to LSP reflects a deep commitment to providing a safe and productive environment, while engaging youth in a range of activities that support safe reintegration into their home communities after placement. This approach moves away from traditional correctional models toward a rehabilitative and therapeutic one that provides support and supervision to young people; considers youth's families to be allies and partners in achieving successful reentry; develops healthy peer-relationships; and provides targeted support and programming that helps young people develop academic, pre-vocational and communication skills. Through evidence-based and promising practice models in juvenile justice, LSP contractors are encouraged to develop programs anchored on the key components listed below, that will ensure a safe and productive time in placement for youth, and will prepare them and their families for a successful return home.

1. LSP contractors must utilize a LSP practice model or approach that will be the basis for all services that are provided in LSP Program sites. The approach or model must be supported by best practices in the field, have evidence of good outcomes in the past, reduces recidivism, utilizes a clear training and coaching curriculum, includes a staff accountability system that assists the provider in ensuring that staff are incorporating their training into their work with youth and families, includes youth/engagement strategies that have been demonstrated to work with the populations served, and includes a clearly articulated behavior management program that also supports academic success.
2. Proven Approach
 - a) LSP Practice Model or Approach
 - i. LSP practice models or approaches are services models that have shown good results and/or outcomes in implementation but have or have not yet been replicated in another community other than the originating community, or do not have comprehensive clinical trial data supporting the model/approach.
 - ii. LSP practice models or approaches are comprehensive service delivery models that utilize specific interventions to improve outcomes for youth and families involved in the juvenile justice system. All LSP practice models or approaches must provide some data that show positive outcomes achieved by the model/approach, as compared to an objective benchmark, in the areas of

reducing recidivism, school achievement, and other positive outcomes for youth and families.

- iii. It is not expected that there will be randomized clinical trial data for LSP practice models or approaches. Examples of acceptable types of data that could support LSP practice models or approaches include, but are not limited to, system reentry data, re-arrest self-report data, case completion data, self-assessments completed by families, and average length of service data.
 - iv. Additionally, a LSP practice model or approach is further defined as a model/approach that is designed using demonstrated best practices with the target population and supported by successful data in similar jurisdictions with a similar target population. All LSP practice models or approaches must also meet the goals, objectives, and requirements of these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*.
3. Data-Driven, Outcome-Oriented Approach
- a) LSP contractors must implement a LSP practice model or approach that is designed to promote ACS' goals with teens and families. The LSP practice model or approach must include built-in capacity to use data to track staff performance and youth outcomes, and to use data to facilitate a continuous quality improvement process.
 - b) LSP contractors shall have a process of systematic collection of information on youth and family characteristics, staff characteristics, and participant service experiences to ensure services are being implemented with fidelity to the LSP practice model or approach program intent and structure.
4. Implementation of Model/Approach
- a) LSP contractors must provide intensive LSP practice model or approach training and coaching to all staff in LSP Programs by engaging a consultant/developer to provide forty (40) to eighty (80) hours of pre-service training for all Contractor staff and ongoing on-site coaching. For the first two (2) years of an LSP Program operation, coaching must take place on-site at least three (3) weeks (fifteen days) per month. After the first two (2) years of initial implementation, coaching must take place on an as need basis or as required by ACS. If the LSP practice model or approach utilized by the LSP contractor has less than the above specified training and coaching requirements, the LSP contractor must demonstrate to ACS how staff will learn the necessary skills to successfully implement the LSP practice model or approach.
 - b) LSP contractors must make accessible all documents of the model/approach training and coaching so that ACS may monitor the success of the model/approach implementation.

- c) LSP contractors must allow ACS access to gather information from the model/approach developer/consultant that is providing the training and coaching on the Contractors' implementation of the model/approach.
- d) ACS may require the model/approach developer/consultant to participate in implementation activities including but not limited to conference calls and meetings.
- e) ACS will contract directly with the model/approach developer/consultants in order to provide technical assistance and streamlined communication related to LSP contractor's performance in model/approach implementation.

5. LSP Practice Model or Approach Adherence

- a) LSP contractors must comply with the LSP practice model or approach in connection with its provision of services. Any deviation from the proposed LSP practice model or approach without direct approval from both ACS and the LSP practice model or approach developer/consultant is not permissible. Adherence includes full compliance with the clinical, administrative, and monitoring requirements set forth by the LSP practice model or approach.
- b) Model/approach adherence requirements include but are not limited to: clinical adherence to each LSP practice model or approach according to the mandates of their respective interventions; including quality assurance activities required by each model/approach.
- c) Quality assurance activities may include but are not limited to: input of case data into database operated by the developers of the LSP practice model or approach; regular and frequent supervision of direct service staff to support and guide their ongoing practice; regular and frequent consultation with therapeutic consultants selected by the LSP practice model or approach developers; and, with the permission of the youth and his/her family, recording of therapeutic sessions to ensure adherence to LSP practice model or approach by staff.

6. LSP Practice Model or Approach Critical Elements

- a) Strength-based youth development approach
 - i. LSP Programs must build on the youths' existing strengths and competencies, while also meeting their developmental needs. The practice model or approach must build on youth and family strengths and work within a clear framework to promote positive change in youth. The goal of programming during and after placement is to support youth to develop to their fullest potential and become

healthy, educated, and constructive members of the community with successful transitions to adulthood.

- ii. LSP Programs shall be designed in a way that youth live with others in their age group, gender, gender identity and/or developmental stage, and/or educational level, such as youth who are twelve to fourteen (12-14) and fifteen to seventeen (15-17) years of age. (Most youth residing in LSP Program sites will be between the ages of fourteen (14) to eighteen (18), however, there may be occasions where LSP Program sites will serve older or younger youth.) Contractors must take school level, such as middle school and high school designations, into consideration when designing LSP programs. All LSP Programs, unless designated for a specialized population with intellectual disabilities, shall have the capability to serve youth with IQs of seventy-one (71) and above, and they shall be able to accept youth with lower IQs, on a case-by-case basis, where low scores are due to mental health conditions.
 - iii. LSP Programs shall provide youth development activities that provide opportunities for youth to develop skills and gain experience in a work environment, in building and maintaining relationships, in community involvement and service, in personal health, in education and career planning and goal setting, and in personal creative expression.
- b) Family engagement and identification of a network of support
- i. To ensure that youth have the support necessary to achieve program goals while in placement, and to support successful reentry, program planning must begin with the identification of family and/or a network of support for each youth. Engagement of and outreach to a youth's family and/or network of support must be sustained throughout a young person's placement, and should include ongoing consultation on treatment planning. Staff must reach out to family members and involve them both as allies in planning and partners in the treatment of young people. Youth's families and/or networks of support will also be eligible for supportive assistance.
 - ii. LSP contractors shall have flexible hours in the early morning, evening and/or on weekends and holidays to accommodate family members or other discharge resources who work, attend treatment or school, or are otherwise engaged in essential activities.
 - iii. Contractors shall hire a family worker to facilitate and promote family engagement, permanency planning, transition planning, and home visits as outlined in these Standards.

- c) Smaller facilities located near youths' homes and families, with closely supervised small groups
 - i. Every effort will be made by ACS to place young people in LSP facilities in or near their home communities to facilitate family and community engagement. Young people will live in closely supervised small groups, where peer-support will be encouraged while youth also receive ongoing individualized treatment.
- d) Use of needs assessments for targeted needs-based service
 - i. The risks and needs of each youth shall determine the service and program focus for each during and after placement. To ensure that programs are targeting youth's specific needs, LSP contractors are required to use validated needs assessments, subject to ACS approval, to inform individualized treatment plans.
- e) Individualized treatment plans and goal-setting
 - i. All youth in LSP must receive an individualized treatment plan detailing identified needs, emerging needs or risks, programming, and achievement. The youth and family must be engaged and encouraged to participate in the treatment planning process. Individualized treatment plans shall be updated throughout placement, shall include identified short and long-term goals for youth, and document the achievement of goals during the course of placement. Treatment goals must be measurable and where appropriate, Contractors shall use tools to measure progress towards meeting individual treatment goals.
- f) Therapeutic interventions
 - ii. In addition to or as part of the LSP practice model or approach that is the basis for the LSP Program services, LSP contractors must provide specific targeted therapeutic services to youth demonstrating behavioral issues and mental health and/or substance abuse needs. These targeted services must include therapeutic interventions that are proven, through data and research, to successfully treat common behavioral issues found in youth involved in the juvenile justice system such as aggressive and assaultive behaviors and running away. These interventions must also be proven, through data and research, to successfully treat common mental health diagnoses found in youth involved in the juvenile justice system such as, but not limited to, Depression, Anxiety, Substance Abuse/Use, Post Traumatic Stress Disorder, and Conduct Disorder. Additionally, these interventions must include targeted services for youth with co-occurring diagnoses as well.

g) Peer-support and small group-work/collaboration

- i. LSP contractors must deliver programming in small group settings (10 youth per group for ACS sites, and ACS suggests 6 youth per group for non-ACS sites) to encourage positive peer relationships among youth. Small group treatment, together with direct support and supervision from staff, will prevent youth from withdrawing and will encourage group accountability for any disruptive or disrespectful behavior. The program design shall include opportunities for group discussion and reflection and promote an environment of support and encouragement for youth. Though groups will have rotating entry and exit as youth are placed and others return home, they shall remain stable and under the supervision of steady program staff, to encourage peer-support among youth. Groups must be formed with young people of similar ages and developmental functioning.

h) Direct and close supervision

- i. To establish an environment where youth feel safe from physical or emotional abuse, and to minimize untoward incidents during placement, LSP staff must practice close and direct supervision. Youth must remain in direct eyesight of the staff, or where necessary for privacy of the youth, the staff must remain in direct earshot of youth at all times. Where youth are sleeping in individual bedrooms, staff must be posted in positions where they can maintain maximum eyesight and earshot of youth. This approach must emphasize observation, relationship-building, direct communication and intervention to prevent new or emerging issues or conflicts between young people. To encourage relationship-building and trust, LSP contractors are expected to have steady staff to supervise youth. Staff are expected to supervise, implement group and individual treatment plans, provide group counseling and develop constructive relationship with youth. To the extent possible, staff must work with the same group of youth from their admission to placement through their release.

i) Seamless transition to the community

- i. To reduce recidivism and improve short and long-term outcomes for all youth in placement, reintegration planning must begin at the time of admission. In coordination with ACS, LSP contractors shall develop an array of strategies, supports and tools for each youth to ensure their successful reintegration into their home community post-release. The LSP contractor must engage and encourage the youth and family to participate in planning for the youth's reintegration. These efforts shall include family reunification and permanency planning; educational engagement; vocational and work skill-building; counseling and emotional support; and connection with community-based services for both youth and their families.

- ii. During year one of LSP, LSP contractors are required to accept youth being transferred from OCFS into LSP Aftercare. The LSP contractor must fully and comprehensively plan for and provide LSP Aftercare services to these youth and families or other discharge resources.

B. Program Components for Youth in Limited Secure Placement

1. Family Engagement, Permanency Planning and Visitation Plans

- a) Family engagement and participation are critical elements in LSP services. All LSP providers must hire a full time family worker (credentials are detailed further in this document) who will work directly with youth and families to promote engagement and participation and to assist with family related discharge planning activities.
- b) Family Engagement: The LSP contractor shall promote the engagement and involvement of parent(s) and/or a network of support consisting of extended family or other discharge resources in every aspect of the youth's life, including but not limited to decisions regarding the service plan, education, medical issues, development and overall well-being.
 - i. Regular communication with family: In addition, the LSP contractor shall take measures to facilitate the attendance of parent(s), family, extended family or other discharge resources at occurrences such as school conferences and medical appointments, and shall update parent(s), family, extended family or other discharge resources on the outcome of such events when they are unable to attend.
 - ii. Responsibility and documentation: Case planning and other support staff are responsible for ongoing engagement with the youth, his/her family, discharge resources and/or network of support. They are also responsible for documenting this work in the case record
 - iii. Staff training: LSP contractor staff shall be given skills training to develop their ability to effectively engage parents, family members and other discharge resources, to understand the challenges that birth parents, families and other discharge resources face when youth are placed in care, and to appropriately address concerns when parents, family members and other discharge resources are not responsive to planning efforts.
 - iv. Family team conferencing: Children's Services will require, as necessary, LSP contractors to implement family team conferencing or family team meetings.

- c) **Permanency planning:** The delivery of services must be anchored in a family service philosophy and approach. It is required that discharge, transition, and permanency planning begin on day one of a youth's placement.
- i. Engagement with youth to identify community network of support: Many teens know best who the caring, committed adults are in their life. Permanency for teens requires a partnership with young people to identify the key people in their lives, including but not limited to parents; members of their extended family such as grandparents, older siblings, godparents, aunts, uncles, cousins; family friends and neighbors; current and former foster parents and group home staff; school and after-school personnel; and other responsible adults whom the youth trusts and with whom the youth feels safe.
 - ii. Coordination with ACS Placement and Permanency Specialist: An ACS Placement and Permanency Specialist will be assigned to the case of every youth. Coordination with the ACS Placement and Permanency Specialist by the LSP contractor, and vice versa, is critical to the success of the placement and permanency plan.
 - iii. Practices to encourage family engagement and reunification: The LSP contractor shall operate according to the following principles and practices in efforts to maximize and improve safety, permanency and well-being for youth in care:
 - (a) Maintain placement stability that minimizes the occurrence of replacements or upward modifications and provides consistency in care throughout the time that youth remain in care;
 - (b) Ensure safety while in care;
 - (c) Implement discharge planning and services to avoid the need for entry or reentry of a youth into foster care and/or juvenile justice system after discharge;
 - (d) Implement services and support for youth to develop to their fullest potential and become healthy, educated, and constructive members of the community with successful transitions to adulthood.
 - iv. Information-sharing: Children's Services will share with the LSP contractor any current assessments of the youth's needs, including court ordered evaluations, such as the Department of Probation's Investigation and Report (I&R) and the Health and Hospitals Corporation's Mental Health Study (MHS).

- d) **Visitation and Telephone Contact with Families:** Contact between youth and family members or other discharge resources is critical to supporting youths' well-being, and helping them sustain relationships with important people in their lives.
- i. **Responsibility:** It is the LSP contractor's responsibility to arrange and facilitate visits and other forms of contact between the youth and parent(s), family, extended family or other discharge resources, unless restricted or prohibited by court order. When appropriate, phone contact between the youth and parent(s), family, extended family or other discharge resources shall occur throughout placement. So long as visitation does not compromise the safety of the youth or is prohibited by court order, LSP contractors must facilitate agency, day and home visits.
 - ii. **Home Assessment:** The LSP contractor shall visit the family's or discharge resources' home and perform a home assessment prior to the youth's first home visit and, throughout the youth's placement (at a minimum).
 - iii. **Documentation and communication:** The LSP contractor is responsible for documenting any reasons why either phone contact with family members or visits with family members are not permitted. Such documentation must be included in the youth's case file and shared with ACS. The LSP contractor must individually discuss how the visit went with the dedicated visiting staff, the youth, and the parent[s], family, extended family or other discharge resources.
 - iv. **Minimum frequency:** In order to maintain relationships and begin the discharge planning process, visits shall begin as soon as possible after placement. The LSP contractor must contact the youth's family to arrange a visit within two business days of the youth arriving in the LSP facility. Youth shall be permitted a minimum of one family visit and two to three telephone calls to family members per week. Prohibiting visits and telephone calls to family members, to under this minimum threshold, cannot be used as a form of discipline or punishment for the youth.
 - v. **Agency Visits:** Visits at the LSP facility shall be arranged in the evening or weekends, when appropriate and necessary, to accommodate the schedules of youth and their parent(s), family, extended family or other discharge resources. Opportunities for visits at the LSP facility shall happen at a minimum of two times per week to accommodate the schedules of youth and their parent(s), family, extended family or other discharge resources. The LSP contractor shall ensure accessibility to family members and other visiting resources with physical disabilities including, but not limited to, developing plans for: making facilities wheelchair accessible, utilizing sign language interpreters and large print informational reading materials. Transportation of any approved visitors to the facility must be provided by the LSP contractor, or reimbursement of costs to the visitor must be made.

- vi. Day Visits: As part of the discharge planning process, and to begin the transition from the LSP facility back to the community, LSP contractor staff supervised day visits by the youth to the home of the parent[s], family, extended family or other discharge resources must begin at the discretion of ACS with information and consultation from the LSP contractor. The youth must have a minimum of 4 (four) supervised day visits prior to the required home visits described below.
- vii. Home Visits: A home visit is defined as an overnight visit to the home of the parents or discharge resources. At a minimum, at least 2 (two) home visits must occur as part of the discharge planning process to foster positive youth and family development.
 - (a) When determining eligibility for a home visit, the provider shall consider the following factors:
 - (i) Assessment of the home of the visiting resource;
 - (ii) Completion of the required 4 (four) supervised day visits;
 - (iii) Youth's overall adjustment to the program;
 - (iv) Youth's length of stay in placement and the proximity of their anticipated release from the LSP facility;
 - (v) Youth's legal history and past community behavior;
 - (vi) Clinical benefits to the youth of a home visit;
 - (vii) What supports can be put into place by the LSP contractor to ensure a successful home visit; and
 - (viii) Likelihood of AWOL
 - (b) All home visits must be approved by the ACS Placement and Permanency Specialist in advance of the visit. The LSP contractor shall notify and seek approval from the ACS Placement and Permanency Specialist at least 48 hours prior to any home visit. This notification shall include the name of the youth and his or her visiting resource; the address the youth will be visiting; the date and time of the youth's departure from and return to the agency; and the mode of transportation.
 - (c) The LSP contractor shall meet with the family and youth after each home visit to assess the success of the visit and determine the appropriateness of future home visits. This information shall be shared and discussed with the ACS Placement and Permanency Specialist to determine if future visits to this visiting resource are appropriate.
- viii. Support during visits: As part of the discharge planning process, the LSP family worker must provide oversight of and clinical services and appropriate support, including mentoring and counseling, to youth and the family during visits in the

community with family or other discharge resources.

- ix. When returning from a day or home visit the LSP contractor must search the youth in accordance with the ACS LSP search policy.

2. Individualized Treatment Planning and Casework

a) Individual Treatment Plan Requirements

- i. All youth in LSP will receive an Individualized Treatment Plan developed by clinically trained staff who are using interventions based in evidence that demonstrates positive outcomes for the specific needs of youth. LSP contractors must involve the youth and family in the development of the Individualized Treatment Plan. The plan shall detail the youth's strengths and interests, specific needs, emerging needs, risks, level of care required and specific measurable goals.
- ii. Within ten (10) days of placement, an interdisciplinary team composed of, but not limited to, a pediatric/adolescent medicine specialist, nurse, dietician (as necessary), psychiatrist or psychologist, mental health clinicians, educational, recreational, and vocational specialists shall meet to determine the most appropriate treatment and permanency plan for each youth. This comprehensive assessment shall integrate medical and nutritional assessments if done prior to the youth's referral.
- iii. Based on the initial assessment of youth's needs, the LSP contractor shall develop individualized written treatment plan (within 30 days) and daily program of schedules and activities that address the mental health, behavioral, and/or other clinical issues that necessitated the youth's placement into residential care and any services ordered to be provided by the court. The treatment plan shall include, at minimum:
 - (a) An assessment of the youth's needs, strengths and interests;
 - (b) Any safety or security alerts including any information related to gang-involvement or victimization;
 - (c) An explanation of the goals set for each youth while in residential care;
 - (d) A summary of services the youth will receive, and the timeframes for delivery of services;
 - (e) Behavioral expectations;
 - (f) Any achievement of treatment goals; and
 - (g) Behavioral Support Plan.

- iv. At minimum, LSP staff should conduct a weekly treatment team meeting to review treatment plans and goals. Treatment team meetings must include, if applicable, medical providers, the youth, parent[s], family, extended family or other discharge resources, and mental health providers, as well as any other relevant service providers, including any case planning agencies responsible for the youth.
 - v. A comprehensive treatment plan must be completed within 90 days of placement.
 - vi. The LSP contractor shall conduct periodic assessments (at least every 6 months) of each youth, and adjust the treatment plan to ensure that the youth is receiving proper and appropriate services based on his/her needs and changing conditions.
- b) Casework Contact
- i. The LSP contractor shall provide casework contacts in accordance with *Title 18 NYCRR Parts 441.21, 423.4, and 443.4* or any successor or amended regulation.
 - ii. Casework contacts with the youth's parent[s], family, extended family or other discharge resources is defined as individual or group face-to-face contacts between the caseworker and the youth's parent[s], family, extended family or other discharge resources for the purpose of assessing whether the youth would be safe if he or she was to return home. Such contacts are also for the purpose of guiding the youth's parents or relatives towards a course of action aimed at resolving problems, supervising the youth and addressing needs of a social, emotional, or developmental nature.
 - iii. In the case of foster youth with the permanency planning goal of APPLA+, such casework contacts are for the purpose of mobilizing and encouraging family support of the youth's efforts to function independently, and to increase his/her capacity to be self-maintaining; evaluating the ability of the parent[s], family, extended family or other discharge resources to establish or reestablish a connection with the youth and serve as a resource to the youth; and, where appropriate, encouraging an ongoing relationship between the parent[s], family, extended family or other discharge resources and the youth.
 - iv. During the first thirty (30) days of placement, casework contacts are to be held with the youth's parent[s], family, extended family or other discharge resources as often as is necessary, but at a minimum, must occur at least monthly unless compelling reasons are documented why such contacts are not possible.

- v. Best case practice dictates that discussion of discharge resources must be part of the case planning process. The LSP contractor is responsible for discussing and reviewing all changes of identified discharge resources during regular casework contacts with the youth and parent[s], family, extended family or other discharge resources, as well as with the ACS Placement and Permanency Specialist.
 - vi. Building on the initial assessment and treatment plan, the LSP contractor shall establish a Treatment Team for each youth, led by LSP contractor staff, to follow the youth's progress, determine the most appropriate treatment for each youth, and determine changes necessary to improve the emotional and physical well-being of the youth, and family/caretaker. The team members shall include but not limited to the following, as appropriate for each youth's service needs and plan: family/caretaker, the youth, a medical professional [Medical Doctor (MD), Register Nurse (RN) or Licensed Professional Nurse (LPN)], developmental specialist, psychiatrist, psychotherapist, psychologist, program director, social workers (including clinical social workers), youth skills trainer, caseworker who has daily contact with the family and educational, recreational, and vocational specialists. Each youth will have a treatment team meeting monthly. The youth and his or her family will attend these meetings, unless compelling reasons are documented in the youth's case file.
 - vii. The LSP contractor shall design a model of integrated practice with a special emphasis on coordinating treatment plans between LSP contractor staff (including on-site clinical staff) and other community service providers. The service plan shall include the full range of health and mental health services, extensive social services, and individually modified, structured, and appropriate recreational activities.
 - viii. All youth shall be assessed for past trauma and presenting trauma symptoms. Youth who have experienced trauma and/or loss shall receive evidence based trauma interventions proven to meet the specific needs of youth who have experienced various types of trauma, focusing on re-establishing physical and emotional safety, and group work sessions that promote a trauma-informed and safety-focused environment.
- c) Transition Planning
- LSP contractors are required to develop a transition plan in accordance with *09-OCFS-ADM-16*, or any successor or amended regulation, that must inform proactive decisions where a youth is leaving care on or after their 18th birthday. The ACS Placement and Permanency Specialist shall review and approve all such transition plans.

3. Expectation Setting, Behavior Management and Supervision

a) Setting Expectations

- i. Initial setting of expectations is critical to establishing a safe and secure environment for young people. LSP contractors must develop and implement a clear orientation process for youth and families that helps them understand what to expect in the facility – including facility policies, facility rules, what rights they have, and how to ask for services or help. The orientation must take place at admission or shortly after and be provided orally by staff in a manner the youth can understand, paying particular attention to language and literacy needs of youth.
- ii. Orientation components must include:
 - (a) Identification of key staff and roles;
 - (b) Rules on contraband and facility search policies;
 - (c) An overview of the behavior management system highlighting incentives for positive behavior;
 - (d) A review of behavior expectations, consequences that may result when youth violate the rules of the facility, and due process protections;
 - (e) Grievance procedures;
 - (f) Access to emergency and routine health and mental health care;
 - (g) Housing assignments;
 - (h) Opportunities for personal hygiene;
 - (i) Rules on visiting, correspondence, and telephone use;
 - (j) Access to education, religious services, programs, and recreational materials;
 - (k) Policies on use of force, restraints, and isolation;
 - (l) Emergency procedures;
 - (m) The right to be free from physical, verbal, or sexual assault by other youth or staff; and
 - (n) Nondiscrimination policies.

b) Youth and Parent Handbooks

- i. The LSP contractor must develop a youth handbook and a parent handbook to be provided to both youth and parent[s], family, extended family or other discharge resources
- ii. The Youth and Parent Handbook must include, at minimum:
 - (a) Description of the program structure – including behavior support plans
 - (b) Description of how supervision is provided to youth
 - (c) What youth and families can expect from the LSP contractor
 - (d) The LSP policy regarding the use of restraints

- (e) A user friendly description of any other applicable LSP policies
- (f) Grievance process

c) Direct and Supportive Supervision

- i. The LSP contractor shall provide supportive supervision that maintains and enhances the youth's functioning, and provides for the youth's safety and security.
- ii. Supervision shall include:
 - (a) Establishing clear rules appropriate to the developmental and functional levels of youth;
 - (b) Providing structured daily routines with clearly defined expectations;
 - (c) Incorporating regular opportunities in the schedule for staff to engage verbally with youth to assess emerging issues or needs;
 - (d) Providing intermittent interventions such as verbal guidance, assistance and monitoring

d) Behavior Management System

- i. The LSP contractor shall design a comprehensive behavior management system compliant with ACS Policy, and subject to ACS approval, that encourages and rewards positive behavior.
- ii. LSP staff must be thoroughly trained and knowledgeable about the system, and capable of delivering clear rules, responsibilities and expectations to young people in LSP.
- iii. The behavior management system must, at minimum, include:
 - (a) A graduated scale of incentives for positive and pro-social behavior;
 - (b) Mechanisms to track and periodically assess youth's behavior;
 - (c) Clearly outlined rules and responsibilities for youth; and
 - (d) Objective guidelines for staff.

e) Discipline

- i. Adherence to the behavior management system is considered the first step in establishing discipline for youth. Before defining what happens when a youth breaks a rule, LSP shall explicitly outline what program incentives a youth can

earn for pro-social, positive behavior. All LSP contractors shall have a written and ACS-approved, positive behavior management system/approach.

- ii. LSP providers must develop procedures regarding discipline, subject to ACS approval, that suit the young person's age, circumstances and developmental needs.
- iii. Disciplinary policies and procedures must be provided to each youth and their family, and must be a part of the orientation for all youth upon admission.
- iv. Disciplinary action may include:
 - (a) Reinforcing desired behavior by making explicit program incentives (e.g., additional phone calls or visits, later bed times, special home visits, etc.) readily available for youth who behave appropriately
 - (b) Modeling appropriate behavior;
 - (c) Giving explanations;
 - (d) Repeating instructions;
 - (e) Offering "time outs" ("time out" is when a youth is removed to a safe, unlocked place from the LSP programs for a limited time, not to exceed 30 minutes); and
 - (f) Enforcing or permitting logical or natural consequences
- v. The LSP contractor shall refrain from the following prohibited forms of discipline in accordance with *Title 18 NYCRR Part 441.9*, or any successor or amended regulation:
 - (a) Deprivation of meals, snacks, mail, personal hygiene, clothing, family visits, routine telephone calls to family, and access to needed health and mental health interventions
 - (b) Corporal punishment
 - (c) Pharmacological restraint
 - (d) Seclusion
- vi. The LSP contractor shall adhere to ACS policy regarding LSP room isolation.
- vii. The LSP contractor shall adhere to ACS policy regarding the use of restraints.
- viii. The LSP contractor shall adhere to ACS policy regarding LSP facility hardware.
- ix. The LSP contractor shall adhere to ACS policy regarding LSP searches.

- x. Discipline shall be prescribed, administered and supervised only by the LSP contractor staff. Such responsibilities shall never be delegated to youth. The LSP contractor must maintain a copy of discipline policies in writing.

4. Education

- a) Educational achievement is essential to a young person's development. All youth in LSP are required to attend a school in accordance with New York State Education Department and Local Education Agency (LEA) regulations. In general, all educational services must be provided onsite (except when youth are transitioning back to the community, at that point youth shall attend their community school or when youth have already received a high school diploma or GED).
- b) For New York City based sites NYC Department of Education (DOE) District 79 Passages Academy will provide the necessary teachers to support a one teacher to twelve student ratio and educational staff to deliver services. Educational services will be focused on youth earning high school credit in pursuit of earning a Regents diploma.
 - i. If the LSP contractor is proposing a site with multiple groups (sites with 12, 18, 24 beds), the LSP contractor must provide New York State certified teachers to support the ratio beyond the DOE staff to student ratio and ensure that each group of 6 youth will be educated separately by their own teacher. These teachers are accountable for adhering to the DOE/District 79 developed curriculum.
- c) For school settings outside of New York City maintained by LSP contractors, the Contractor must demonstrate that they are in good standing with the New York State Education Department. Additionally, Contractors must demonstrate that youth will earn credits that can be transferred to New York City schools, have access to all State exams and that youth will attend school on a regular basis.
- d) As part of the youth's transition back to their community and if determined after an individual assessment to be in the best interests of the child, the youth may attend his or her home school. LSP contractors are required either to transport all youth in their care attending a community school to and from school every day or, if it is decided, in conjunction with ACS, that a youth will be responsible for their own transportation to and from school, for maintaining a close relationship with the community school to ensure the youth is arriving on time, attending and achieving academic and behavior progress at the school. There will be constant communication and planning between the LSP contractor, DOE, and ACS. LSP contractors must obtain copies of Individualized Education Plans (IEP) and evaluations conducted by the DOE, and incorporate the IEP goals into the youth's overall service plan, including behavioral plans used in placement. The LSP

contractor must work with DOE, parents, foster parents, and youth to ensure that key transitions in youth's educational progress receive adequate attention. These key transitions include application to high school for eighth (8th) graders, and application to higher education or vocational training for youth leaving high school.

- e) LSP contractors in New York City and outside of New York City are required to hire qualified behavioral support staff that will accompany youth while in school on site each day to support the students and teaching staff in maintaining school wide and classroom environments conducive to learning and to assist DOE staff and LSP contractor teachers so that youth will be engaged in the learning process, and assist with positive behavioral interventions with individual students.
- f) LSP contractors are required to collaborate with the DOE to promote educational engagement and achievement with the intent to support youth in earning credit and pass Regents exams in pursuit of a high school diploma. Educational programming efforts will include:
 - i. Educational Assessment: LSP contractors are required to use an education based psycho-social assessment for youth and their family/guardian(s), which will be used, in coordination with DOE and ACS assessments, to determine the most appropriate level of educational services for the youth. The assessment shall include, but not be limited to:
 - (a) Educational goals and aspirations;
 - (b) Supports in the home to help youth achieve educational goals;
 - (c) Historical educational behaviors and attitudes; and
 - (d) Factors the family/guardian(s) feels they and the youth need for the youth to succeed.
 - ii. Educational Plan: LSP contractors shall provide for and work in collaboration with DOE to develop an educational plan for every youth that is appropriately based on an assessment of the youth's educational level. LSP staff must work in collaboration with the Case Manager and parent(s), family, extended family or other discharge resources to address any educational concerns; build and maintain collaborative relationships with the schools; provide advocacy on behalf of the youth; negotiate with the DOE staff to ensure the implementation of appropriate educational services; and monitor on-going performance.
 - (a) Components of educational plan for middle school youth: Middle school youth will have a plan that promotes their developmental, social, emotional, and academic growth measured by local/state assessments preparing them for high school. This includes services provided through the DOE Committee on Special Education, if indicated.

- (b) Components of educational plan for high school students: Students will improve skills measured by passing credit-bearing courses and local/ state assessments preparing them for graduation with a diploma, GED, post-secondary education, and/or skills for adulthood.
 - (c) Components of educational or vocational plan for youth with high school diploma or GED: Special consideration and planning is required of the LSP contractors for youth who have already received their high school diploma or GED.
- ii. Achievement track: LSP contractor staff shall ensure that adolescents are receiving appropriate educational services placing them on track to achieve a Regent's high school diploma, (except for situations where this standard is deemed unrealistic by an assessment of the particular youth's capacity). In situations where this standard is deemed unrealistic, LSP contractor staff shall assist the youth and family in the development of an alternative educational plan to maximize the youth's reading and math competency. The LSP contractor shall collaborate with DOE as DOE works to promote a Free and Appropriate Public Education (FAPE).
- iii. Tutorial services: The LSP contractor is required to secure and/or provide tutorial services as needed for all youth.
- iv. Coordination and communication with DOE personnel: LSP contractors are required to work with school personnel to develop and monitor plans for the youth's educational achievement. Existing educational deficits should be identified and addressed collaboratively by LSP contractors and DOE staff.
- v. Collaborative transition planning: The LSP contractor shall work with DOE, parents, foster parents, and youth to ensure that key transitions in youth's educational plan receive adequate attention. These include application to high school for eighth (8th) graders, and application to higher education or vocational training for youth leaving high school.
- vi. Special Education Planning: LSP contractors are responsible for engaging in special education planning when needed.
- vii. Individualized Education Plans (IEP): When applicable, LSP contractors should incorporate IEP goals into the youth's overall service plan.
- g) Communication with Youth's School: LSP contractor staff shall meet regularly with school guidance counselors, teachers, and other school staff to determine that youth are developing and learning at sufficient competency levels. When possible, appropriate school staff should be invited to a youth's treatment team meetings.

- h) Family Engagement with Youth's School: The LSP contractor shall engage the birth parent/caretaker and foster parent as active participants in the youth's education, and work to facilitate the birth parent/caretaker's involvement with the child's school
- i) Dedicated Staff: Each LSP contractor is required to identify at least one (1) Educational Liaison who shall have experience in education programming or a related field. The identified staff shall have an ability to make use of DOE data, education performance data provided by Children's Services, and educational information obtained by the case manager in support of best practice and case planning.
- j) Compliance: Children's Services will measure LSP contractor compliance including promotion of behavioral and academic achievement, and the Division of Policy Planning and Measurement will work with LSP contractors whose educational interventions with children are in need of improvement.
- k) Advocacy: LSP contractors shall advocate with the DOE for the provision of needed educational services; obtain legal assistance from education advocacy programs; and make use of technical assistance from Children's Services and community resources when needed.

5. Enrichment and Recreational Activities

Young people shall experience activities in LSP that are age-appropriate, healthy, and encourage pro-social behavior. It is critical that youth experience a mix of large muscle activities, structured group activities, and quite individual time to internalize work happening in the LSP facility and to dream about their future. The LSP contractor shall ensure that youth in placement are provided recreational opportunities in accordance with *Title 18 NYCRR Part 442.20* or any successor or amended regulation. Youth must be provided with opportunities to go outdoors regularly, engage in physical exercise, participate in a range of recreational activities including psycho-educational programming and culturally relevant programming, and practice their religion.

- a) Activities Plan and Schedule:
LSP facilities must adhere to a daily schedule of activities in each living unit that incorporates both structured and free time. Planned recreation programs shall be described in the LSP contractor's manual, and recreation schedules shall be posted in all LSP facilities. Both indoor and outdoor activities and other events from outside sources shall be included in the plan and schedule. LSP staff shall be required to log the date and reasons for any deviations from scheduled activities.
- b) Multidisciplinary Approach:

LSP contractors must keep youth occupied through a comprehensive multi-disciplinary program that builds skills, health, and increases youth's confidence and advancement.

c) Group Activity:

To the extent possible, without compromising safety or security, activities should be structured around small groups to encourage peer-support, teamwork, and a safe and collaborative environment.

d) Recreational Activities:

Recreation must include a range of structured activities appropriate for the gender, age and developmental level of youth in the LSP Program that include a mix of large muscle activity, quiet individual down-time, and structured group activities. Recreational activities shall take place in dayrooms or common areas inside and outside the LSP Program site, including but not limited to, reading, listening to the radio, watching television or videos, board games or other group activities, drawing or painting, listening to or making music, and letter writing. Additionally, All LSP contractors must deliver psycho-educational programming and where appropriate, that programming will utilize gender specific program models and culturally relevant programming that exposes youth to a diverse range of activities.

e) Frequency of Recreation:

i. Youth must go outside for recreation/exercise for at least one hour a day, weather permitting.

ii. Youth must have two hours of large muscle activities daily.

a) Preparing Youth for Adulthood (PYA):

Services that meet the long-term interests and needs of the population should be integrated into the programming. Youth who receive PYA services shall be provided programming that is specifically adapted to their psycho/educational functioning and which serves the long-term interests and needs of each youth.

f) Special Events:

Youth shall be involved in planning special events. These events shall be recorded in logs and reports.

g) Religious Observance:

LSP contractors must have written policies on religious observance, instruction and training. Access to religious services and clergy of the faith for each youth must be provided, as set forth in the written policy.

- h) **Special Populations and Gender-specific Programming:**
Planned recreational programs/activities shall be provided for all youth in care including special populations of children (e.g., mother-baby, special needs). The LSP contractor must provide appropriate gender specific programming as part of the overall facility recreation and program schedule. In the case of the mother-baby population, the LSP contractor shall offer recreational opportunities for the mother that permit respite from child-care responsibilities, and provide opportunities for child-bonding/relationship building.
- i) **Cultural Relevant:**
LSP programming must reflect the interests and needs of various racial and cultural groups within the facility, and shall be gender-responsive. The facility shall offer a range of activities such as art, music, drama, writing, health, fitness, meditation/yoga, substance abuse prevention, mentoring, and voluntary religious or spiritual groups. LSP contractors must continually assess the population and adapt programming to better engage the interests and needs of youth.
- j) **Direct Supervision:**
There shall be adequate supervision during *all* recreational activities (a minimum of two (2) staff members for every six (6) children). Staff should practice direct supervision favoring engagement, verbal communication and prevention of conflict, to ensure a safe and secure environment during recreational activities.

6. Programs Promoting Financial Independence

- a) **Financial Literacy:**
As set forth in *Title 18 NYCRR 441.12*, or any successor or amended regulation, LSP contractors shall provide youth in placement with financial literacy training and a regular allowance appropriate to the age of each child in care, which shall not be used to meet basic needs, and kept in the custody of the LSP contractor, separate from agency funds. Financial literacy programming shall include, but not be limited to:
 - iii. Financial Literacy – What does it mean to youth?
 - iv. Access to information on financial management
 - v. Understanding money in our society
 - vi. Practicing money management: saving, spending, budgeting, investing, and debt.
 - vii. Establishing and protecting credit: paying bills on time, role of credit cards, and role of credit scores
 - viii. Strategies for minimizing debt
- b) **Employment-related Training and Service Learning:**
LSP contractors shall offer opportunities for youth in placement to receive employment-related training and service learning in accordance with *Title 18 NYCRR*

430.12(f)(2)(i), or any successor or amended regulation, including but not limited to the:

- i. Assessment of the youth's abilities to find employment and keep a job: social and interpersonal skills, and self-awareness to develop a plan to improve and maximize the youth's skills.
- ii. How to prepare for the world of work, whether paid or unpaid: interview skills, how to conduct a job search, grooming, dress, punctuality, instructions, and completing tasks.
- iii. Referrals for career counseling, vocational assessments, and for training to identify appropriate placements and supports needed to secure and sustain employment.
- iv. Developing job leads in the private sector and working with potential employers.
- v. Developing linkages with local merchants, trade unions, and trades people to arrange possible apprenticeships, summer jobs, and other opportunities for young people.

7. Gender Specific and Gender Responsive Services for Young Women

- a) LSP contractors must provide LSP Program services that are responsive to the unique needs of youth. At the sole discretion of ACS, based on the youth in LSP Program sites, LSP contractors will be required to serve either female or male youth.
- b) LSP contractors must provide staff with tools and skills to enhance their understanding of gender specific youth development, especially the impact of physical, sexual, or emotional abuse, family dynamics and gender non-conforming youth.
- c) Programing and recreation must include activities that interesting to young females.
- d) LSP contractors must provide a comprehensive, culturally sensitive program that includes opportunities for promotion of female career paths including non-traditional careers and education of positive cultural icons.
- e) LSP contractors must provide a comprehensive, culturally sensitive program that includes assessment of risk factors and safety issues related to sexual exploitation followed by individual, group, and family counseling that focus on trauma, shall be provided to address the underlying causes of the youth's acts and move toward changing their behaviors.
- f) Youth who have been commercially sexually exploited, must receive all the support, treatment, and understanding necessary to meet physical, emotional, chemical

dependency/use and developmental needs, in a manner that provides them with the skills necessary to live healthy, productive, and self-sufficient adult lives. The LSP contractor shall meet the full range of physical, emotional, chemical dependency/use and psychological needs of the youth and describe the resources available to serve them.

- i. Specialized assessment services, followed by individual, group, and family counseling that focus on trauma, shall be provided to address the underlying causes of the youth's acts and move toward changing their behaviors. LSP contractors shall address specific issues encountered by the youth using creative and effective ways to assess risk factors and problems areas, encourage dialogue, and promote healing and positive progress.
- ii. The LSP contractors shall integrate structured educational programs and structured, closely supervised recreational events into their residential programs. Emphasis will be placed on promoting healthy, age-appropriate activities and interaction, while still providing a therapeutic milieu, including counseling, support and psychiatric consultation.
- iii. The LSP contractor must provide positive care and support for the youth while advising against and informing him/her of the dangers of their behavior. Youth will be empowered to thrive on their own, armed with the knowledge and technical skills to live independently.
- iv. Prior to discharge it must be assessed if the abuser continues to pose a risk to the minor youth in the home or community to which the youth is to be discharged. If a significant threat exists, the ACS Placement and Permanency Specialist must be consulted concerning the discharge plan.
- v. The LSP consultant shall ensure that the post-discharge parent[s], family, extended family or other discharge resource is fully trained about commercially sexually exploited youth and how to best support their youth. The training curriculum for a parent[s], family, extended family or other discharge resource shall be the same as that provided for a foster parent. Discharge planning shall be done in conjunction with the youth's mental health providers. Whenever possible, the youth shall maintain the same mental health and/or chemical dependency treatment providers upon discharge in as much as it is possible. Services to youth should be based in the community where they are being returned.

8. Services for Youth Who Identify as LGBTQ

- a) LSP contractors shall provide services that meet the wide range of needs demonstrated by youth who identify as LGBTQ.

- b) LSP contractors must adhere to the *ACS Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System policy*.
- c) Youth who identify as LGBTQ often experience difficulties in gaining acceptance from their families for a myriad of reasons. In these circumstances, LSP contractors must utilize best practices in this field to facilitate positive family reunification and functioning.
- d) LSP contractors shall ensure that youth who identify as transgender or gender-nonconforming receive services that provide holistic support accounting for the youth's general wellbeing, including medical and mental health supports.
- e) If a youth has identified as LGBTQ with their family, LSP contractors shall work with parent[s], family, extended family or other discharge resource to accept the youth and that the plan to move home is safe for the youth. If the youth has not identified as LGBTQ with their family, LSP contractors must ensure that the youth has a safe discharge plan and will be linked to appropriate LGBTQ supports in the community.
- f) Discharge planning shall be done in conjunction with the youth's medical and mental health providers to ensure the youth has the necessary supports as they transition home. Whenever possible, the youth shall maintain the same mental health and/or chemical dependency treatment providers upon discharge. Additionally, services to youth should be based in the community where they are being returned.
- g) Youth shall be assessed and linked with aftercare services prior to discharge from placement. This assessment shall begin upon admission to the LSP facility, and be revisited regularly thereafter to ensure a continuum of service that the family/youth can rely on after discharge. Indicated referrals to an aftercare rehabilitative program shall be made as soon as a need is identified.

9. Sexual Health Education and Services

- a) The LSP contractor shall reference Children's Services' *"Policy Guidelines for Family Planning and Pregnancy Related Information and Services"* dated 11/8/07, and any subsequently released policies, that describes activities foster care providers must take to ensure that children in their care receive timely and comprehensive sexual health information and services.
- b) The LSP contractor shall assure that all youth in care aged twelve (12) years old and over, and younger children who are known to be sexually active, receive

comprehensive information about family planning and sexual health issues, and have access to the full range of services including contraception (including but not limited to condoms, emergency contraception, and prescription methods), options counseling (including abortion and adoption services), and education and treatment related to sexually transmitted infections (“STIs”) and HIV/AIDS within thirty (30) days after placement and every six (6) months thereafter, and provide them with such services upon request. The LSP contractor shall comply with standards for assessment and testing of HIV as set forth in *Title 18 NYCRR 441.22(b)* or any successor or amended regulation.

- i. The LSP contractor shall ensure that such notification is made both in writing and verbally and must be recorded in each youth’s medical record and in the system(s) of record as part of the youth’s health history. The LSP contractor shall ensure that such notice complies with the Law including *Title 18 NYCRR Part 463.2* or any successor or amended regulation. The notice must inform the youth of his/her rights to confidential sexual and reproductive health services and social, educational, health, and medical family planning services.
- c) The LSP contractor shall notify the parent[s], family, extended family or other discharge resources of all youth of the availability of family planning services within thirty (30) days after placement and every six (6) months thereafter
- d) The LSP contractor shall ensure that the provider agency and LSP contractor staffs’ religious beliefs are not to be conveyed to any youth with regard to family planning during initial or semi-annual written or verbal notification of the availability of family planning services nor shall it be included in the curriculum of structured family planning programs.

10. Mental Health Services

- a) Initial Mental Health Screening
 - i. The LSP contractor shall develop a strategy for completing or obtaining current age-appropriate mental health screenings within seven (7) days from the date of placement and at least annually thereafter. If the LSP contractor is unable to complete a youth’s mental health screenings within seven (7) days of placement, the LSP contractor shall document the reasons the screenings were not completed in the system(s) of record, the case record, and the medical record. These screenings shall use validated instruments, and the LSP contractor shall inform Children’s Services’ auditors which instruments they are using at the time of audit.
 - ii. The mental health screening must include, at minimum: history of treatment with medications and response, including allergies; history of hospitalization and

outpatient treatment; history of suicidal, self-harm or violent behavior; history of victimization or exposure to traumatic life events; social history; substance abuse history; history of present illness(es) if applicable; current mental status including, but not limited to, suicidal and homicidal ideation; current medications, if any, and response to them; pertinent family history; interviews of parents or guardians; a review of prior records; and an explanation of how the youth's symptoms meet diagnostic criteria for the proffered diagnosis or diagnoses. The LSP contractor must prepare in advance of a youth's initial assessment utilizing prior records and speaking with previous clinical providers where appropriate.

- iii. The mental health screening process shall also cover chemical use/dependence in accordance with ACS Policies and the Section of these Juvenile Justice Limited Secure Placements Quality Assurance Standards entitled "Substance Abuse Services."
- iv. Where the initial screening or history indicates a need for mental health services, the LSP contractor must ensure that qualified staff, or a qualified contracted mental health professional, performs a full assessment within 48 hours of the initial screening.

b) Full Assessment/Evaluation

- i. Assessments must take into account available diagnostic and treatment information, the efficacy or lack of efficacy of treatments and behavioral interventions, and the outcomes of prior treatments and behavioral interventions with the youth being assessed.
- ii. LSP contractor staff shall arrange for follow-up treatment for youth whose mental health, psychological and/or psychiatric evaluation, administered by a qualified mental health professional, indicates a need for further mental health or behavioral health services.
- iii. The LSP contractor shall ensure that a mental health or behavioral health service treatment goals and care plan is developed, a copy of which shall be included in the youth's case record.
- iv. If a psychiatric referral is needed, that referral must be made promptly upon indication of the need, and in no event later than one (1) business day after the need is identified.
- v. If, after completing the assessment/evaluation, the youth requires **transfer** to a setting which is more appropriate to his/her mental health diagnosis and needs,

transfer will need to be approved by the ACS Placement and Permanency unit. ACS Placement and Permanency staff will consult with mental health experts on staff at ACS before approving or disapproving a transfer. If a transfer is approved, the LSP contractor will be required to initiate procedures to transfer the youth to the required setting immediately as outlined in these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*.

c) Mental Health Service Provision

- i. The LSP contractor shall ensure that all mental health services are delivered on site by qualified New York State-licensed/credentialed mental health providers, and that all services are documented.
- ii. Mental and behavioral health services offered by LSP contractors shall include, at minimum, crisis intervention, research-informed/validated individual treatment, group work and therapies, and substance abuse prevention and treatment. LSP contractors are to ensure integrated, coordinated and non-duplicated care.
- iii. LSP contractors shall provide population-sensitive mental health services including services for youth who have experienced trauma, youth who are pregnant and parenting, youth who identify as LGBTQ and youth transitioning into adulthood.
- iv. Qualified mental health professionals providing services to youth are required to develop and update a consistent working diagnosis or diagnoses with written treatment plans.
- v. Communication is critical, LSP mental health staff or contracted providers are required to communicate with families, guardians, prior and current providers, on prior mental health treatment, current needs and progress, and recommended care post-release.
- vi. The LSP contractor shall make best efforts to ensure that parent[s], family, extended family or other discharge resources are meaningfully engaged in the youth's mental health treatment, including participating in family counseling, if recommended, if not restricted or prohibited by court order. The LSP contractor shall follow-up to determine that the mental health services are being utilized by the parent[s], family, extended family or other discharge resources, that the mental health and LSP service plans are coordinated, and that the services are accomplishing the treatment goals.
- vii. LSP contractors shall work with family members or other discharge resources to provide appropriate training for proper and safe administration of medication. LSP contractors shall also train the family members or other discharge resources

on the diagnosis associated with the medication and provide information on the medication that is being administered.

- viii. The LSP contractor shall recognize indicators of mental health issues in parent[s], family, extended family or other discharge resources and refer families or other discharge resources to a provider who can provide assessment, diagnosis, testing, psychotherapy, specialized therapies and interventions.
- ix. For more information on support services, refer to the “Support Services for Parent[s], Family, and Extended Family or Other Discharge Resources” section of these Standards.

d) Suicide Prevention

- i. The LSP contractor must have a suicide prevention plan that addresses training, screening and assessment at intake, communication with all levels of supervision of suicidal youth, intervention, reporting and follow-up to suicide attempts.
- ii. The LSP contractor must adhere to ACS policies related to special watches for youth.
- iii. At a minimum, the LSP contractor is required to provide at least eight hours of pre-service training and four hours of annual refresher training for all direct care staff in suicide awareness, assessment, prevention, and response to suicide attempts.
- iv. Training curricula must be specifically geared to suicide prevention in juvenile facilities.
- v. For more information and resources on suicide prevention, LSP contractors can refer to SAMHSA <http://www.samhsa.gov/prevention/suicide.aspx>

e) Staff Workload Ratios and Coverage

- i. All LSP contractors must provide adequate and appropriate staffing coverage. Services shall be available to children in the afternoons, evenings and weekends. The LSP contractor shall maintain a current list of per-diem staff who meet credentialing and clearance requirements available to fill in on as-needed basis in order to fulfill adequate coverage for staff outages (e.g. vacation and illness).
- ii. General staffing requirements for Mental Health Services

(a) At minimum, staffing at all LSP Program sites must include, for every twelve

(12) youth (or fraction thereof):

- (i) One (1) full time (forty (40) hours per week) on site mental health clinician,
- (ii) One (1) full time (forty (40) hours per week) on site family worker,
- (iii) One (1) supervising clinician, and
- (iv) One (1) clinical director.

f) On-Call and Emergency Contacts

- i. LSP contractors must arrange for on-call availability of LSP contractor, key staff and providers for urgent mental health services 24 hours a day, 7 days a week including holidays and vacations. Coverage must include, but not be limited to, phone triage and management of suicidality, homicidality, and psychosis.
- ii. Each LSP contractor must develop a protocol to ensure that agency staff can access emergency care information to share with mental health care providers as necessary.
- iii. LSP contractors must train direct care and other staff, as appropriate, on strategies to employ to address a youth's mental health crisis while awaiting arrival of a qualified mental health professional.

11. Substance Abuse Services

- a) LSP sites are required to have OASAS licensure or become a licensed satellite clinic with a licensed provider so that substance abuse services are provided on-site.

b) Initial Substance Abuse Screening and Assessment

- i. The LSP contractor shall use evidence-based/promising practices to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
- ii. The mental health initial screening process shall include standardized questions/screening instrument related to the youth's history of trauma as well as the use or abuse of alcohol and/or other drugs. Adolescent-level tools with developmental appropriateness are to be used by the LSP contractor.
- iii. Where initial screening indicates a need, the LSP contractor is to complete a full substance use assessment of current and past symptoms, past treatment, trauma (client-specific and intergenerational), exposure to alcohol or other drugs in utero, and co-occurring conditions such as mental health disorders and learning disabilities.

- iv. Chemical use/dependency risk and behavior assessments of youth are to include self reports and can include random urinalysis drug screening of the youth. Urinalysis drug screening is permissible as part of substance abuse services as provided below by an OASAS licensed provider.
 - v. The LSP contractor is to conduct a thorough diagnostic evaluation of youth testing positive in order to identify individually-tailored treatment needs and intensity for youth identified with clinical use disorders.
- c) Substance Abuse Service Provision
- i. Counseling and Education: The LSP contractor shall ensure that youth who use substances receive alcohol and other drug education and counseling on-site and substance abuse interventions that are either evidence-based or on Substance Abuse and Mental Health Services Administration's (SAMHSA) approved list of modalities <http://www.nrepp.samhsa.gov>
 - ii. Treatment: If a youth is regularly using, abusing, or is chemically dependent, this young person requires treatment. Residential substance abuse treatment is different than counseling or education, and can only be provided on-site if the LSP contractor holds an OASAS license to provide treatment and has a Credentialed Alcohol and Substance Abuse Counselor (CASAC) to deliver it.
 - iii. LSP sites are required to have OASAS licensure or become a licensed satellite clinic with a licensed provider so services can be delivered on-site.
 - iv. Substance use services and treatment shall engage youth and their families, and shall address risk factors such as family histories of substance use, intergenerational trauma and co-occurring conditions.
 - v. LSP contractors shall facilitate the engagement of youth and their families as well as the youth's adherence to prescribed treatment.
 - vi. Parents, families and other discharge resources who need chemical dependency/use treatment shall also be offered services. For more information refer to "Support Services for Parent[s], Family, and Extended Family or Other Discharge resources" section of these Standards.
 - vii. Staff Workload Ratios and Coverage
 - (b) All LSP contractors must provide adequate and appropriate staffing coverage. Services shall be available to children in the afternoons, evenings and weekends. The LSP contractor shall maintain a current list of per-diem staff

who meet credentialing and clearance requirements available to fill in on as-needed basis in order to fulfill adequate coverage for staff outages (e.g. vacation and illness).

- (c) General staffing requirements: At minimum, substance abuse staffing at all facilities must include, for every 12 children, full time (forty (40) hours per week) on site substance use/dependency services.
- (d) These services can be integrated into the mental health services and be provided by the mental health clinician as long as the mental health clinician providing the services has the required credentials outlined in these Standards.

12. Medical, Psychiatric, and Dental Health Services

- a) Children's Services will establish contractual relationships with health providers for medical, dental and psychiatry services to be provided on-site at LSP contractor locations. The LSP contractor shall be the care coordinator for all health services provided to their youth ensuring continuity of care as well as coordinated and integrated care throughout the youth's placement with the LSP contractor and in cases where the youth transfers to other contractors and/or transitions out of placement. The ACS - contracted medical, dental and psychiatry providers will have contractual obligations to communicate with LSP contractors on diagnoses, treatment plans and provided services to ensure integrated care for placed youth.

13. Care Coordination

- a) LSP contractor shall act as a single source of coordinated and integrated care.
- b) LSP contractors shall assign qualified staff to coordinate mental and behavioral health, and substance abuse services as well as information received from ACS-contracted psychiatric, medical, and dental health services providers in order to prevent fragmented care.
- c) LSP contractor must communicate effectively and seamlessly with ACS staff and ACS contracted health, dental and psychiatry service providers, and other entities in the Child Welfare and Juvenile Justice systems.
- d) LSP contractor shall see to it that access is provided to all health, dental and psychiatric treatment resources.
- e) LSP contractor shall forge partnerships with crisis intervention programs, mentoring programs, youth and parent advocacy.

- f) LSP contractor shall see to it that psychopharmacologic services are integrated with other approaches as much as possible.
- g) LSP contractor shall secure, maintain and update health and mental health records.
- h) General Staff Coverage for Care Coordination
 - i. All LSP sites must have on site care coordination staff coverage on a full time (forty (40) hours per week) basis. These services may be provided by the LSP program Caseworker or other similarly qualified staff as part of their duties.

14. Medication Administration

- i. LSP contractors, who do not have ACS contracted medical staff on site to administer medications under the, must have the capacity (under the supervision of and in communication with the prescribing ACS contracted medical staff) to administer medication. LSP contractors must follow ACS policies regarding administration of medication. Additionally, all LSP contractor staff administering medication must be trained in medication administration.

15. Continuity of Medical and Mental Health Care

- a) It shall be the treatment philosophy of the ACS Division of Youth and Family Justice/Office of Youth and Family Development (DYFJ/OYFD) for LSP contractors to seek the active participation of the youth, his/her parent(s)/legal guardian(s), and previous health care, mental health providers, and dental providers, in the care and treatment of youth in LSP. To best serve all youth, the LSP contractor shall seek to obtain accurate and current information concerning youths' medical and psychiatric care and medication in order to ensure continuity of care.
- b) DYFJ supports continuing the previously provided medical and psychiatric care, including medications. The LSP contractor shall ensure that its health/mental health care provider continues all medical and psychiatric care, including medication that the youth was receiving prior to admission to LSP unless modified by medical professionals.
- c) The LSP contractor shall develop a strategy for creating a continuum of care to adequately meet the full range of health needs of the youth being served through participation in community-based health coalitions, consortia, and networks, including the Children's Services Coordinated Initiative and coordination with borough-based family support service providers in the mental health system. This includes coordination, planning and working closely with the ACS contracted medical and psychiatric provider(s) and the youth's community doctors to ensure

continuity of care. Details concerning medical services coordination must be included in the LSP contractor's program manual.

16. Client Grievance Procedures

- a) The LSP contractor shall adhere to ACS's policy related to grievance procedures.

17. Legal Services, Court Appearances, and Reports

- a) Compliance with Court Orders

The LSP contractor shall complete timely court ordered reports as necessary; attend Family Court proceedings; and comply with all court orders. LSP contractor staff with substantive knowledge of the case situation must be ready to testify in court on request as to the LSP contractor's safety and permanency assessments and the LSP contractor's position related to the current placement and permanency when necessary. The LSP contractor must be prepared to respond to these requests on an expedited basis, at times within 24 hours.

- b) Communication with Family Court Legal Services

The LSP contractor shall provide Children's Services' Family Court Legal Services (FCLS) attorneys with updated information including child status, location, assigned caseworker and supervisor, as needed for court appearances. The LSP contractor shall maintain contact with FCLS attorneys to review any important developments, and communicate with lawyers for youth as necessary, pursuant to communication protocols. LSP contractor staff must cooperate with FCLS attorneys in preparing court cases for trial.

- c) Reporting

The LSP contractor must also be prepared to appear in court on post-dispositional report dates on the youth's juvenile delinquency case and submit written reports to the court about the youth's adjustment to placement; the treatment goals, plan, and youth's progress; the youth's academic progress; and visits home to the family or discharge resource. Written reports shall be objective and data-focused and shall avoid the use of qualifying language. If reports are inadequate, corrective action plans must be implemented and must be adhered to by the LSP contractor.

- d) LSP staff shall have adequate knowledge of the youth's psychosocial and legal history and current status and be ready to testify in court when necessary;

- e) LSP staff shall complete timely and detailed court reports, as required; attend Family Court and/or Criminal Court proceedings; and comply with all court orders in coordination/consultation with Children's Services;

- f) LSP staff must be responsive to inquiries made by youths' attorneys. LSP staff must inform the FCLS attorney of any such inquiry.

18. Transportation

- a) The LSP contractor shall provide all transportation necessary to fulfill its duties within these Standards. The LSP contractor shall ensure that transportation services are readily available to transport youth to the hospital, medical and mental health appointments, home visits, community school (part of the youth's transition process back to the community) and other subspecialty providers as necessary. Once a youth is placed with a LSP contractor, that LSP contractor is responsible for transporting the youth from detention, or other current location of the youth, to the LSP facility.
- b) The LSP contractor is required to have two staff present at all times during transportation of youth in LSP.

C. Services for Birth Parents, Family, and Youth's Network of Support

1. Mental Health Services

The LSP contractor shall recognize indicators of mental health issues in parent[s], family, extended family or other discharge resources and offer to arrange for assessment, diagnosis, testing, psychotherapy, specialized therapies and interventions to parent[s], family, extended family or other discharge resources that require them.

- a) Parent[s], family, extended family or other discharge resources who need mental health services shall be referred, as necessary by the LSP contractor, to appropriate service providers.
- b) The LSP contractor shall be familiar with and develop linkages with home- and community-based clinical service providers; mental health case management programs for adults and children; and OMH Home and Community-Based Services Waiver programs for children with serious emotional disturbance.
- c) The LSP contractor shall provide parent[s], family, extended family or other discharge resources with basic information about children's mental health, including but not limited to trauma and the emotional impact of abuse/maltreatment on children; the range of behaviors traumatized children may express, what they mean and how to appropriately intervene; common children's mental health issues and treatments; the importance of mental health screening and early intervention; and psychotropic medications and how they are used as part of an overall mental health treatment plan. Parent[s], family, extended family or other discharge resources shall

also receive education about parent mental health (including maternal depression) and its impact on children.

- d) As needed, parent[s], family, extended family or other discharge resources shall be educated about the importance of being meaningfully engaged in their children's mental health treatment, including participating in family treatment as recommended.
- e) LSP contractors shall provide parenting skills training and psycho-education to parents or other discharge resources to address the issues that led to youth's placement. In addition, many if not most, parents shall be able to receive appropriate training and support regarding the developmental needs and growth of teenagers, especially regarding ways to avoid major parental/youth conflict.

2. Support Services for Parent[s], Family, Extended Family or Other Discharge Resources of Youth with Serious Health and Mental Health Needs

- a) The LSP contractor shall make support services available, directly or by referral, to parent[s], family, extended family or other discharge resources caring for youth with serious health and mental health needs. Such support services may include, but are not limited to:
 - i. Twenty-four (24)-hours-a-day, seven (7)-days-a-week crisis hotline services;
 - ii. Caretaker support groups;
 - iii. Birth parent support and advocacy, which can be accessed through the Department of Health and Mental Hygiene's Family Support Programs;
 - iv. Home visits;
 - v. Planned and crisis respite;
 - vi. Education and information about community-based resources and services, including crisis services;
 - vii. Informational mailings; and
 - viii. Specialized trainings.

3. Health Education

LSP contractors shall give child-focused health education to parents and discharge resources.

4. Transportation

LSP contractors shall provide parent[s], family, extended family or other discharge resources with transportation to the office/facility for meetings and family visits if the facility is located outside of New York City or the visiting resource demonstrates need. LSP contractors shall transport or cover the cost of transportation for youth to visit their families or other discharge resources.

5. Other services for families

LSP contractors shall support additional needs and presenting circumstances of parent[s], family, extended family or other discharge resources and extended family members to achieve successful reunification. These include, but are not limited to:

- a) Concrete needs, such as housing, public assistance, Medicaid and food stamps;
- b) Job training and employment assistance;
- c) Chemical dependency disorder: prevention, treatment, aftercare and community support services;
- d) Domestic violence screening; when domestic violence is indicated or suspected, counseling and/or referral to support services for the survivor, youth and abusive partner;
- e) Health services, including those that address underlying medical conditions and physical disabilities that put youth at risk for maltreatment;
- f) Education about trauma and the impact of abuse/maltreatment on their youth, and training and supports to care for their child's/youth's needs upon reunification;
- g) Cultural and linguistic barriers to services;
- h) Connections to community supports and services;
- i) Immigration status;
- j) Impact of incarceration on permanency plans;
- k) Understanding of legal status regarding Family Court—and specifically, juvenile delinquency—proceedings; and
- l) Support for responding to their own or their youth's sexual orientation and/or gender identity/gender expression.

PART V: SPECIALIZED LIMITED SECURE PLACEMENT

A. Specialized Residential Programs and Services

1. Specialized Residential Care Programs refers to facilities that are designated for youth with a specialized need as delineated below. These facilities will be operated by LSP contractors with the specialized expertise and physical setting or facilities required for youth specialized needs and/or conditions. All youth in these specialized LSP placements will be adjudicated delinquents.
2. In addition to serving youth in the specialized settings below, specialized programs will be required to have the ability to house and appropriately serve youth who are eligible for generalized services.
3. Specialized residential programs include services for children/youth with:
 - a) Intellectual/developmental disabilities;
 - b) Problematic sexual behaviors;
 - c) Serious emotional disturbance; and/or
 - d) A need for temporary intensive support
4. Specialized Residential Care, Treatment and Social Work Services
 - a) For youth in the specialized LSP facilities, the team compiling the comprehensive assessment shall include professional staff with special expertise in the needs and risks of the youth in the specialized LSP.
 - b) For all specialized LSP programs, the approved direct care staff ratios is six (6) youth to two (2) staff at all times. Staff are not permitted to sleep during any shifts. LSP contractors are required to have staff on-call and available to report to work within 30 minutes if additional staffing is necessary or required by ACS. Documentation of this staffing ration shall include the names of staff on call for each shift, hours of coverage, and plans for providing backup staff in emergencies.
 - c) Staff assigned to specialized facilities must be trained in topics critical to the safe care and effective behavior change of youth in specialized placements. Specialized training topics are listed below.
 - d) Facilities for specialized populations may also have specific design-requirements as specified by ACS and/or OCFS.

5. **Youth with Intellectual/Developmental Disabilities:** *This section contains those standards that are specific to LSP Program services for youth with Intellectual/Developmental Disabilities. These standards apply in addition to those in previous sections of the Juvenile Justice Limited Secure Placements Quality Assurance Standards. In some areas, standards in this section may be more stringent than those in the main text of the Juvenile Justice Limited Secure Placements Quality Assurance Standard. Where this is the case, this section takes precedence.*

- a) Youth in this category include but are not limited to youth with:
 - i. Youth with Neurological Impairment and Severe Muscular Disorder,
 - ii. Youth with Autism Spectrum Disorder,
 - iii. Youth with Severe Learning Disabilities,
 - iv. Youth with Intellectual Disability with an IQ below 70,
 - v. Autism Spectrum Disorder,
 - vi. Cerebral Palsy,
 - vii. Fetal Alcohol Spectrum Disorders (“FASD”), and
 - viii. Down Syndrome.
- b) Youth who are served in Specialized IDD LSP facilities shall receive all the support, treatment, and understanding necessary to meet their broad range of physical, emotional, and developmental needs, in a manner that maximizes their chances for reunification with their families or discharge resources. When these options are not possible, programs must provide them with the skills necessary to live healthy, productive, and self-sufficient adult lives if possible. Youth with IDD shall be placed in the most appropriate, least restrictive and safest setting available which would provide them with the skills necessary to live as healthy, productive, and self-sufficient adults.
- c) Youth with IDD diagnoses shall receive special, appropriate treatment services in a highly structured setting. The provider shall ensure that clinical interventions address the individualized developmental, social, and medical needs of youth.
- d) In addition to the required general mental health, substance abuse and care coordination services and staffing requirements outlined in these *Juvenile Justice Limited Secure Placements Quality Assurance Standards* and as necessary, LSP sites serving youth with IDD diagnoses must have access to a minimum of on-site speech and language pathology services 2 (two) hours per week, per youth. If a youth requires more than 2 (hours) per week, the LSP contractor must ensure that the youth receives on-site services as required.
- e) LSP Facility Care, Treatment and Social Work Services
 - i. The following is a list of services the provider must offer to youth in the program:

- (a) Youth shall be educated about their developmental need and its various effects and lifestyle implications. Additionally, they should receive information relevant to their particular medications, its effects and side effects or the use of medical equipment and other devices necessary for the treatment and maintenance of their condition.
- (b) Youth, their siblings, and other family members, shall be provided with ongoing counseling to help increase functioning. When appropriate youth must receive additional health care and personal hygiene information specific to their disability and/or medical condition.
- (c) The LSP contractor must also supply or arrange for speech, occupational, and physical therapy as needed and when recommended by the primary care provider.
- (d) Assessments to determine the need for referrals to ACS' Developmental Disabilities Unit for youth requiring long term residential supports and services, through New York State Office for People With Developmental Disabilities must be completed by the provider.
- (e) The LSP contractor shall develop and implement youth-specific training curriculum for parent[s], family, extended family or other discharge resources along with special extended family support. This curriculum must include the following elements:
 - (i) provide parent[s], family, extended family or other discharge resources with information on the youth's condition and its effect on growth and development;
 - (ii) provide information on how to access professional evaluations and other community resources through established provider protocols;
 - (iii) prepare parent[s], family, extended family or other discharge resources for the demands of caring for a youth with specialized needs, (including need for intensive supervision, emotional stress, concerns expressed by family and neighbors, etc.); and provide parent[s], family, extended family or other discharge resources with training on stress reduction;
 - (iv) ensure that parent[s], family, extended family or other discharge resources receive training relevant to the psychological and treatment goals of the youth in their care; and

- (v) prepare parent[s], family, extended family or other discharge resources to address the complex social, medical, and emotional needs of youth with these conditions or experiences.
 - f) All LSP IDD facilities must comply with the Americans with Disabilities Act and applicable state and local laws to make services and service locations accessible to youth and family members with physical disabilities including, but not limited to, developing plans for: making facilities wheelchair accessible, utilizing sign language interpreters and large print informational reading materials. All LSP contractor sites that are group homes must comply with *Title 18B Part 448.3* or any successor or amended regulation except in those instances that approval has been granted by Children's Services and approved by OCFS.
 - g) The LSP staff shall connect the parent[s], family, extended family or other discharge resources to in-home supports that are available at the time of the youth's discharge (e.g., New York State Office of Mental Health (OMH) Home and Community Based Waiver programs, the New York State Bridges to Health Waiver program services through the New York State OMH or New York State Office for People with Developmental Disabilities (OPWDD) services.
 - h) In addition to required residential care training described in the *Juvenile Justice Limited Secure Placements Quality Assurance Standards*, the LSP contractor shall provide supplementary training to staff who care for or interact with IDD youth to help them meet the their specialized needs. The training shall take into account the individual needs of the youth served and shall be provided by either the provider or an outside educational institution. The LSP contractor shall provide all staff continuous and ongoing training to meet the need the changing needs of the IDD population.
6. **Youth Who Have Demonstrated Problematic Sexual Behaviors:** *This section contains those standards that are specific to LSP Program services for youth who have demonstrated problematic sexual behaviors. These standards apply in addition to those in previous sections of the Juvenile Justice Limited Secure Placements Quality Assurance Standards. In some areas, standards in this section may be more stringent than those in the main text of the Juvenile Justice Limited Secure Placements Quality Assurance Standards. Where this is the case, this section takes precedence.*
- a) Youth Who Have Demonstrated Problematic Sexual Behaviors include, but are not limited to:
 - i. Youth who have been found by Family Court to have committed what would be a crime of a sexual nature (excluding prostitution) if committed by an adult (note that not all youth adjudicated on these charges will be required to be placed in a specialized program), and

- ii. Youth who have in the past been found by a court to have committed what would be (or was) a crime of a sexual nature.
- b) Youth who have sexually abusive behaviors who require limited secure juvenile justice placement shall receive specialized treatment services in a highly structured setting that addresses their needs. Through the provisions of this specialized service, the youth will learn impulse control; guidelines for appropriate sexual behavior; privacy; and respect for boundaries. The youth will be held accountable for his/her actions, and learn to fundamentally change harmful behaviors. These youth shall receive extensive treatment to address the issues which have led or contributed to their offending behaviors.
- c) Some of the youth may have a dual-diagnosis such as substance abuse or mental health issues, which is determined to be a serviceable issue either at the time of referral or during/after referral to this program. However, the sexual behavior problems should be the primary reason for the referral, and the provider must utilize due diligence where possible and appropriate to address the other issues as they are assessed.
- d) Mental Health Staffing
 - i. In addition to the required general mental health, substance abuse and care coordination services and staffing required in these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*, LSP sites serving youth who have demonstrated problematic sexual behaviors must have for every twelve (12) youth (or fraction thereof):
 - (a) One (1) on-site supervisor at all times;
 - (b) Four (4) hours per week of on-site clinical psychologist coverage; and
 - (c) One (1) hour per week per child of on-site case worker coverage.
 - (d) If a youth requires more services, the LSP contractor must ensure that the youth receives on site services as required.
- e) LSP Facility Care, Treatment, and Social Work Services
 - i. Specialized assessment services, followed by individual, group, and family counseling, shall be provided to address the underlying causes of the youth's harmful acts and move toward changing their behaviors. The LSP contractor shall integrate structured educational programs and structured, closely supervised therapeutic recreational events into their residential programs.
 - ii. The LSP contractor must provide positive care and support for the youth while advising against and informing him/her of the dangers of their problematic

sexual behavior. Youth shall be empowered to thrive on their own, armed with the knowledge and technical skills to live independently.

- iii. The LSP contractor will provide treatment for different levels of sexual behavior problems: the offenses can range from touching and fondling to other forms of sexually abusive behaviors.
- iv. A specialized treatment model and high level of services must be implemented that will also address the underlying issues leading to the youth's problematic sexual behavior. This specialized program design must offer structured educational services, recreational events, comprehensive safety, and a structured behavior management system to monitor youth and record their level of progress. Intensive psychological and psychiatric services must be available on a regular basis through program staff. Psychiatric consultation and medication management must be provided when needed.
- v. Youth shall receive specialized assessments, treatment, and support services in a residential care setting, with staff who have received specialized training to care for this population. Staff must be trained to identify behaviors and triggers that can lead to further abuse by the youth. Assessments must include youths' history of sexual abuse, and inappropriate sexual behaviors, exploration of presenting trauma symptoms and past trauma. Youth who have experienced trauma and/or loss must receive counseling with a focus on re-establishing physical and emotional safety. LSP contractors must provide close supervision at the residence, school, and in the community, and implement a structured, individualized program for each youth.
- vi. The LSP contractor shall provide skill building for academic and social activities. Additional program activities will vary depending on the age of the youth. A positive and predictable environment must be established for youth via a structured behavior management system with consistent follow-through on consequences; thus, providing the youth with boundaries, consistency, expectations regarding their behavior, improvement in their self-esteem, and safety for youth and staff. The LSP contractor will thoroughly train all staff and discharge resources about the system and about each youth's safety and behavior management plan.
- vii. The LSP contractor shall make at minimum two (2) contacts each week with the youth's school in order to monitor the youth's academic progress, behavior and socialization. More frequent contacts will be made based on how the youth is functioning. Staff should also provide school-based behavioral interventions and academic support as needed.

- viii. A safety plan for each youth must be created to establish guidelines for interacting with peers in school, around other youth in the community or facility and interacting with staff and family members.
 - ix. The LSP contractor shall provide individual, group, and family therapy/counseling to address the underlying causes of youth's harmful acts and move toward changing their behaviors.
- f) Discharge Planning and Transitional Services
- i. Parent/caretaker acknowledgement of the problem, buy-in, support, and active participation is paramount for the family's successful completion of the program and re-integration of youth in a stable supportive environment. Parent[s], family, extended family or other discharge resources will also address the impact of their child/youth's behavior on their family (particularly if the child was sexually abusive toward a sibling or other family member), and ensure that the caretaker fully understands how past abuse (if any) may have impacted his/her inappropriate/offending behavior.
 - ii. All discharge plans must address the following areas: personal responsibility, victim empathy, self-awareness and safety planning. Additionally, the discharge plan must include a comprehensive safety plan with: a documented risk assessment, a relapse prevention plan, and an understanding of the vulnerabilities that may lead to re-offending. The comprehensive safety plan must be signed by the youth and the family, if the youth is returning home, or by the caretaker the youth will be living with if not returning home. When the youth is returning to a home where the victim lives a victim impact statement must be part of the discharge planning.
 - iii. Special planning regarding interaction with victims, particularly if they are within the household to which the youth will be discharged after the LSP placement, must occur. If victims are in the household to which the youth will be discharged, a thorough, comprehensive safety plan must be crafted prior to discharge, and any and all treatment and supports needed by the victim must be provided or arranged by the LSP contractor, including engaging the victim's system of care as appropriate. ACS must provide written approval of discharge to a setting in which a victim of the youth is residing.
- g) In addition to the training requirements outlined in these *Juvenile Justice Limited - Secure Placements Quality Assurance Standards*, all LSP contractor staff shall receive training on the overview and treatment of sexually problematic behaviors, sexual abuse, sexual exploitation, family systems counseling, family therapy/counseling play therapy, group therapy and trauma resolution/treatment. Staff shall also be trained in non-violent crisis intervention techniques, the use of de-escalation,

mediation and CPR/First Aid, the overview of youth substance abuse and treatment, and treating youth with dual diagnoses.

7. **Youth with Serious Emotional Disturbance (SED) Diagnosis and Youth Who Have**

Demonstrated Fire Setting Behaviors: *This section contains those standards that are specific to LSP Program services for children/youth with serious emotional disturbance and youth who have demonstrated fire setting behaviors. These standards apply in addition to those in previous sections of the Juvenile Justice Limited Secure Placements Quality Assurance Standards. In some areas, standards in this section may be more stringent than those in the main text of the Juvenile Justice Limited Secure Placements Quality Assurance Standards. Where this is the case, this section takes precedence.*

- a) The LSP contractor shall accept youth considered seriously emotionally disturbed, as that term is defined by the New York State Office of Mental Health.
- b) In addition to accepting youth with specific SED diagnoses, LSP contractors shall accept youth with DSM IV Axis I diagnoses that could benefit from service provision as outlined in this section.
- c) These Specialized LSP Program sites, must also serve youth who have demonstrated fire setting behaviors. There will be four (4) designated beds within the LSP Program site dedicated for youth who have demonstrated fire setting behaviors. At the sole discretion of ACS, the LSP contractor may utilize the four designated beds to serve youth who have not demonstrated fire setting behaviors.
- d) Youth with serious emotional disturbance and fire setting behaviors served in specialized limited secure juvenile justice residential care settings must receive all the support, structure, treatment, and understanding necessary to meet physical, emotional, chemical dependency/use and developmental needs, in a manner that maximizes their chances to live healthy, productive, and self-sufficient adult lives. The LSP contractor shall meet the full range of physical, emotional, chemical dependency/use and psychological needs of the youth and describe the resources available to serve them.
- e) Youth with serious emotional disturbance and fire setting behaviors have treatment or safety-related needs that require the specialized treatment opportunities provided by residential care facilities shall be provided such care.
- f) The treatment plan for each youth must include all components of care, including psychiatric, behavioral, educational, health, family, and psychosocial needs. Discharge planning begins on intake, and discharge objectives are reflected in all treatment plan write ups. The family and the youth shall be considered to be members of the treatment team, as well as the ACS Placement and Permanency staff, if appropriate, and other designated community providers.

- g) Medication management, if warranted, is an integral support for youth with serious emotional disturbance. LSP contractors must have psychiatric and nursing professionals to assist the youth and the family in ensuring medication is taken as prescribed, and in gaining an understanding of the prescribed medication regimen, including the benefits and side effects of the medication, and how the youth can learn to manage the medication regimen independently.
- h) LSP Facility Care, Treatment and Social Work Services
 - i. LSP contractors must provide a comprehensive, culturally sensitive program that includes assessment of risk factors and safety issues related to serious emotional disturbance and fire setting behaviors. LSP contractors shall work with youth and their families (when appropriate) to provide therapy, life-skills coaching and access to community resources.
 - ii. Specialized assessment services, followed by individual, group, and family treatment; shall be provided to address the underlying causes of trauma. LSP contractors will address specific issues encountered by the youth using creative and effective ways to assess risk factors and problems areas, encourage dialogue, and promote healing and positive progress.
 - iii. The LSP contractor shall integrate structured educational programs and structured, closely supervised therapeutic recreational events into their residential programs. Emphasis shall be placed on promoting healthy, age-appropriate activities and interaction, while still providing a therapeutic milieu, including counseling, support and psychiatric consultation.
 - iv. The LSP contractor is required to collaborate with a local fire department to ensure all appropriate fire safety and prevention measures have been undertaken in the facility.
 - v. For youth who have demonstrated fire setting behaviors, the LSP contractor is required to provide an intensive level of services and structure, including but not limited to:
 - (a) A closely-supervised therapeutic environment;
 - (b) A multidisciplinary clinical team that includes psychologists, psychiatrists, and occupational therapists;
 - (c) Fire safety instruction for youth;
 - (d) Clinical services focusing on relapse prevention;
 - (e) A model of behavior change that has been shown to be effective with youth who set fires; and
 - (f) Counseling focusing on re-establishing physical and emotional safety.

i) Discharge Planning and Transitional Services

- i. Youth shall be assessed and linked with aftercare services prior to discharge from placement. This assessment shall begin upon admission to the LSP facility, and be revisited regularly thereafter to ensure a continuum of service that the family/youth can rely on after discharge. Referrals to an aftercare rehabilitative program, including psychiatric and/or psychological treatment as needed, shall be made as soon as a need is identified. Such referrals shall be made based on the youth's clinical needs, not simply the permanency plan.
- ii. For youth who have demonstrated fire setting behaviors, prior to discharge the likelihood of continued fire setting behaviors must be assessed.
- iii. In addition to the general discharge planning requirements, discharge planning for youth who have demonstrated fire setting behaviors must focus on safety planning with the youth and all discharge resources, as well as on relapse prevention. The discharge plan must include a comprehensive safety plan which must include a documented risk assessment.

j) Staff training for this specialized placement shall include, but not be limited to:

- i. Modality of treatment to be utilized including evidence based clinical interventions for SED and fire setting youth;
- ii. Understanding and treating trauma and its manifestations;
- iii. Effective safety planning;
- iv. Relapse and relapse prevention;
- v. Fire safety;
- vi. Effective safety planning and the ability to work with parents or other discharge resources to effectuate safety plans planning with the youth and all discharge resources;
- vii. Appropriate expectations of behavior for psychiatric diagnoses common to this population and strategies for behavior change of youth with these diagnoses; and
- viii. Psychotropic medication administration, management, and recognition of side effects.

k) Mental Health Staffing

- i. In addition to the direct care, mental health, substance abuse and care coordination staffing requirements for all LSP Program sites, Specialized SED LSP Program sites must, for every twelve (12) youth (or fraction thereof), have fifty-two (52) hours per week, on-site, clinical psychologist with flexible hours to accommodate school and other activities in which the youth are participating (forty (40) of the clinical psychologist hours are to replace the full time general

mental health clinician hours, and the remaining twelve (12) hours fulfill an hour per youth per week of onsite coverage).

- l) In addition to the required LSP staff outlined this section and in these Standards, the following staff are required to provide services for youth who have demonstrated fire setting behaviors:
 - i. Occupational Therapist: Must have NYS License to practice Occupational Therapy, with experience working with adolescents who exhibit pervasive fire-setting behaviors.
 - ii. Fire Safety Trainer: BA preferred in a related field, with demonstrated experience working with adolescents who exhibit pervasive fire-setting behaviors.

8. **Intensive Short Term Support:** *This section contains those standards that are specific to LSP Program services for children/youth in need of short-term placement in an intensive support setting. These standards apply in addition to those in previous sections of the Juvenile Justice Limited Secure Placements Quality Assurance Standards. In some areas, standards in this section may be more stringent than those in the main text of the Juvenile Justice Limited Secure Placements Quality Assurance Standards. Where this is the case, this section takes precedence*

- a) Intensive Support will be used at the discretion of ACS for youth and families in need of crisis management and support during periods of time of a maximum of approximately three (3) weeks or 21 days.
- b) Intensive Support placements must include assessments, counseling, medical and mental health intervention, and crisis management services for youth and families with the goal of establishing stability, identifying treatment needs and service resources for youth and families.
- c) Placement in Intensive Support will be subject to ACS approval and may be used as an intermediary step between placement options, as required.
- d) A crisis management plan must be added to individualized treatment plans for youth in Intensive Support and will include assessments describing the underlying cause of the youth and family's crisis and/or need for temporary intensive support; as well as the short-term goals established to get the youth and/or family through the temporary crisis, and achievement of such goals.
- e) Staffing

- i. In addition to the minimum direct care, mental health, substance abuse and care coordination staff coverage for all LSP Program sites, the Specialized IS LSP Program site must have a minimum of:
 - (a) clinical psychologist on-site coverage of four (4) hours per week for every six (6) youth (or fraction thereof); and
 - (b) in addition to the minimum required direct care staffing ratio, the Specialized IS LSP Program site shall have one (1) supervisor on site at all times for every six (6) youth (or fraction thereof).
- f) Medication management, if warranted, may be an integral part of supporting youth during temporarily placement. LSP contractors must work closely with the ACS contracted psychiatric and medical professionals to assist the youth and the family in ensuring medication is taken as prescribed, and in gaining an understanding of the prescribed medication regimen, including the benefits and side effects of the medication, and how the youth can learn to manage the medication regimen independently.
- g) The LSP contractor shall integrate structured educational programs and structured, closely supervised therapeutic recreational events into the Intensive Support programs. Emphasis shall be placed on promoting healthy, age-appropriate activities and interaction, while still providing a therapeutic milieu, including counseling, support and psychiatric consultation.
- m) Staff training for this specialized placement shall include, but not be limited to:
 - i. Modality of treatment to be utilized;
 - ii. Working with highly aggressive and assaultive youth;
 - iii. Understanding and treating trauma and its manifestations;
 - iv. Intensive de-escalation techniques; and
 - v. Effective safety planning.
- n) Staffing shall be consistent with the LSP staffing ratio of two (2) staff members for every six (6) children. In addition, Intensive Support placement shall have one (1) supervisor on site at all times.

PART VI: AFTERCARE

Following a period of limited secure placement, aftercare is the next step in the continuum for adjudicated juvenile delinquents in New York City. LSP contractors shall deliver their own aftercare services to support youth returning to their families and home communities through the provision of evidence-based or promising practice models, as well as linkages to various local community-based organizations (unless the provision of aftercare by another LSP contractor is more appropriate to the situation of the youth and family). The aftercare component of limited secure placement is critical to the success of reentry and reunification and requires regular, open communication among all parties involved. LSP aftercare staff will work collaboratively with the ACS Placement and Permanency Unit, as well as LSP residential staff to offer the necessary support to every youth and family served. Aftercare staff shall begin communication with the ACS Placement and Permanency Unit and LSP residential staff during the placement period and initiate engagement with the youth and family prior to release, on a case-by-case basis, to help facilitate a smooth transition.

A. Agency Goals and Objectives

1. ACS is committed to helping youth returning from LSP to reintegrate safely into their home communities and to return to family settings when possible. ACS's goals and objectives are to provide quality aftercare services to the JD population of young people who are transitioning back into their home communities through the use of an evidence-based model or promising practice model. Programming shall work to help stabilize the family while increasing the family's utilization of community resources for the youth to remain safely at home while receiving services and avoid any further interaction with the juvenile or criminal justice system. LSP aftercare staff shall foster engagement in pro-social community activities such as sports, art and/or music programs (at no cost to the youth's family). Additionally, to promote the continuity of services from placement through aftercare, there must be continuity between the behavior management system utilized in LSP facilities (described in Part IV of these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*) and the system utilized in aftercare.
2. These program models will:
 - a) Serve youth and their families in their own neighborhoods;
 - b) Prevent recidivism;
 - c) Stabilize youth within the family;
 - d) Improve family functioning;
 - e) Reduce truancy, substance use, curfew non-compliance and other teen-specific maladaptive behaviors;
 - f) Strengthen parenting skills; and
 - g) Ensure all youth are safe, healthy and well cared for.

B. Eligibility

1. All LSP-placed youth will be provided an aftercare service.
2. All aftercare programs must be able to accommodate their own placement population, with the necessary accommodations made for youth with developmental disabilities.
3. All LSP aftercare programs that provide group programming must also be designed in a way that youth participate with others in their age group, gender, gender identity where appropriate, and/or developmental stage.
4. All LSP aftercare programs must adhere to the ACS *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System* policy².

C. Communication and Case Coordination

1. Communication and case coordination are critical for the success of youth transitioning from placement to the community and require the following:
 - a) LSP residential staff shall confirm the aftercare plan with the ACS Placement and Permanency Unit no later than day 60 of the placement so that the appropriate LSP aftercare staff can participate in discharge planning.
 - b) Cases will be discussed as part of the “LSP Contractor Agency Conference Calls.”
 - c) The agenda for the Aftercare Services Conference Calls is as follows:
 - i. Purpose: To discuss youth who have been released to aftercare services.
 - ii. Required Participants:
 - (a) ACS CTH Placement and Permanency Specialist
 - (b) LSP aftercare staff administrators and/or clinicians
 - (c) LSP case planner or other designated residential staff familiar with the case (when youth are on trial discharge)
 - (d) Foster care agency case planner (when youth are in foster care)
 - (e) DCP representative (when there is an open ACS case)

² Draft is currently being finalized.

- (f) FCLS attorney if there is a pending Article 10 case.
- iii. Optional Participants:
 - (a) ACS CTH Director of Placement and Permanency
- iv. Frequency: Weekly
- v. Agenda:
 - (a) The ACS CTH PPS will report on the youth's overall adjustment to release and aftercare, including the youth's compliance with reporting, school attendance and credit transfer issues, as well as any areas of concern, including any community safety risks.
 - (b) The LSP residential representative will provide an update on the trial discharge.
 - (c) The LSP aftercare representative(s) will discuss the youth's progress in treatment, as well as any barriers.
 - (d) The aftercare representative(s) will discuss plans and continued efforts to support the youth's success in the community and prevent the need for release revocation.
 - (e) The aftercare representative(s) and ACS CTH PPS will discuss any proposed release revocations.
- d) Responsibilities and Communication Two Weeks Prior to Release
 - i. In a manner consistent with ACS e-mail security policy, two (2) weeks prior to a youth's release, the ACS CTH PPS will submit a copy of the most up-to-date treatment plan and an ACS LSP Agency Modification Request to the DYFJ MCCU via email for approval to internally modify the youth's placement for ACS community supervision.
 - (a) The ACS CTH PPS will forward a copy of the treatment plan and ACS LSP Agency Modification Request to the LSP aftercare staff member via email so that the worker can make plans to contact the family.
 - e) Prior to the youth being released, the LSP contractor agency case planner, the ACS CTH PPS, the youth, and the parent or other discharge resource shall sign the required Conditions of Release form, Statewide Curfew, and Notice Concerning Discipline Rules of Conduct which will reflect that the youth participate in post-residential services and the aftercare services that will be provided, or any other required program.
 - f) Upon release, within 24 hours, the youth must contact the ACS CTH PPS by phone to confirm his/her arrival home. The CTH PPS will then communicate with the

aftercare worker who will also be responsible for making his or her first therapeutic contact with the family within 72 hours of the youth's release.

- i. For child welfare involved youth, the ACS CTH PPS will coordinate with the LSP case planner to conduct a special pre-release home assessment. The ACS CTH PPS will work with the ACS foster care contractor agency to ensure that the child welfare placement plan is in place and ready to receive the youth upon discharge from LSP. If the LSP contractor or ACS CTH PPS have concerns about the ACS foster care provider agency's plan for the youth, they must contact the ACS Confirm Unit. For youth who will be entering foster care for the first time upon discharge from an LSP, the ACS PPS will make best efforts to ensure that a foster care placement has been identified so that a joint visit can occur including all individuals involved in planning for the placement, and that the youth and planning resource(s) can learn about and discuss the aftercare plan together.
- ii. The LSP aftercare worker shall make contacts in keeping with the requirements of the evidence-based or promising practice model being implemented.

D. Release Revocations

1. The ACS CTH PPS will make a decision about whether to remove a youth from the community and return the youth to out-of-home care (revoke the youth's release) when he or she has engaged in serious misconduct; has been arrested and/or found guilty of having committed a serious offense; or for a combination of other factors that have made the youth's release unsafe or untenable. The revocation decision must be made in consultation with staff on the managerial level and will be based on an assessment of the severity of the behavior within the context of the youth's adjustment to aftercare services in the community. The ACS Placement and Permanency Unit will have an internal case conferencing process, to assure that revocations are consistent with ACS procedures and practices. Prior to the decision to revoke the youth's release, efforts shall be made to engage the youth, family, ACS CTH PPS, and aftercare worker to develop a plan to prevent revocation. The following may also be reasons for ACS to revoke a youth's release which have been adapted from 9 NYCRR Section 169.1:
 - a) Failure to adhere to a reasonable curfew set by the ACS CTH PPS;
 - b) Association with persons whose influence would have a detrimental effect, including but not limited to persons previously convicted of crime or having a known criminal background;
 - c) Once youth is connected to an appropriate school, failure to attend school in accordance with the provisions of part I of article 65 of the Education Law and/or cooperate with the CTH PPS and/or aftercare worker in seeking to obtain and in accepting employment and employment counseling services;
 - d) Failure to abstain from the use of alcoholic beverages, hallucinogenic drugs, habit forming drugs not lawfully prescribed, or any other harmful or dangerous substance;

- e) Failure to report to the CTH PPS as directed;
- f) Commission of an act which would be a crime if committed by an adult;
- g) Operation of a motor vehicle without a license;
- h) Failure to obey all reasonable commands of parents or other persons legally responsible for care and treatment;
- i) Running away from the lawful custody of parents or other lawful authorities; and
- j) Failure to abide by any other reasonable condition of which the youth is informed.

E. Discharge

1. Case completion will be defined by the evidence-based or promising practice guidelines with guidance of the model consultants. Case completion may occur prior to the expiration of the youth's placement order.
2. LSP aftercare services end on the expiration date of a youth's placement. Treatment may continue beyond the expiration date, as clinically warranted but shall be on a voluntary basis only.
3. Discharge readiness and plans shall be discussed during the appropriate conference call.

F. Program Site Location(s) and Facility Standards

1. Nearly all aftercare services should be provided in the family's home or at locations in the communities in which the youth and family live (e.g. the youth's school, community-based mental health clinics, community-based after-school programs, community settings, and not in the aftercare worker's office). LSP contractors must consider the safety needs of families when determining if home-based services are appropriate, for example, when there is a history or evidence of domestic violence in the family. ACS also recognizes that LSP contractors may need to supplement home-based services in certain situations. For example, some families' living situations may prevent effective home-based treatment due to multiple families sharing a common space, or when language translation services are required.
2. The program facility (or collection of facilities) must be readily accessible and usable by individuals with disabilities, including but not limited to, people with visual, auditory, and/or mobility disabilities. The facility should be easily accessible to youth and families being served and only a short walking distance of some form of New York City public transportation.

G. Community Partnerships

1. ACS encourages the forming or enhancement of existing community partnerships or linkages with community based organizations. LSP aftercare staff shall work to develop and support holistic, seamless local networks of service providers, community members and families, and other stakeholders with the goal of assisting families and offering safety and support where they reside. Agencies shall identify community needs and draw upon community resources to address those needs and work to identify and overcome obstacles to success. Aftercare programs are encouraged to connect youth and their families to a partnership (if one exists) in the community to which the youth is returning from limited-secure placement. Besides ACS contractors, community partners are thought to include representatives from health, mental health, substance abuse, and domestic violence service providers and will be encouraged to continue to build this network. Partnerships include birth/caretaker families and foster families. They also include residents, community leaders, school personnel, police precinct staff, employment readiness programs, child and youth development programs, housing organizations, faith and civic groups, and local business owners.

H. Neighborhood-Based Services

1. LSP contractor staff shall establish linkages and referral protocols with neighborhood-based service providers when appropriate to the model.
2. The aftercare worker shall build supportive services and work in partnership with other providers in the community to best meet the needs of children and families living in the community.
3. Aftercare staff shall make every effort to actively participate in the Neighborhood Network within their community. A Neighborhood Network is a collaboration between community-based ACS staff, ACS contract agencies assigned to specific community districts, other local service providers, and community stakeholders.

I. Accessibility of Services

1. The LSP contractor shall describe the geographic proximity of its aftercare service site(s) to the youth and families most likely to receive services. The LSP contractor shall detail the modes of transportation available to access the service site(s) and the approximate travel time and distance from public transportation locations to the site(s).
2. The LSP contractor shall develop a general strategy for ensuring that the program site's hours of operation reflect the needs of the youth and families to be served. This

strategy shall include flexible hours to accommodate school hours and working family members in a manner that is least disruptive to daily life activities, religious proscriptions, medical and health related conditions, and neighborhood safety conditions.

- a) The aftercare worker shall assess the communication skills of each youth and family to be served and shall address identified family literacy limitations so that oral and written communications occur at an appropriate level, to ensure the client's full participation in and understanding of the services offered.
- b) The aftercare worker shall make services accessible to clients with physical disabilities. Strategies for doing so may include, but not be limited to, offering TDD services, raising staff consciousness about disabilities, utilizing large print informational reading materials, and establishing referral protocols to programs serving disabled communities.

J. Social Work Services and Advocacy

- 1. Aftercare staff shall establish linkages with organizations providing expert and specialized services to individuals with chronic physical, mental or developmental disabilities, prenatal and postnatal counseling and services, parenting services, alcohol and substance abuse. Staff will implement protocols for referring clients to neighborhood-based services when such services are appropriate and available.
- 2. Aftercare staff must have a process of systematic collection of information on participant characteristics, staff characteristics, and participant service experiences to ensure services are being implemented with fidelity to the model, program intent, and structure.

K. LSP Aftercare Contractor Staff

- 1. Staff Qualifications
 - a) LSP aftercare contractor staff shall ensure that culturally and linguistically competent services are provided through a staff that is representative of the population served and fluent in the languages spoken by participating youth and family members, including hiring staff from the same community where the program services are being provided. Social work staff shall have experience and skills with the practices and concept of family treatment/family systems and evidence based interventions, as well as knowledge of and experience with youth development, domestic violence issues, and substance abuse issues.
 - b) The LSP contractor shall profile the credentials of its staff, including, but not limited to, the number of staff, educational degrees, languages spoken and areas of

specialization, and describe how these impact upon and address service needs of the targeted population.

- c) Social work staff shall have demonstrated experience and skill with, and commitment to, the practices and concept of family treatment, as well as knowledge of and experience with domestic violence issues and substance abuse issues.
- d) Staff shall adhere to all program model qualifications and experience requirements for the proposed model as listed in the Standards & Indicators.
- e) Staff must demonstrate expertise and commitment to the evidence-based model or promising practice model to be utilized for this population.

2. Staff Training and Development

- a) The LSP contractor shall ensure that all appropriate staff receive periodic and regular training about relevant child welfare and juvenile justice topics including, but not limited to, substance abuse, adolescent development, psychotropic medication and medication management, working with families, concurrent planning, domestic violence, teen relationship abuse, HIV/AIDS, behavior modification and management, child development disorders, LGBTQ training curriculum³, gender identity, and expression, sexually acting-out, crisis intervention, trauma theory, neglect and abuse, and youth and gang violence.
- b) The LSP contractor shall ensure that all appropriate staff receive training specific to the provision of neighborhood-based services, including training on community characteristics, resources, and needs, and on how to successfully negotiate services for youth within a neighborhood-based environment.
- c) The LSP contractor will make every effort to ensure that training incorporates and encourages the participation of representatives from community-based service providers who provide culturally appropriate and linguistically supported programs including services for young women, pregnant and parenting youth, lesbian, gay, bisexual, transgender and questioning youth (youth questioning their sexuality), such as local hospitals, police precincts, and drug treatment centers, as well as community residents.
- d) The LSP contractor shall provide training in about how to recognize and assess the presence of domestic violence and substance abuse as well as methods for performing appropriate interventions.
- e) The LSP contractor must ensure that all of its staff are trained or are being trained in the use of the treatment model being implemented.
- f) The LSP contractor shall provide training to aftercare staff on the model being used in the residential facility to promote a more seamless transition from placement to aftercare.
- g) A strategy for guiding staff in balancing the task of delivering program content while being responsive to a family's cultural beliefs and immediate circumstances.

³ (In progress)

- h) A method to train staff on delivering the model with a supervisory system to support direct service staff and guide their ongoing practice.
- i) Reasonable caseloads that are maintained and allow direct service staff to accomplish core program objectives.

L. Monitoring, Evaluation and Quality Improvement

1. Case Record and Record Keeping
 - a) The LSP contractor shall cooperate with ACS and OCFS assessment, evaluation and technical assistance systems, and shall provide all information necessary to allow ACS to fulfill these responsibilities.
 - b) The LSP contractor shall maintain adequate case files and fiscal records, and ensure that staff follow appropriate record-keeping practices and procedures, in a manner which is in compliance with and supports all existing Federal, State, and City laws, rules, and regulations, and is consistent with policies, procedures, and standards promulgated by ACS, including the utilization of electronic data management systems such as the New York State systems of record (i.e. Child Care Review Service [CCRS] and CONNECTIONS [CNNX]).
 - c) The LSP contractor shall provide sufficient information to ACS to enable data collection and monitor additional performance indicators as appropriate and as part of a full evaluation process.
 - d) The LSP contractor shall comply with any ACS request to obtain additional data specific to the needs of this population.
 - e) The LSP contractor shall comply with any ACS request to submit critical incident/fatality reports.

M. Quality Assurance

1. The LSP contractor shall comply with ACS policies and procedures regarding evaluations, best practices and improvement strategies as appropriate.
2. The LSP contractor shall work with ACS' Juvenile Justice Planning and Measurement (JJPM) Unit, Agency Program Assistance (APA), DYFJ, and/or Program Development (PD) consultants and monitors to ensure performance standards are maintained, including, but not limited to, scheduling site visits, access for case record reviews and evaluations and attendance at pertinent meetings and trainings. JJPM, APA, and Provider Agency Measurement System (PAMS) Scorecard staff are responsible for ongoing monitoring of contractor agency practice at the program level, through case reviews and quality improvement efforts.

3. The LSP contractor shall have access to clinical consultants who are associated with the model being provided, to provide case consultation and advice on program and clinical issues.
4. The LSP contractor shall comply with the program model's policies and procedures regarding case documentation and quality assurance measures.
5. The LSP contractor shall work with Conference Facilitators/Specialists employed by Children's Services who are involved in case planning and decision-making on individual cases, traditionally done through Family Team Conferences (FTC) convened at regular intervals, and at critical points in a family's involvement with child welfare services. ACS will work with the contractor to make modification to FTC requirements to ensure compliance with the program model.
6. The LSP contractor shall maintain internal quality assurance systems that demonstrate continuous program improvement, utilizing program specific data to inform that process.

N. Scorecard

1. Programs will be evaluated using an ACS Scorecard, with indicators developed specifically for LSP. Performance measures will capture programs' performance in meeting regulatory requirements, achieving desired outcomes for the families they are serving, and sustaining a high-quality service delivery system. The Scorecard will capture data through monthly reports required from all programs, qualitative reviews conducted by ACS and other required reporting mechanisms. The reporting mechanisms will vary depending on the categorization of the program (i.e., preventive or otherwise) and will include but not be limited to the NYS Child Care Review Service data base (CCRS) and Connections (CNNX). The evaluation will be conducted regularly, and programs will be expected to initiate corrective action plans as needed to address deficiencies identified in the evaluation. In addition, ACS may base decisions about contract renewal and program capacity on the results of the annual Scorecard. Modifications to the Scorecard tool may be made to ensure model fidelity.

PART VII: PERSONNEL REQUIREMENTS

A. Staff Qualifications

1. Social Work Services

- a) Director of Social Work Services: A master's degree in social work and a minimum of three (3) years of experience in a supervisory capacity supplemented by or including experience in the field of juvenile justice.
- b) Supervisor of Social Work Services: A Master's degree in social work and a minimum of (3) years of experience, at least one of which shall have been under qualified supervision in the field of juvenile justice.
- c) Site Director (for General Programs): At minimum, a BA/BS/BSW in an appropriate discipline with seven (7) years documented satisfactory experience working with court-related youth and at least three (3) years of experience working in a residential setting. The site director should also have at least two (2) years of supervisory experience.
- d) Site Director (for Specialized Programs): LMSW or equivalent human services graduate degree and a minimum of seven (7) years documented satisfactory experience working with court-related youth; at least three (3) years of experience working in a residential setting; and at least two (2) years working with the specific specialized population that the site will serve.
- e) Supervisor of Direct Care: Shall be qualified by appropriate training and have experience with children living in a group living facility.
- f) Direct Care Worker: Shall have at least a high school or equivalency diploma and shall have experience working with at risk and challenging adolescents.
- g) Intake Worker: MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. (May be shared across multiple programs).
- h) Caseworker/Social Worker: MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

2. Recreation Therapist: BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field. This staff is recommended to help LSP contractors enhance their recreational services.
3. Care Coordinator: MSW or equivalent human services graduate degree or BA/BS/BSW with at least two (2) years of documented clinical experience. The duties under this position can be performed by the LSP Caseworker.
4. CASAC: Bachelor-level CASAC.
5. Mental Health Services
 - a) Psychologist: Licensed as a psychologist in New York State. Masters-level or doctoral-level clinical psychologist is to provide services where indicated.
 - b) Mental Health Clinician: LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.
 - c) Occupational Therapist: Licensed in New York State with at least two (2) years documented relevant experience.
 - d) Speech-Language Pathologist: Licensed in New York State with at least two (2) years documented relevant experience.
 - e) Family Worker: MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented experience in family engagement and treatment.
6. Educational/Vocational Specialist: BA/BS/BSW or MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field (including Masters in Ed w/ CRC) with at least two (2) years documented relevant experience.
7. Parent Advocate: Persons who have previously received child welfare or juvenile justice services, have successfully addressed the issue(s) which brought their families to the attention of the child welfare system, have been reunified with their children, if applicable, and subsequently have been trained as parent advocates to work within the child welfare system as set forth in *Title 18 NYCRR 441.2(o)*.
8. Consultants
 - a) LSP contractors may utilize consultants that include, but are not limited to:

- i. Psychologist: certified as a psychologist in New York State.
 - ii. Psychiatrist: New York State licensed physician with a specialized rating in adolescent psychiatry.
 - iii. Physician: licensed pediatrician (or family medicine) and currently registered to practice medicine in New York State.
 - iv. Mental Health Professional: LCSW (preferred) or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.
 - v. Substance Abuse Professional: CASAC Bachelor-level CASAC
 - vi. Dietician: Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.
- b) LSP contractors that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided. These staff may be shared across multiple programs.
9. To the degree possible, the LSP contractor shall supply on-site speech, occupational and physical therapy when ordered by the primary care provider.
10. Family Team Conference Facilitator (if necessary): MSW or equivalent human services graduate degree or two (2) years casework and one (1) year group work experience and/or one (1) year supervisory experience.
11. Add-On Staff: It may be necessary for the LSP contractor to hire special staff for a particular youth or group of youth, on a case-by-case basis. ACS must be informed of an agency's decision to hire special staff. In some cases, the decision will be made collaboratively between ACS and the LSP contractor, based on the specialized needs presented by a youth.
12. Staffing and Staff Qualification shall be in accordance with *18 NYCRR Part 442.18* or any successor or amended regulations.

B. Staffing Requirements

1. The LSP contractor shall have staff, professional consultants, or close linkages with resources that are qualified to address the full range of medical, clinical, and developmental needs presented by children and adolescents in residential care.

Whenever possible, the LSP contractor shall employ social work staff with at least a BSW or equivalent level of education and/or experience. Staff shall be skilled at engagement of youth and their families, and have a thorough understanding of child and adolescent development. The LSP contractor shall ensure staff are committed to working with juvenile delinquent youth and are experienced and qualified to support youth to obtain the skills and resources necessary to live healthy, productive, and self-sufficient adult lives. Social work staff shall be familiar with the practice and concept of family treatment, and receive training/have experience as well as experience in screening for domestic violence and chemical dependency/use issues and making referrals to appropriate providers for further assessment and services. Experience and qualifications shall include previous work experience with similar populations and credentials in the specific areas of expertise (e.g. CASAC for chemical dependency/use counselors).

2. The LSP contractor shall designate a staff person to be the Domestic Violence (DV) Services Coordinator. This person will schedule and document staff training in domestic violence, and participate in Children's Services-organized forums for domestic violence education and information on issues such as chemical dependency/use and domestic violence, immigration, working with abusive partners, the effects of domestic violence on children, etc. The DV Service coordinator shall receive on-going regular training and education, including case conferencing, on an as needed basis. The DV Services Coordinator monitors provision of domestic violence assessments with birth families and foster families, and the use of the Children's Services DV Screening Tool and Children's Services DV Protocol at intake and periodically afterwards, receives reports of indicated domestic violence from Children's Services CPS and other referring organizations, and conducts outreach and liaison to establish a network of services for domestic violence.
3. The LSP contractor shall designate a staff person (Director level or above) to be the LGBTQ Point Person to serve as a source of support to youth and as a resource to staff on LGBTQ issues. This person will schedule and document staff training in LGBTQ issues, and participate in Children's Services-organized forums for education and information on LGBTQ issues. The LGBTQ Point Person shall receive on-going regular training and education, including case conferencing, on an as needed basis. The LGBTQ Point Person is responsible for conducting outreach and liaison to establish a network of services for LGBTQ youth and their families.
4. The LSP contractor shall assure that all clinical staff including physicians, nurse practitioners, psychologists, nurses, etc. are licensed professionals and meet the qualifications as described here. For those limited services that will not be provided on site, all staff and neighborhood-based medical and mental health professionals working with the LSP contractor shall have demonstrated experience and skill with, and commitment to, the practices and concept of effective health care management, as well

as knowledge and experience with issues affecting health care provision, coordination, and integration.

5. The LSP contractor shall be responsible for the verification of credentials and references and screening of all current and prospective employees in accordance with ACS policy. Such screening shall include but not be limited to the following:
 - a) New York State Central Register Clearance (SCR)
 - b) Criminal History Record Check
 - c) Applicant's Employment History
 - d) References
 - i. LSP contractors shall obtain from all prospective staff the names, addresses and, telephone numbers of three (3) references who can verify the applicant's employment history, work record and qualifications is required. LSP contractors shall request written statements from three (3) references including previous employers. When written statements are not received, the LSP contractor shall follow up by telephone. These statements shall become part of the individual's employment record.
 - e) Physical Examination
 - i. A physical examination shall be required of all staff as a condition of employment, which shall include an intradermal tuberculin test, with chest x-rays where such test result is positive. The candidate needs to be certified in writing for fitness of employment. Such certification shall be retained by the LSP contractor and kept available for inspection.
6. See *Title 18 NYCRR Part 442.18* or any successor or amended regulations for additional information regarding institutional personnel requirements.

C. Probationary Employment

1. The LSP contractor may retain an employee on a probationary basis in accordance with Children's Services' policies, pending the results of the record review conducted by DCJS and the SCR. For such probationary hires, the LSP contractor shall keep in confidential personnel files documentation describing supervision and measures taken to ensure the safety of children with whom such staff is working, pending background clearance. The LSP contractor shall notify Children's Services of decisions to hire employees on a probationary basis pending the results of a criminal background check.

D. Suspected Abuse or Maltreatment of Children/Youth by an Employee

1. The LSP contractor must adhere to ACS policies and all applicable Federal and State laws and regulations regarding suspected abuse or maltreatment of children/youth by an employee.

E. Children's Services' Request for an Employee Review

1. Children's Services reserves the right to request that the LSP contractor review the performance of any employee who has direct contact with children and/or families referred by Children's Services pursuant to their contract. Upon completion of the review, the LSP contractor shall take appropriate action with respect to the employee, and thereafter notify Children's Services of such action.

F. Staff Development Supervision

1. All caseworkers must receive at least one hour per week of individual supervision for the purpose of professional development from an MSW, or equivalent human services graduate degree, level supervisor. In the event of extended absences/vacancies in a supervisory position, the director of the program shall arrange for coverage and maintain the provision of weekly individual supervision and case reviews.
2. It is recommended that supervisory case reviews occur in the context of supervision (individual and/or group) with the caseworker(s), child care staff and supervisor(s) and that the case reviews include thorough discussion of the preceding and current case issues and dynamics; careful monitoring of the quality of the casework provided; and clear support and guidance to staff in making critical case-related judgments and decision.
3. Supervisors are responsible for maintaining a record, outside of the system of record case record, of weekly supervision meetings with each of their staff. Weekly occurrences of supervision for professional development shall be documented at minimum in a monthly summary of the key aspects of supervision bulleted above. Supervisors shall also keep records of all performance reviews.

G. Performance Evaluation

1. Performance evaluations of all staff shall be conducted annually at a minimum. For new staff, the first review is conducted within six (6) months and annually thereafter. Performance evaluations shall be based on information from direct observation of job performance on an ongoing basis during weekly staff supervision and monthly social

worker/foster parent contact and includes observed interaction with the child and/or birth families/discharge resources. Results of performance evaluations shall be incorporated into the performance plan for the coming year. Performance evaluations shall result in the LSP contractor's effort to strengthen constructive behavior and reward positive performance. Performance evaluations shall also be used to develop training objectives for staff.

H. Cultural Competence

1. LSP contractors shall ensure that programs are operated with understanding and respect for community needs and cultures. Culturally and linguistically competent services shall be provided by a staff that is representative of the community served and fluent in the languages spoken by youth and family members. To the extent possible the LSP contractor shall recruit and hire appropriately qualified staff from the community served. When it is not feasible to hire bilingual/bicultural staff from each different ethnic/cultural group in the community served, the LSP contractor shall have a Memorandum of Understanding (MOU) with community-based organizations or have access to interpreter and translation services needed to serve non-English speaking youth, parents, discharge resources and kinship resources.
2. The LSP contractor shall provide culturally and linguistically competent services through staff that is representative of the communities served and fluent in the languages spoken by participating children and family members. Such staff shall reflect that the LSP contractor is able to assess the needs of the local community and is meaningfully linked to local community/ies resources, and that the program is led and operated with understanding and respect for community/ies needs and cultures. The LSP contractor shall make diligent efforts to recruit and hire qualified staff that reflects the ethnicity/race of the community served. When it is not feasible to hire bilingual/bicultural staff from each different ethnic/cultural community group, the LSP contractor shall have "letters of linkage," memoranda of understanding, or other written agreements with community-based organizations or have contractual arrangements with interpretation and translation services needed to serve non-English speaking children and family members.

I. Political Activity/Religion

1. LSP contractor staff may not engage in or promote partisan political activity or religious worship, instruction or proselytizing during the conduct of their employment. The religious affiliation of the LSP contractor or individual staff members shall not influence the delivery of services as set forth in *Title 18NYCRR 441.11(a) and (b)*, or any successor or amended regulation.

J. Staff Training and Development

1. LSP contractors shall continually assess the training needs of the LSP contractor staff based on the population of youth in the LSP contractor's care and tailor the training to ensure that its staff receives appropriate training.
2. LSP contractors shall have an annual training plan, which describes the specific trainings and hours of each that are required of and offered to each staff level. LSP contractors shall be able to track and monitor staff compliance with annual training requirements.
3. The attendance, time and substance of all pre and in-service training must be documented and available to ACS.
4. LSP contractors must provide comprehensive training for staff who come into contact with youth to equip them with skills to deal positively and effectively with problem behavior; assist them in meeting the needs of a diverse population of youngsters in their care; receive information on techniques in identifying trauma and addressing trauma triggers, understanding adolescent development, managing behavior and preventing abuse/maltreatment, and meeting the contractual requirements of the service contract.
5. Training for staff coming into contact with youth and their supervisors shall consist of both on-the-job and classroom training. In addition to covering the specific topics listed below, the training shall provide a common language and open communication about behavior challenges and solutions for staff – including social service staff, direct care staff, therapists, educational specialists, parents and youth.
6. All training for staff coming into contact with youth and their supervisors shall be geared toward developing an understanding the needs and characteristics of the population in care and skills building to provide emotional support and care, and appropriately manage the behavior of youth in placement. Such training shall also include all skills that are identified as needing improvement in the individual staff's annual performance evaluation.
7. All LSP staff must receive training in the ACS designated program approach. This can include, but is not limited to, two weeks of pre-service training in addition to the pre-service training requirements below. Additionally, LSP contractor staff are required to participate in intensive ongoing coaching and technical assistance provided by ACS.
8. All LSP staff who have contact with youth, or who supervise staff who have contact with youth, shall also receive a minimum of eighty (80) hours of pre-service training in, but not limited to, these topics (the number of hours for each topic is at the discretion of the provider, except required Suicide and Crisis Management and Physical Restraint Interventions):

- a) Overview on Family Court, and particularly the juvenile justice system;
- b) Critical thinking, case decision-making, communication skills, and report writing;
- c) All reporting requirements, including mandated reporting of child abuse;
- d) Crisis Management and Physical Restraint Interventions: The LSP contractor must utilize the ACS designated crisis management and physical restraint intervention technique. The LSP contractor shall ensure that the LSP contractor's trainers are trained and certified by the ACS provided training. Ongoing training shall also be provided. The LSP contractor's training to staff must provide, at minimum, the following to all direct care staff:
 - i. Appropriate procedures for preventing the need for physical restraint, including the de-escalation of problematic behavior, relationship building, and the use of alternatives to restraint;
 - ii. Instructions for developing individual behavior plans for each youth;
 - iii. The methods for evaluating the risk of harm in individual situations in order to determine whether the use of restraint is warranted and the description and identification of dangerous behaviors on the part of youth that may indicate the need for physical restraint;
 - iv. The simulated experience of administering and receiving a variety of physical restraint techniques, ranging from minimal physical involvement to very controlling interventions (ACS Policy outlines specific allowable physical restraint techniques);
 - v. Instructions regarding the effects of physical restraint on the person restrained, including instruction on monitoring physical signs of distress and obtaining medical assistance;
 - vi. Instructions regarding debriefing with staff after a physical restraint has taken place;
 - vii. Instruction regarding documentation and reporting requirements and investigation of injuries and complaints; and
 - viii. Demonstration by participants of proficiency in verbal de-escalation and administering physical restraint through successfully passing a skills exam.

- e) Emergency procedures, including fire and “disaster” escape planning, fire safety, establishment of a disaster plan, and emergency medical procedures
 - f) Youth development; the effects of abuse (including sexual abuse), maltreatment, trauma, loss and separation, and living with domestic violence on youth; and the range of behaviors, including substance abuse, that youth engage in to cope with these issues, and how to appropriately respond to them;
 - g) Gender specific service provision differences and program practices to meet the differing needs of girls and boys in limited secure placement;
 - h) Common psychological and psychiatric diagnoses in youth in LSP, including what types of behaviors to expect from youth with diagnoses and how to manage and change behavior;
 - i) Medication administration and training on common psychotropic medications used with youth, including the risks/side effects associated with such medication and basic information about the use of psychotropic medications and diagnoses;
 - j) Family planning and sexual health, including youth’s rights to access confidential services on their own and HIV/AIDS;
 - k) Supporting lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth in care, in accordance with ACS policy; *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System*;
 - l) The importance of initial and ongoing medical and mental health treatment and the importance of keeping scheduled appointments as well as compliance with treatment;
 - m) Information about the education system in the City, including the special education system, and the importance of continued education for youth; and
 - n) Cultural Competency.
9. All LSP staff who have contact with youth, or who supervise staff who have contact with youth, shall also receive a minimum of thirty (30) hours of in-service training annually (forty (40) hours of in-service training for LSP staff in specialized programs, additional training required as outlined in Part V of these Quality Assurance Standards) which may include, but not limited to, the topics listed above.

10. The LSP contractor shall ensure the provision of at least eight hours of pre-service training and four hours of annual refresher training for all direct care staff in suicide awareness, assessment, prevention, and response to suicide attempts.
11. The LSP contractor shall ensure that all staff receive training specific to the provision of neighborhood-based services, including training on community characteristics, resources, and needs, and negotiation of services for youth within a neighborhood-based environment.
12. The LSP contractor shall make every effort to ensure that training incorporates and encourages the participation of community-based service providers, such as local hospitals, mental health providers and family support programs, police precincts, and drug treatment centers, as well as community residents and leaders.
13. Supervisors shall have the ability to assess the professional development needs of their staff, and support those needs and provide opportunities for growth. Supervisors shall conduct quality assurance case reviews with staff, and provide staff with reflective supervisory support and regular evaluations.
14. Staff Training – Providers of Health, Mental Health and Substance Abuse Services, and Coordinators of Health Services
 - a) In addition to clinically appropriate trainings, the LSP contractor shall develop a strategy to ensure that health coordinators as well as mental health and substance abuse service providers who are working with youth in their care receive orientation or training in issues such as the importance of a strength based approach to assessment and treatment as well as the following topics:
 - i. The LSP contractor’s responsibility for coordinating the health care provided to youth in its care, the need for documentation of provided health services, and how HIPAA applies to youth in placement;
 - ii. How the health care coordinator will interact with the ACS contractor health provider, the youth's discharge resources and other service providers; and
 - iii. Common health, emotional and behavioral issues affecting youth in juvenile justice placement, including the trauma that often results from abuse/maltreatment, community violence, and separation from one’s parents.

PART VIII: REQUIRED DOCUMENTS AND RECORDKEEPING

A. Program Manual

1. The LSP contractor shall develop a comprehensive program manual which includes, but is not limited to; a comprehensive overview of the program model, LSP contractor administrative and organizational information, site specific information, description of program services and permanency planning, description of support services for families, case practice information, personnel policies and procedures, the LSP contractor's responsibility in case flow, and record keeping and data management information. This manual shall also include a directory of resources, which shall be updated on a calendar basis by each LSP contractor.
2. In addition to LSP contractor policies relating to the provision of services in LSP, the Program Manual submitted must include, but is not limited to the following:
 - a) Organizational papers such as a true copy of the Certificates of Incorporation filed with the New York Secretary of State, by-laws, and any other related documentation reasonably requested by Children's Services;
 - b) Personnel policy practices including such matters as job descriptions and qualification requirements, hiring and selection practice, personnel grievance procedures, benefits and leave, salary increases, holiday schedules and other related matters;
 - c) Purchasing policy and procedures;
 - d) Fiscal policies and procedures;
 - e) Intake and planning procedures;
 - f) A completed safety plan that provides specific and detailed procedures for responding to a range of incidents, including natural disasters;
 - g) Management practices and procedures; and
 - h) Written description of Quality Assurance Plan.
3. Appropriate Children's Services personnel/staff will review and must approve the LSP Program Manual. Children's Services may direct the LSP contractor at any time, and from time to time, to rescind, modify or add to its Program Manual to bring the

Standards and Procedures in compliance with these *Juvenile Justice Limited Secure Placements Quality Assurance Standards*, the Law and Children's Services Policies.

4. Children's Services Review

- a) The LSP contractor, when requested, shall make available for Children's Services review, a copy of the Program Manual.

5. Previously Submitted Program Manual

- a) If, in response to a request by Children's Services, the LSP contractor believes they had previously submitted a copy of its Program Manual, the LSP contractor shall give written notice to Children's Services of the date of submission and shall certify that the Program Manual of Standards, Policies and Procedures stated therein are currently in effect. ACS may review, in whole or in part, or decline to approve the Program Manual of the LSP contractor. ACS may direct the LSP contractor at any time, and from time to time, to rescind, modify or add to its Program Manual to bring the Program Manual into compliance with the law, and/or ACS policies.

6. Changes to Program Manual

- a) The LSP contractor shall notify ACS in writing within thirty (30) days of any changes in its Program Manual.

B. Documentation of Case Records

1. The LSP contractor shall maintain adequate case files and fiscal records, and shall ensure that its staff follows appropriate record-keeping and retention practices and procedures, in a manner that is in compliance with and supports all existing federal, state and City laws, rules, and regulations, and is consistent with policies, procedures, and standards promulgated by Children's Services. The LSP contractor shall keep separate files and records for each youth so that they may be readily identifiable from those relating to other activities of the LSP contractor. In addition to information normally kept by the LSP contractor in individual files, such as basic information about the individual, describing and recording each use of the services by the individual, and the individual's progress, the LSP contractor shall include such other information in individual files as Children's Services may require. The files and records of each recipient shall be made available to Children's Services at reasonable times upon reasonable notice and request.
2. The LSP contractor shall upon reasonable notice and request by Children's Services, provide information and records relating to youth in the custody of Children's Services. Children's Services shall have access to information and records including, but not limited to, information and records pertaining to programs, birth parent[s], family,

extended family or other discharge resources, foster parents, and compliance with legally mandated activities. The LSP contractor shall collect and maintain all information and records requested by Children's Services.

3. The LSP contractor shall cooperate with Children's Services assessment and evaluation systems, including the new Scorecard system, and shall provide all information necessary to allow Children's Services to fulfill these responsibilities. Appropriate LSP contractor staff shall be trained in the use of electronic data entry record systems, including CNXX, Legal Tracking System (LTS), CCRS, and SSPS and any subsequent tracking systems or databases as required by ACS, OCFS or the law.
4. The LSP contractor shall ensure that its staff, consultants and subcontractors shall at reasonable times and upon reasonable notice, be made available to Children's Services or its Counsel upon request for consultation either at the office of the LSP contractor or at the offices of Children's Services.
5. The caseworker (and child care worker, where appropriate) shall have primary responsibility for the development, documentation and maintenance of all case records within his/her caseload. LSP contractor policies and procedures shall clearly define the requirements of the caseworker and child care worker in documenting and maintaining case records, including required forms, content and format of other documentation, and storage.
6. Primary documentation of case record information will be maintained in a system of record identified by ACS. Hard copies of all other information unable to be captured in the system of record shall be kept in physical case records. In general, case records shall contain: demographic and contact information; the reason for a request or referral for services; up-to-date assessments; copies of all signed consent forms; a description of services provided by referral; individual behavior plan, and documentation of routine supervisory review.
7. A LSP contractor's documentation procedures shall also define the documentation requirements for all service providers, e.g. medical, psychiatric, chemical dependency/use prevention, and treatment and after care providers as well as education professionals.
8. The LSP contractor shall adhere to *Title 18 NYCRR Part 466* or any successor or amended regulations.

C. Incident Reporting

1. The LSP contractor shall adhere to ACS and OCFS incident reporting policies.

D. Authorization for Release of Health Information and Consent Form

1. Consent for the Release of Health Information

- a) A signed authorization from the youth's parent(s) or guardian(s) must be obtained for the release of medical information from health care providers who have previously treated the youth and for copies of medical records from such health care providers. If written authorization for the release of such records cannot be obtained from the parent(s) or guardian(s), a court order must be obtained.

2. Medical Consent Forms

- a) Within ten (10) days of admission into care, authorization in writing must be requested from the youth's birth parent/caretaker for routine medical and/or psychological assessments, immunizations and medical treatment, and for emergency mental health, medical or surgical care in the event that the birth parent/caretaker cannot be located at the time such care becomes necessary. Such authorization must become a permanent part of the youth's medical record.
- b) Informed consent for non-routine medical treatment shall be sought from the child/youth's birth parent/caretaker, unless their rights have been terminated or surrendered per *Children's Services' Bulletin 99-1 (10/18/99) "Guidelines for Providing Medical Consents for Children in Foster Care."* Providers can consent for medical treatment when the parent is unavailable. In situations where the time necessary for seeking parental consent would present a danger to the child/youth's life, health, or immediate welfare, the child's physician has the authority to grant consent if he/she deems the situation to be an emergency as defined by law.
- c) Informed consent for treatment implies that the following information has been obtained/explained or sent in writing to the consenting party:
 - i. Risks and benefits of the treatment;
 - ii. Treatment alternatives;
 - iii. Expected outcomes;
 - iv. Time frame to observe expected outcomes;
 - v. Proposed length of treatment; and
 - vi. Names and contact phone numbers of the clinical provider of proposed procedure/treatment.

E. Health Records & Documentation

1. Health Records & Documentation

- a) LSP contractors are responsible for maintaining complete health information in each youth's case and system(s) of record (and other database required/specified by ACS), per Children's Services policies. In addition to the requirements for the medical documentation contained in SYSTEM(S) OF RECORD, the LSP contractor shall establish a comprehensive health history for each youth by working with the birth family/caretaker, ACS-contracted health providers, Child Welfare agencies and known previous health providers for the youth. LSP contractors shall adhere to all timelines for collection of such information as required by Children's Services.
- b) All LSP contractors responsible for a youth's care shall have health information about the youth's health status and history on a "need to know" basis, as appropriate to maintain the youth's confidentiality, so as to maximize the opportunity for effective care and coordination. The LSP contractor shall maintain standards for access to confidential HIV-related information as set forth in *Title 18NYCRR 431.7*, or any successor or amended regulation. The LSP contractor shall maintain each youth's individual health history in a user-friendly, readily transferable manner that details all critical information regarding the child/youth's health status and history, including achievement of major milestones. This includes, but not limited to, mental and behavioral health information, substance use information and information provided by ACS-contracted health providers. The LSP contractor will comply with provisions governing the disclosure of a youth's health history to an authorized agency to which the child is moved per *Title 18 NYCRR 357.3(b)(1)*, or any successor or amended regulation.
- c) The following forms and notices must be included in the youth's medical record and in the medical section of the FASP and/or SYSTEM(S) OF RECORD Health screen, where appropriate. Additional details regarding documentation appear in the subsequent sections.
 - i. The initial health examination;
 - ii. All periodic health examinations (as recommended by the American Academy of Pediatrics/Child/Teen Health Plan (CTHP) schedule) and well-child examinations;
 - iii. A list of all of the youth's health-related needs, including special healthcare needs, with a corresponding plan to address each need;
 - iv. All on-going medical treatment (including medications, see below) and corresponding reason for treatment;
 - v. The youth's treatment progress, including response to treatment and non-compliance shall be documented;

- vi. All specialty and subspecialty referrals, including referrals to home-and community-based health, mental health and substance prevention/use programs;
 - vii. All hospitalizations and corresponding summary discharge notes;
 - viii. Copy of an updated Medical Passport (defined below);
 - ix. All laboratory results and results of diagnostic examinations and procedures;
 - x. Prenatal and birth-related information when available;
 - xi. Documented evidence that initial and semiannual risk assessments are performed for HIV, STDs and Family Planning (Form CM 1036);
 - xii. Documentation of strategies to keep the youth's CIN number/Medicaid number readily available when needed by a health care provider; and
 - xiii. Documentation of all mental health and substance abuse-related treatment and diagnostic procedures.
2. Physical Examination
- a) LSP contractors shall document the results of a youth's physical examinations using the Child's Health Record or a comparable form.
3. Continuing Health History
- a) The LSP contractor must keep a hard copy of the youth's health history and other relevant health documents that are not scanned or recorded in system(s) of record (and other database required/specified by ACS).
4. Health Summary Form
- a) The LSP contractor will maintain a Health Summary Form for each youth in its care. The summary form will be completed, in collaboration with the ACS-contracted providers, during the first one (1) month of placement with the results of the initial comprehensive health and mental health examinations. The form will be up-dated every six (6) months the youth remains in care in conjunction with the FASP. The Health Summary will include information on health, mental health and substance use/abuse status; health care providers; dental, vision and hearing test results; current immunization history and any follow up referrals that are necessary in accordance with *Title18 NYCRR Part 441.22 C(1)*, or any successor or amended regulation.
5. Health Passport
- a) The LSP contractor shall have a Health Passport for each youth and updated by health service providers at each visit. The Health Passport shall not be used as a substitute for the full medical record maintained by the ACS-contracted medical, dental and psychiatry providers. A copy of the youth's most up-to-date Health

Passport shall be kept in the child's health record. The passport shall be updated as often as possible and at minimum every six (6) months. An acceptable Health Passport is available free upon request from the City of New York Department of Health and Mental Hygiene.

6. Mental Health and Substance Abuse Screening, Assessment and Treatment Documentation

a) The LSP contractor is required to:

- i. Document all contacts with children and collateral contacts
- ii. Record all ACS-required information into the Systems of Record
- iii. Ensure all documentation is complete, accurate, timely and legible
- iv. Ensure that all mental health and substance use documentation, notes and summaries are charted in a timely manner on site

b) Medication-Related Documentation: All information related to all medications given to youth while in placement shall be documented in the medical record. For each medication, this includes (but not limited to):

- i. The name of the medication(s) currently being taken by the youth (including dose and dosage schedule);
- ii. The purpose of the medication(s) or condition/diagnosis being treated or managed;
- iii. The name and credentials of the prescriber;
- iv. Documentation of appropriate consent [e.g., provider consent for "freed child," parental/guardian consent, consent from a youth over eighteen (18)] and consent procedures followed by the provider;
- v. All associated health facility visits, specialty and subspecialty care associated with the medication;
- vi. Documentation that the provider has provided appropriate administration of the medication;
- vii. Documentation of refusals of prescribed medications and what was done by the LSP contractor; and
- viii. Documentation of any allergies or adverse reactions that the child may have had to any past medication(s), and the incident report associated with each adverse reaction (while the child was in the provider's care).

c) Care must be taken to ensure that all consents for treatment were obtained and documented appropriately.

F. Court Documents

1. The LSP contractor shall furnish documents to FCLS attorneys as requested by them for their work on cases under the LSP contractor's care. These documents may include, but not be limited to, case records, family assessment and service plans, notes, medical records, and evaluations, as well as written reports prepared specifically for the court. All documents shall be furnished, whenever possible, at a reasonable time in advance of the court hearing, so that the attorney can discuss the use of the documents with the LSP contractor.

G. Disposal of Confidential Data

1. The case record and any documents contained therein are confidential. Other confidential items include, but are not limited to, documents containing: child and family names, addresses, social security numbers, case information, details of allegations of abuse, confidential employee information, medical information, and other personal information. LSP contractors must comply with New York State law and regulation and ACS policies regarding record retention and disposal.

PART IX: MONITORING, EVALUATION, QUALITY IMPROVEMENT AND FISCAL RECORDING

A. Quality Assurance Plan, Ongoing Data Collection and Program Evaluation

2. The LSP contractor shall have a quality assurance plan in place that describes how it will provide quality assurance, planning and program evaluation for LSP youth placed in its care.
3. LSP contractor participation in collection of information for review procedures: The LSP contractor shall participate in on-going Children's Services and OCFS assessment, evaluation, and monitoring review procedures on the performance of LSP services and provide all information appropriate to allow Children's Services and OCFS to conduct these review procedures and complete a full review of the LSP contractor's LSP program.
4. All records kept by the LSP contractor pursuant to their LSP contract agreement shall be subject at all reasonable times to inspection, review or audit by City, state, or Federal personnel and other personnel duly authorized by Children's Services.
5. Children's Services' will supervise, monitor, audit and review the activities of the LSP contractor in providing the LSP services in accordance with their LSP contract agreement. The LSP contractor staff should be aware that a program and facilities review, including unannounced visits, meeting with youth and families/discharge resources, review of service records, review of service policy and procedural issuances, review of staffing ratios and job descriptions, and meetings with any staff directly or indirectly involved in the provision of services, may be conducted at any reasonable time by Children's Services staff, state and federal personnel, or other persons duly authorized by Children's Services. The LSP contractor shall provide the information required for any review or evaluation requested by Children's Services.
6. Children's Services data collection and program evaluation:
 - a) Children's Services shall collect and monitor data as part of a full evaluation process and monitor program performance indicators as appropriate and as needed.
 - b) Children's Services will establish and notify the LSP contractor of evaluation standards prior to their implementation. Standards will be established in advance of the evaluation period. The LSP contractor will be afforded the opportunity to rebut an evaluation before it is made final by Children's Services.

- c) Children's Services shall at its sole discretion:
 - i. Implement monitoring methods including, but not limited to, direct contact with youth and family/discharge resource by telephone or mail to assess the sufficiency, efficiency and adequacy of the services performed.
 - ii. Have Children's Services personnel visit the LSP contractor to enable Children's Services to assess and determine the effectiveness of the LSP contractor's staff on a regular basis. During site visits, Children's Services personnel may provide technical assistance in solving problems affecting the provision of LSP services.
 - iii. Review all program activities, procedures, records, and records recording, and conduct other evaluation activities as Children's Services deems necessary and appropriate, including, at reasonable times, unannounced and unscheduled visits.
- d) Duplicate all of LSP contractor's records, forms, and other data, which Children's Services deems necessary.
- e) Children's Services shall provide the executive director and board of directors of the LSP contractor with written information concerning the results of the monitoring visit or evaluation.
- f) As a result of all service inefficiencies uncovered by the monitoring visit or evaluation, the LSP contractor is required to implement any corrective action plan required by Children's Services.

B. Children's Services' Annual Data Collection and Program Evaluation Review

1. Scorecard Evaluation

- a) The Scorecard is a comprehensive performance measurement and quality improvement system designed to:
 - i. Evaluate the quality of practice and services provided by foster care/residential programs, as well as their outcomes; and
 - ii. Function as a tool for quality improvement.
- b) The Scorecard will be organized into categories and measurements that are meaningful to LSP contractor practice.

- c) An LSP contractor agency measurement system will also be developed and implemented in the first year of operation of the LSP contracts.
- d) The outcomes measures evaluate the work LSP contractors do with the children/youth in their care (in LSP Program sites and in LSP Aftercare) – categorized to account for differences by age, need and time in care, including but not limited to:
 - i. Successful Discharge/Program Completion
 - ii. AWOLs;
 - iii. Lateral moves (e.g. moves from LSP facility to another);
 - iv. Restraints;
 - v. Forms of discipline;
 - vi. Upward modifications, defined as any move from a LSP facility to a more restrictive setting;
 - vii. Step-downs, defined as any move between residential care, as defined above, and family-based care;
 - viii. Educational achievement of youth in LSP;
 - ix. Post-release recidivism and other outcome measures; and
 - x. Revocations.

C. Maintenance and Utilization of Electronic Systems of Record

1. Connections (CNNX)

- a) The LSP contractor shall document all processes and activities regarding children/youth and families in their care in CNNX, the New York State electronic system of record. This includes, but is not limited to:
 - i. All case information as detailed in *Children's Services Procedure 108 and Children's Services Bulletin 05-1*;
 - ii. Health, Education and Permanency Hearing Report information as detailed in the *CNNX Build 18.9 Procedures No 108/Bulletin No 05.1 and 1008/03*; and
 - iii. All system changes and updates detailed in the CNNX Build 18.9 Procedure.
- b) The LSP contractor shall ensure that all relevant staff receives the necessary introductory and ongoing training to ensure knowledge of and proficiency with the CNNX system as well as all pertinent policies and procedures.

2. Legal Tracking System

- a) LSP contractors will have read-only access to the Legal Tracking System (LTS), and shall make use of this capability in this regular course of business. Each LSP contractor shall designate at least one (1) LTS liaison for all LTS-related issues and updates. The liaison will communicate regularly with designated individuals at Children's Services.
- b) Uses of LTS shall include, but not be limited to, the reviewing of court orders, hearing outcomes, and attorneys' court action summaries..
- c) The LSP contractor shall update designated individuals as soon as possible, but no later than each month, regarding changes in assigned caseworker or other information as listed in LTS. The LSP contractor shall not re-disclose the information contained in LTS to third parties, absent instruction from Children's Services.

3. Child Care Review System (CCRS)

- a) CCRS is a statewide system used to track children in foster care as well as children placed with ACS for limited secure placement. Children's Services shall open cases within three (3) business days of placement. Children's Services and the LSP contractor shall mutually strive to keep CCRS accurate and timely at all times. After Children's Services has opened a CCRS case the LSP contractor is required to enter data related to:
 - i. Absence and return to care;
 - ii. Inter- and intra-agency transfers; and
 - iii. Adoption codes.

4. Statewide Service Payment System (SSPS)

- a) SSPS is a statewide payment system used to process payment for children in foster care, placed with ACS for limited secure placement, and the children of minor children. LSP contractors are expected to:
 - i. Submit an initial request for payment of services for each month by the fifth (5th) business day of the following month, i.e. on February 5th 2008 they would request payment for services provide in January 2008.
 - ii. Work with the Children's Services Reconciliation Center and Financial Services staff to reconcile any discrepancies.

- iii. Submit the final request for payment of services for each month by the seventh (7th) business day before the end of the following month, i.e. on February 21, 2012 they would request payment for services provide in January 2012.
- iv. Work with Children's Services Reconciliation Center, Financial Services and program area staff to rectify payments including any overpayments and underpayments, i.e., payments requested but not processed.

D. Reimbursements, Statistical and Fiscal Recording

1. Financial Management System: In accordance with OMB Circular A-110, Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and other Nonprofit Organizations, LSP contractors must maintain a financial management system that provides for the following:
 - a) Accurate, current and complete disclosure of the financial results of each federally-sponsored project or program in accordance with the reporting requirements. If a Federal awarding agency requires reporting on an accrual basis from a recipient that maintains its records on other than an accrual basis, the recipient shall not be required to establish an accrual accounting system. These recipients may develop such accrual data for its reports on the basis of an analysis of the documentation on hand.
 - b) Records that identify adequately the source and application of funds for federally-sponsored activities. These records shall contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, outlays, income and interest.
 - c) Effective control over and accountability for all funds, property and other assets. Recipients shall adequately safeguard all such assets and assure they are used solely for authorized purposes.
 - d) Comparison of outlays with budget amounts for each award. Whenever appropriate, financial information should be related to performance and unit cost data.
 - e) Written procedures to minimize the time elapsing between the transfer of funds to the LSP contractor and payment to satisfy any accounts receivables.
 - f) Written procedures for determining the reasonableness, allocability and allowability of costs in accordance with the provisions of the applicable Federal cost principles and the terms and conditions of the award.

- g) Accounting records including cost accounting records that are supported by source documentation.
2. Accounting System: LSP contractors should have accounting systems which outline the methods, procedures, and standards followed in accumulating, classifying, recording, and reporting financial events and transactions. The accounting system should include the formal records and original source data and should also be able to produce financial information and financial statements.
- a) A LSP contractor's accounting system must make it possible to:
 - i. Present fairly and with full disclosure the funds and activities of the LSP contractor in conformity with generally accepted accounting principles; and
 - ii. Determine and demonstrate compliance with financial-related legal and contractual provisions.
3. General Ledger: The general ledger contains all of the financial accounts of a LSP contractor; and contains offsetting debit and credit accounts (including control accounts). The general ledger is the core of the LSP contractor's financial records. These constitute the LSP contractor's central "books", and every transaction flows through the general ledger. These records remain as a permanent track of the history of all financial transactions since day one of the life of an organization. A LSP contractor's accounting system will have a number of funds. All the entries that are entered (called posted) to these funds will transact through the general ledger account.
- a) The two primary financial documents of any organization are the Statement of Position or the balance sheet and the Statement of Activities or the profit and loss statement. Both of these are drawn directly from an organization's general ledger. The order of how the numerical balances appear is determined by the chart of accounts, but all entries that are entered will appear. The general ledger accrues the balances that make up the line items on these reports, and the changes are reflected in the profit and loss statement as well.
4. Fund Accounting: A LSP contractor's accounting system must be organized and operated on a fund basis. A fund is a group of functions combined into a separate accounting entity having its own assets, liabilities, equity, revenue and expenditures/expenses. The types of funds used are determined by generally accepted accounting principles. The number of funds established within each type is determined by sound financial administration.
- a) LSP contractors should establish and maintain funds received by ACS through sound financial administration. Only the minimum number of funds consistent with legal

and operating requirements should be established. Unnecessary funds result in inflexibility, undue complexity, and inefficient financial administration.

5. Generally Accepted Accounting Principles for LSP Contractors: All LSP contractors are to adhere to Generally Accepted Accounting Principles (GAAP). GAAP is a uniform minimum standard of and guidelines to financial accounting and reporting. The GAAP are the framework within which financial transactions are recorded and reported resulting in financial statements that provide comparability between entities, consistency between accounting periods and reliability for internal and external users of financial statements. The Financial Accounting Standard Board (FASB) sets the General Accepted Accounting Principles (GAAP) for Nonprofit Organizations. LSP contractors should follow FASB announcements in order to ensure their accounting systems are up to date with new GAAP requirements.
6. Basis of Accounting: An entity's accounting basis determines when transactions and economic events are reflected in its financial statements. Listed below is the basis for recording financial transactions. All LSP contractors should follow the accrual basis of accounting.
7. Accrual Basis: A system recording financial transactions when they occur, irrespective of when actual cash is received or paid. Revenues are recorded when **earned** or when the LSP contractor has the right to receive the revenue. Expenses are recorded when **incurred**. Expenses for which the LSP contractor is liable within the fiscal year are counted in that fiscal year.
8. Accounting Calendar: The accounting calendar is a schedule of anticipated dates for financial activities through-out the month. It is important that LSP contractors establish an accounting calendar and adhere to the schedule in order to ensure all financial transactions are appropriately recorded. The accounting calendar is divided into two sections:
 - a) Management Reports
 - i. Report Month
 - ii. Report Date
 - iii. Scheduled Closing Date
 - b) Transaction Due Date
 - i. Departmental Deposits
 - ii. Journal Entries
 - iii. Interface Billings & Reallocation

9. Bookkeeping - Defined: Bookkeeping is the practice of recording the transactions of a business; financial transactions which are either monetary-cash, or non-monetary inventory or volunteer's time.
10. Accounting – Defined: Accounting is the bookkeeping methodology involved in creating a financial record of a business transaction. It includes the preparation of statements concerning assets, liabilities (Balance Sheet), expenses and revenue (Income Statement) and operating results of a business. Accounting is the management of assets and financial information.
11. Chart of Accounts: LSP contractors should establish a chart of accounts that list asset, liability, net asset, revenue and expense accounts used to record financial transactions in the general ledger.
12. Monthly Close: Every organization should close their financial books every month, produce a trial balance, adjusting entries, closing entries and financial statements.
13. Bank Account: The LSP contractor shall establish and maintain a bank account in a New York Chartered Bank located in New York City and/or a bank authorized to do business in New York State to be used solely in connection with funds received from ACS. The LSP contractor should establish one bank account to receive all ACS payments made to the LSP contractor. LSP contractors can request a waiver from this requirement from ACS. This request should be sent to the ACS Budget Department and must be approved by the Assistant Commissioner of Finance. If approved the LSP contractor may use a general bank account or a set of accounts for deposits and disbursements.
 - a) The bank account must have a minimum of three signatories with access to the bank account. At least two of the signatories must be Board Members. The LSP contractor will provide to ACS immediately upon request, copies of all bank records including bank statements and cancelled checks. The LSP contractor will also inform ACS within five business days of any change or substitution of a person authorized by the LSP contractor to receive, handle, or disburse monies.
14. Bank Credit Line: ACS encourages all LSP contractors to seek a bank line of credit to fill temporary or seasonal needs. This credit line is generally an unsecured loan made on the basis of the borrower's financial strength. Banks usually require compensation for offering a credit line in the form of balances and/or fees. The interest rate on a loan may be negotiated depending on the level of balances held at the bank.
15. Cash Transaction: Some activities of organizations may be most easily handled with cash. This may result in large amounts of cash being handled at one time. Some simple procedures can limit the possibility of theft or any accusations of theft.

- a) Have cash receipts counted and recorded as soon as possible from the time that the receipts are received.
- b) Always ensure that there are at least 2 people present when cash is being handled.
- c) Once cash has been counted, lock it up in a location that can only be accessed by authorized individuals.
- d) Make bank deposits regularly to avoid having significant amounts of cash on hand.
- e) In cases where cash is being distributed, request receipts or have the individuals receiving the cash sign a form stating that they have received it.

16. Checks: Checks provide an easy-to-follow paper trail for organizations. One risk with checks is the possibility of forgery. While this risk may be relatively small, the increasing popularity of automated teller machines (ATMs) and the accompanying trend toward less personal banking can make it more tempting for some individuals to attempt to pass forged checks. The following actions can help reduce this risk.

- a) Keep all blank checks in a secure and preferably locked location.
- b) Keep signed cancelled checks that are returned from the bank in a secure and preferably locked location.

17. Signing Authority: A standard safeguard in a LSP contractor's organization is to require two authorized officers to sign all checks. In many organizations three or four persons will be authorized to provide the two (2) signatures so that if an authorized person becomes ill or goes on an extended trip, the organization always has at least two other authorized persons to sign checks.

- a) This procedure is ineffective if one (1) of the officers signs a quantity of blank checks in advance. While probably well intentioned, this person has abdicated their duty as an officer and director and has put the organization's funds at risk. Signing officers and the entire board should always insist on all checks being completely filled in before anyone signs. Officers with signing authority may also want to verify the checks against the corresponding invoices before signing.

E. Resolution of Disputes between ACS and the LSP Contractor

1. In the event of a dispute between the LSP contractor's staff and Children's Services' staff relating to case planning, case practice and service planning, and positions to be taken at any court or administrative hearing, Children's Services and the LSP contractor shall follow the steps below to resolve such disputes expeditiously, and cooperate with each other in such situations and/or inquiries to the fullest extent possible. Disputes involving positions on Court cases must be resolved prior to appearing in Court. If the dispute cannot be resolved because of time constraints, the LSP provider must endeavor to minimize any conflict with Children's Services while appearing in Court. If the LSP

contractor fails to report the presence of any dispute or submit an appeal within the time frames indicated below shall constitute a *waiver* of any such dispute.

2. If after the performance of an internal review of its position, the LSP contractor's executive director disagrees with Children's Services on a decision relating to case planning, case practice and service planning, and/or a position to be taken at any court or administrative hearing, the LSP contractor shall present its position and recommendation in writing ("Notice of Dispute") within five (5) business days of the occurrence of an event giving rise to the dispute to the appropriate Children's Services Assistant/Associate Commissioner for the Children's Services organizational unit involved. The Notice of Dispute shall include all the facts, evidence, documents, or other basis upon which the LSP contractor relies in support of its position. The Children's Services Assistant/Associate Commissioner will make every reasonable and good faith attempt to resolve the dispute after due consideration of the opinion, expertise and professional judgment of the LSP contractor, and render a written decision within five (5) business days from the date the dispute was referred to him/her. If the Children's Services Assistant/Associate Commissioner is unavailable to meet or unable to render a decision within such five (5) business days, the time for decision-making may be extended at the sole discretion of Children's Services.
3. If the Children's Services Assistant/Associate Commissioner fails to act or if the dispute remains unresolved after the decision of the Children's Services Assistant/Associate Commissioner, the LSP contractor, within five (5) business days of receipt of such decision may appeal the decision by submitting its appeal in writing to the Children's Services Deputy Commissioner responsible for the Children's Services organizational unit involved. A copy of the LSP contractor's appeal must be submitted simultaneously to the Children's Services Assistant/Associate Commissioner making the initial decision. The written appeal must contain the following information and documentation (i) a brief statement of the substance of the dispute and the reason(s) the LSP contractor contends the dispute was wrongly decided by the Children's Services Assistant/Associate Commissioner; (ii) a copy of the decision of the Children's Services Assistant /Associate Commissioner, and (iii) a copy of all materials submitted by the LSP contractor to the Children's Services Assistant/Associate Commissioner. The Children's Services Deputy Commissioner will make every reasonable and good faith attempt to resolve the dispute after due consideration of the opinion, expertise and professional judgment of the LSP contractor, and render a written decision within five (5) business days from the date the dispute was referred to him/her.
4. If the dispute remains unresolved after the decision of the Children's Services Deputy Commissioner or his/her designee, the LSP contractor, within five (5) business days of receipt of such decision, may present a final appeal to the Commissioner. The written final appeal must contain the following information and documentation:

- a) a brief statement of the substance of the dispute and the reason(s) the LSP contractor contends the dispute was wrongly decided by the Children's Services Assistant/Associate Commissioner and the Children's Services Deputy Commissioner; and
 - b) a copy of the decisions of the Children's Services Assistant/Associate Commissioner and Children's Services Deputy Commissioner, and a copy of all materials submitted by the LSP contractor to the Children's Services Assistant/Associate Commissioner and the Children's Services Deputy Commissioner.
- 5. The Commissioner will make every reasonable and good faith attempt to promptly resolve the dispute after due consideration of the opinion, expertise and professional judgment of the LSP contractor.
 - 6. The decision of the Commissioner shall be binding upon all parties.
 - 7. At any stage during the above described procedure, where a decision is made which the LSP contractor does not wish to present to the next level of supervision such decision shall promptly be carried out by the LSP contractor to the extent that it is required to do so and to the extent that it is not required to carry out such decision, the LSP contractor shall not impede the carrying out of such decision.
 - 8. During the appeal process described above, the LSP contractor shall take no action which may undermine or impede the then current decision of Children's Services.

APPENDIX 2

FOSTER CARE QUALITY ASSURANCE STANDARDS AND INDICATORS



Foster Care Quality Assurance Standards

January 2011

John B. Mattingly, Commissioner

These standards represent Children's Services expectations for provision of foster care and residential services and related supports, and they cover the full scope of program activities and operations. They reflect the foster care agreements as well as ACS policy and procedure, and also supplement those in many areas. Pages 14-131 and 159-165 cover standards common to all program types, and 132-153 and 169-187 communicate additional or different standards for specific programs. These standards are designed to be a set of guidelines and expectations that will evolve as needed to match progress and new developments in the delivery of services. If and when changes are made, ACS will give providers advance notice and an opportunity for comment. Comments and questions about the document should be directed to Children's Services' Program Development Unit.

FOSTER CARE QUALITY ASSURANCE STANDARDS

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DEFINITIONS & ACRONYMS

Definitions

Whenever the following terms and phrases are used in these *Foster Care Quality Assurance Standards*, they shall have the following meanings, unless it is expressly indicated that such term or phrase is to have a different or additional meaning. All such other terms and phrases that shall not be specifically defined in this Part II shall have the meaning ascribed to it by Law, or, in the event that such term or phrase is not described in the Law, it shall have the meaning as is commonly ascribed to it.

A. "ACS Policies" shall mean all applicable ACS policies, procedures guidelines, bulletins and standards as amended.

B. "Administrator" or "Commissioner" or "Agency Head" shall mean the Commissioner of the ACS or her/his duly authorized representative. The term "duly authorized representative" shall include any person or persons acting within the limits of her/his authority.

C. "Case Planning" shall mean the following functions and activities of the Provider in connection with Recipients of Service which includes but is not limited to: conducting ongoing safety assessments for all children in a household and performing the regulatory function of child protective service monitor; scheduling all required Family Team Conferences with the appropriate attendees; assessing service needs of children in care and their families; planning for service needs; arranging for service provision; coordinating service provision and/or participating in joint planning, when appropriate; evaluating the outcome of service provision; completing, approving and implementing the FASP; conducting minimum required casework contacts; and providing necessary documentation in the case record. The Provider, through its assigned caseworker(s), carries out planning functions for the entire family unit. When a family is authorized to receive services from a single foster care provider, that provider is always the primary case planning foster care provider. The primary case planning foster care provider always has the responsibility to coordinate services for the entire family, to prepare the single, family-focused case record and to arrange and conduct Service Plan Review conferences. The above definition may change from time to time based on changes in ACS Policies, the Law, Federal and State Court orders, and stipulations of settlement or decree.

D. "City" shall mean the corporation of the City of New York, its departments and political subdivisions.

E. "CONNECTIONS" or "CNNX" means the New York State automated system designed to create a single integrated statement system for collecting and recording child protective, preventive, foster care and adoption services information.

F. "Day" shall mean a calendar day unless otherwise specified in these *Foster Care Quality Assurance Standards*.

G. "Days of Care" shall mean the number of days in which a Foster Child/youth is in placement in, and physically present at, a program operated by the Provider, plus the number of days of allowable absences during the time in which the Foster Child/youth is in placement in such program.

H. "Regular Placement" shall mean the placement of a child/youth into Foster Care which must be made immediately because of the need to ensure the safety and the welfare of the child/youth.

I. "Regular Vacancy" shall mean a Provider vacancy that may be filled by a Regular Placement.

J. "Foster Home" shall mean a residence owned, leased or otherwise under the control of a single person or family who has been approved or certified by an authorized agency to care for children, and such person or family receives payment from the agency for the care of such children.

1. "Approved Relative Foster Home" shall mean a Foster Home in which the foster parent is a relative within the second or third degree of the parent(s) or stepparent(s) of the child/youth and who is approved to care for specific related children/youth in accordance with *Title 18 NYCRR 443.7* (for expedited approval) and/or with *Title 18 NYCRR 443.3*, or any successor or amended regulations, for full approval.

2. "Certified Foster Home" shall mean a Foster Home in which the foster parent is certified to care for the number of children indicated on the certificate in accordance with the requirements of *Title 18 NYCRR 443.7* (for expedited certification) and *Title 18 NYCRR 443.3* or any successor or amended regulations.

K. "Foster Child (ren)" shall mean a person or persons placed in and receiving services from the Provider's family foster care program pursuant to this Agreement, ACS Policies and the Law. Generally, Foster Children meet the following criteria:

1. The child/youth is under the age of eighteen (18) years or is between the ages of eighteen (18) and twenty one (21) years and entered foster care before his/her eighteenth (18th) birthday and has consented to remain in foster care past his/her eighteenth (18th) birthday; and

a. is a student attending a school, college or university; or
b. is regularly attending a course of vocational or technical training designed to prepare him or her for gainful employment; or
c. lacks the skills or ability to live independently.

2. The child/youth is cared for away from his/her home twenty four (24) hours a day in a Family Foster Care, Residential Care Facility or combination thereof.

3. The child/youth's care and custody or guardianship and custody has been transferred to an authorized agency pursuant to the provisions of *SSL §§ 384 or 384-a* or the child/youth has been placed with a social services official pursuant to *Article 3, 7 or 10 of the Family Court Act*.

L. "Law(s)" shall mean all applicable Federal, State and City laws, regulations, ordinances and rules and any successor and any amendments thereto including but not limited to the New York City Charter, the New York City Administrative Code, a local law of the City of New York, and any ordinance, rule or regulation having the force of law and including any waivers issued by OCFS.

M. "Office of Children and Family Services" or "OCFS" shall mean the New York State Office of Children and Family Services which is responsible for, among other things, regulating and monitoring child welfare services in New York State.

N. "Planned Placement" shall mean the placement of a child/youth with the Provider following a planning process whereby, at the time of the placement, a Placement Packet (psychiatric, psychological and psychosocial) has been completed.

O. "Recipients of Services" shall mean a child/youth, his/her family unit, biological, adoptive or other family unit entrusted with the care of the child/youth, his siblings and significant others related or unrelated to a child/youth who are determined by the Provider and ACS to be an actual or potential source of support, care or assistance for the Foster Child/youth.

P. "Residential Care Facility" shall mean a foster care facility other than a Foster Home. Such facilities include:

1. "Agency Operated Boarding Home" or "AOBH" shall mean a family-type home for the care and maintenance of not more than six (6) children/youth operated by an authorized agency in quarters or premises owned, leased, or otherwise under the control of such authorized agency except as may be permitted under *Title 18 NYCRR 427.3*.

2. "Group Home" shall mean a licensed family-type home operated and staffed by an authorized agency for the care and maintenance of seven (7) to twelve (12) Foster Children/youth.

3. "Group Residence" shall mean a licensed institution operated and staffed by an authorized agency for the care and maintenance of up to twenty five (25) children/youth.

4. "Institution" shall mean a licensed facility operated and staffed by an authorized agency for the care and maintenance of thirteen (13) or more Foster Children/youth.

Q. "State" shall mean the State of New York.

R. "Suspended Payment" shall mean the cessation of payments by the City to the Provider when a Foster Child/youth placed with the Provider is not physically present and is not on an allowable absence.

S. "Tuition" shall mean the per pupil cost of all instructional services, supplies and equipment, and the operation of instructional facilities as determined by ACS. Approved Tuition shall be computed from expenditures for which no revenue has been received from the following sources:

1. Receipts from the federal government;
2. Any cash receipts which reduce the cost of an item applied against the item there for, except gifts, donations and earned interest; and
3. Any refunds made or any apportionment or payment received from the State.

T. "Written approval" or "approval" shall refer to paper or electronic correspondence, unless otherwise stated, and shall be rendered within thirty (30) days of receipt unless another date is agreed upon by the parties.

Acronyms

Whenever the following acronyms are used in these *Foster Care Quality Assurance Standards*, they shall have the following meanings, unless it is expressly indicated that such acronym is to have a different or additional meaning.

- (ABC) - Adult Basic Education
- (AIDS) - Acquired Immune Deficiency Syndrome
- (AOBH) - Agency Operated Boarding Homes
- (APA) - Office of Agency Program Assistance
- (APLA) - Another Planned Living Arrangement
- (ASQ) - Ages to Stages Questionnaire
- (ASFA) Adoption and Safe Families Act
- (B2H) - Bridges to Health
- (CANS) - Child and Adolescent Needs and Strengths
- (CAR) - Comprehensive Adoption Report
- (CAP) - Corrective Action Plan
- (CASAC) - Credentialed Alcohol and Substance Abuse Counselor
- (CCRS) - Child Care Review System
- (CHIPP) - Children of Incarcerated Parents Program
- (CIN) - Client Identification Number
- (CNNX) - CONNECTIONS
- (CPP) - Community Partnership Program
- (CPS) - Child Protective Services
- (CSC) - Child Safety Conferences
- (CTHP) - Child/Teen Health Plan
- (DCP) - Division of Child Protection
- (DCJS) - Division of Criminal Justice Services

(DOE) - Department of Education
 (DOH) - Department of Health
 (EPSDT) - Early and Periodic Screening, Diagnosis and Treatment
 (ESL) - English as a Second Language
 (FASP) - Family Assessment and Service Plan
 (FCLS) - Family Court Legal Services
 (FFC) - Family Foster Care
 (FPC) - Family Permanency Conferences
 (FPS) - Division of Family Permanency Services
 (FSU) - Family Support Unit
 (FTC) - Family Team Conference
 (FBI) - Federal Bureau of Investigation
 (FAHD) - Foster Adoption Home Development
 (GED) - General Equivalency Diploma
 (GPS) - Group Preparation and Selection
 (HIV) - Human Immune-deficiency Disease
 (JD) - Juvenile Delinquent
 (IEP) - Individualized Education Plans
 (LGBTQ) - Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ)
 (LTS) - Legal Tracking System
 (MOU) - Memorandum of Understanding
 (MAPP) - Model Approach to Partnerships in Parenting
 (NYCRR) - New York Codes, Rules and Regulations
 (OASAS) - Office of Alcoholism and Substance Abuse Services
 (OCFS) - Office of Children and Family Services
 (OFVPE) - Office of Family Visiting and Parent Education
 (OFPTC) - Office of Family Permanency Team Conferencing
 (OMH) - Office of Mental Health
 (OPA) - Office of Placement Administration
 (OPWDD) - Office of Persons with Developmental Disabilities
 (OSI) - Office of Special Investigation
 (PAD) - Office of Program Analysis and Development
 (PH) - Permanency Hearing
 (PPG) - Permanency Planning Goal
 (PINS) - Person In Need of Supervision
 (PSAT) - Preliminary Scholastic Assessment Test
 (PYA) - Preparing Youth for Adulthood
 (PAMS) - Provider Agency Measurement System
 (QCC) - Quarterly Case Conference
 (QPC) - Quarterly Permanency Conference
 (RIT) - Rapid Intervention Team
 (SPR) - Service Plan Review
 (STD) - Sexually Transmitted Disease
 (SAT) - Scholastic Assessment Test
 (SCR) - Statewide Central Registry
 (SSPS) - Statewide Service Payment System

(TPR) - Termination of Parental Rights

(VESID) - Vocational and Educational Services for Individuals with Disabilities

(YMCA) - Young Men's Christian Association

FOSTER CARE QUALITY ASSURANCE STANDARDS

PART I: CHILDREN'S SERVICES' MISSION AND GOALS

Mission Statement

On January 10, 1996, the New York City Administration for Children's Services (Children's Services or ACS) was created as the first agency devoted solely to serving children and their families. Children's Services' mission is to ensure the safety and well-being of New York City children.

Quality Practice Model

- All children coming into contact with the child welfare system will be protected from abuse and maltreatment.
- All families needing and wanting help to keep their children safe will receive the help they need.
- All children coming into contact with the child welfare system will receive the help they need to be healthy and achieve their full developmental and intellectual potential.
- All children in the child welfare system will leave our care with a caring, committed, and permanent family.
- Every team member at Children's Services and each of our partner agencies can expect guidance, respect, and emotional support to achieve our goals. Every child, family, community member, and foster parent we come into contact with will be treated with the same concern and respect.

Family Foster Care (FFC) Services and Residential Care Services

Key outcomes that are especially important for Children's Services, FFC, and Residential Care programs are:

- Youth in family-based settings shall be placed in homes that are located in each youth's home community whenever it is safe to do so.
- Siblings entering care together shall be placed in the same home unless it would be contrary to the health, safety or welfare of one of the siblings.
- Child(ren)/youth in care shall not experience additional maltreatment.
- The median time to reunification and to adoption shall be reduced.
- Child(ren)/youth reunified with their families will not re-enter foster care.
- Child(ren)/youth will not have to move from one foster home to another except for safety or family/sibling reunification-related reasons.

Improved Outcomes for Children

IOC brings a new level of case management authority and responsibility to providers of foster care services. Providers should take note of IOC-related delegated casework functions. The following summarizes those casework functions that are being newly delegated to provider agencies, in addition to those already articulated in this document.

Delegated Casework Function to Foster Care Agencies

Family Assessment Service Plan (FASP) Approval

- Reassessment FASP
- Plan Amendments

Approval for Permanency Goal Changes

- Placed in Another Planned Permanent Living Arrangement
- Discharge to Adult Residential (Custodial) Care

Approval for Discharges

- Trial Discharge
- Final Discharge

Approval for Movements in Foster Care

- All Intra-Agency Transfers
- All Inter-Agency Transfers

PART II: RECRUITMENT, TRAINING AND CERTIFICATION OF FOSTER AND ADOPTIVE PARENTS

A. Identification of Foster and Adoptive Parents

1. Recruitment

The Provider shall make diligent efforts to promote the recruitment of foster and adoptive parents who are able to provide a safe, nurturing home environment in accordance with the Law and Children's Services' Policies, and have both the capacity and interest to become foster and/or adoptive parents.

Recruitment efforts are successful when they involve a variety of strategies reflected in a written recruitment plan developed with the input of a cross-section of Provider staff, foster parents, and child(ren)/youth in care. It is expected that recruitment and resource parent support efforts/strategies will be coordinated with and involve the Community Partnerships in which the Provider is a participant, if applicable.

Providers need to develop recruitment strategies aimed at engaging the following:

- Current and former foster and adoptive parents;
- Provider Staff;
- Child(ren)/youth in care;
- Caring adults in the child's life; and
- Local community (including businesses, schools, faith-based institutions and community organizations).

Desired qualifications for foster parents include:

- capacity to work flexibly with concurrent planning;
- willingness to support children's connections to birth family/caretaker and other significant individuals and community;
- a strong commitment to nurturing the child(ren)/youth's educational potential;
- an understanding of the trauma caused by abuse and maltreatment and the resulting behaviors, and a commitment to collaborate with service providers who are working with the child(ren)/youth;
- an understanding of and willingness to care for children and youth from varied cultural backgrounds;
- an understanding and willingness to care for lesbian, gay, bisexual, transgender and questioning child(ren)/youth;
- an understanding of and willingness to care for children with chronic-illnesses; medical complex conditions, and developmental disabilities;
- an understanding and willingness to care for child(ren)/youth who are pregnant and/or parenting, and their babies;
- willingness and ability to work with birth families/caretakers toward the goal of reunification; and

- willingness to care for and work with child(ren)/youth leaving residential care programs for family based care.

The Provider shall encourage staff to become foster or adoptive parents at another Provider (i.e. Provider that does not employ the staff). The Provider shall ensure that their policies do not preclude staff from becoming foster or adoptive parents.

(a) Community-based Efforts

According to their contracted service area and program size, each Provider shall establish a sufficient number of foster homes to serve children needing substitute care within their own communities or as close to their own communities as possible.

(b) Specific populations

Each Provider shall adjust its recruitment and retention efforts based on the assessment of its own placement data and data provided by Children's Services that indicates the need for homes in particular communities for children by age group, gender, medical conditions, culture/ethnicity, language needs, and the need for homes for sibling groups. Specialized recruitment shall take place to identify foster parents who are willing to care for children with very high needs, including those who are receiving Bridges to Health (B2H) and other in-home services.

(c) Child(ren)/youth/family Identified Resources

For many children/youth, the best placement, when appropriate, is with a caring adult who already knows and loves them. This may be a relative, but it may also be a non-relative (godparent, neighbor, family friend, school personnel and other members of the child(ren)/youth's community) with a caring connection to the child(ren)/youth. Identifying those caring adults with whom the child already has a connection starts during the child protective investigation and informs the decisions made at the Child Safety Conference (CSC). If a caring adult known to the child(ren)/youth has not been identified prior to the placement into care, the Provider responsible for the child(ren)/youth's foster care, must revisit and continue to re-assess and appropriately act on this issue. If an identified family resource wants to become a foster parent, he/she must meet all requirements for licensure. All family identified resources must be educated about the child's needs and provided with the necessary supports and services. When appropriate, family/identified resources will be informed about resources available in other systems of care, such as the Department of Aging's Grandparent Resource Center and NYS OCFS' Kinship Navigator.

2. Preparation of Foster and Adoptive Parents Foster/Adoptive Parent Orientation

An orientation to foster care and foster parenting must be provided to all applicants either prior to application or prior to home study. For emergency licensed homes, the orientation must be provided within fourteen (14) days of initial placement of a child in the home. The topics that must be covered during orientation are outlined in *Children's Services Procedure No. 105/ Bulletin No. 01-1, Certification/Approval of Foster Boarding Homes*, dated 2/8/01. Note that

“orientation” and “training” cover different subject matter and one may not be substituted for the other.

i. Pre-Service Training/preparation

1. Newly recruited foster parent applicants must receive and satisfactorily complete Model Approach to Partnerships in Parenting (MAPP) training *prior* to certification or approval. Pre-certification MAPP training, called “Group Preparation and Selection (GPS)”, consists of thirty (30) hours of training following the GPS curriculum.

It is expected that foster parent applicants will attend all scheduled training sessions. If any are missed, they must be made up before a foster child(ren)/youth is placed in the home. “Make-up” sessions may be provided with another GPS group or as one-on-one instruction either at the foster parent’s home or another suitable location.

An alternative to MAPP/GPS is MAPP/Deciding Together. ‘Deciding Together’ is based on the ‘GPS program’, and provides a comprehensive preparation and mutual selection process for individual foster and adoptive families who have the interest and willingness but not the means to participate in a group process: (e.g., parents have conflicting work schedules or some other situation which prevents them from attending group meetings). This program requires at least (seven) 7 consultations, each of which consists of approximately two and one-half (2½) hours of training with the family and a certified Deciding Together leader in one-on-one consultation. If this option is selected, there shall be accompanying documentation detailing why Deciding Together was provided rather than GPS.

2. For both MAPP/GPS and MAPP/Deciding Together, the determination of “satisfactory” completion is a consideration in the final decision to license the home. This assessment must be documented and shall be based on attendance of all sessions or full completion of all consultations and a qualitative assessment of the prospective foster parent’s suitability as demonstrated by his/her participation, interest and acceptance of the MAPP/GPS or MAPP/Deciding Together curricula.

Providers are encouraged to make “MAPP for Children” training available to any foster parent applicant with children of their own.

B. Certification or Approval

- (a) Foster parent(s)/homes must be certified or approved in accordance with *Title 18 NYCRR 443.7* and any successor or amended regulation. Certification and approval requirements are the same; however, ‘certification’ applies only to regular foster parent homes, ‘approval’ applies only to the foster homes of relatives discussed in “Emergency” homes below.

(b) Foster Parent Certification and Requirements

1. Applicant shall be twenty-one (21) years of age and older;

2. Applicant must lease or possess his/her legal residence (no boarders): (deed or lease must be in applicant's name);
3. Applicant must be medically cleared (free from illnesses or disabilities that would impede service provision to child/ren)/youth;
4. Applicant and everyone in the household eighteen (18) years of age and older must have an inquiry completed with the State Central Registry (SCR) to determine if they have been the subject of an indicated report of child abuse or maltreatment; a determination based on this information must then be made on whether to approve the home, a copy of which must be maintained in the foster parent record;
5. Applicant and everyone in the household eighteen (18) years of age and older must be fingerprinted for Criminal History clearance;
6. Applicant must complete pre-service (MAPP) training hours; and
7. The Provider must have a completed written home study for that home.

(1) Application

All prospective foster parents shall be screened by the Provider and are expected to provide the following documentation:

- Proof of age – twenty-one (21) years of age and older;
- Source of income or receipt of Public Assistance;
- Education history; and
- Employment history.

If married and living with a spouse or with a paramour, he/she shall be included in the process. In addition, the Provider shall adhere to *Title 18 NYCRR, Part 443.2* and any successor or amended regulation.

(2) Statewide Central Register of Abuse and Maltreatment Clearance

- a. Prior to licensure as a foster parent, the Provider shall clear with the NYS Central Register of Child Abuse and Maltreatment (SCR) all prospective foster parents and adoptive parents who are to have contact with children in order to determine whether the applicant has been or is currently the subject of an indicated child abuse/maltreatment report. Additionally, in accordance with the *Adam Walsh Child Protection Act of 2006*, the provider must also inquire of each state whether the applicant and/or any person eighteen (18) years of age and older residing in the home of the applicant, who lived for any period of time in another state during the previous five (5) years, had been a subject of an indicated abuse or maltreatment report in that state.
- b. In-home/out-of-home and emergency caretakers who provide child care for employed foster parents shall be included as part of the foster family's household, and shall be included in the foster parent home study. All such caretakers shall be cleared through the SCR to determine whether they have ever been or are currently the subject of an indicated child abuse/maltreatment report in New York, and during the previous five years in another state after their 18th birthday, as noted in 'a' above.

- c. Children's Services shall make available to the Provider, contact information for such clearance requests in all states.

(3) Criminal History Record Check

A Provider shall conduct criminal history records checks with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) for every prospective foster parent and each person eighteen (18) years of age and older who is currently residing in the home of such prospective foster parent before the foster parent can be approved or certified for the placement of a foster child. See *Children's Services Guidance # 2008/09 (10/01/08)* for details. In addition, the Provider shall adhere to *Title 18 NYCRR Parts 443.8 and 443.9* and any successor or amended regulation.

(4) Fingerprinting

The Provider shall arrange for the submission of fingerprints of every applicant and every person eighteen (18) years of age and older, including foster children who are over eighteen (18) years of age, who currently reside in the home of such prospective or existing foster parent in the manner prescribed by the New York State Office of Children and Family Services (OCFS) and such other information as is required by the OCFS, the DCJS and the FBI.

The Provider shall make available to the applicant sufficient blank fingerprint cards and a description of how the completed fingerprint cards will be used upon submission to the DCJS. Providers shall supply applicants with criminal history 'Consent for the Release of Confidential Information' forms, which shall be completed and signed by applicants and any person eighteen (18) years of age and older who resides in the applicant's home. Such *consents* shall be in a manner prescribed by OCFS. Consents provide for the release to the Provider of criminal history record information provided by the FBI to OCFS. The Provider or its designee must promptly transmit such fingerprint cards to OCFS. When there is indication in either or all registries, the Provider shall adhere to *Title 18 NYCRR 443.8* and any successor or amended regulation regarding a decision to certify or approve that foster parent applicant.

(5) Home Study

The Provider shall conduct a Home Study that meets NYS licensing and certification and/or approval requirements, as per *Title 18 NYCRR Part 443* or any successor or amended regulation and all Children's Services Procedures, and collect the types of information and documentation prescribed by the NYS Comprehensive Adoption Report (CAR) guidelines, *Transmittal: 07-OCFS-INF-02*.

(6) References

The Provider shall obtain statements from three (3) references for every applicant: two (2) in writing, and one (1) through face-to-face interviews conducted by qualified staff or consultants engaged by of the Provider. These statements shall be documented in the foster parent's record.

(7) Inspection of the home to be occupied

The foster home must be in compliance with all applicable provisions of State and local laws, ordinances, rules, and regulations concerning health and safety in accordance with *Title 18 NYCRR Part 443.3* and any successor or amended regulation.

Homes to be certified include, regular foster homes (including kinship and adoptive homes) and emergency foster homes. The differences between “certified” and “approved” homes (regular foster homes and emergency foster homes) are discussed below.

(c) Certification or Approval of the Foster Home

- 1 Certified Foster Home: A certified foster home offers the provision of temporary or long-term care to child(ren)/youth whose care and custody or guardianship and custody have been transferred to an Provider pursuant to the provisions of *Title 18 NYCRR Part 384 or 384-a* of the Social Services Law, or who has been placed with a social services official pursuant to article 3, 7 or 10 of the Family Court Act and is cared for twenty-four (24) hours a day by a foster parent who is duly approved by an Provider in accordance with *Title 18 NYCRR Part 443.3* and any successor or amended regulation.
- 2 Approval of Foster Home: Approval of a foster home shall meet the health and safety standards, and physical plant requirements in accordance with *Title 18 NYCRR, Part 433.3*. An approved foster home is a home in which temporary or long-term care is provided to a child whose care and custody or guardianship and custody have been transferred to an Provider pursuant to the provisions of section 384 or 384-a of the Social Services Law or who has been placed with a social services official pursuant to article 3, 7 or 10 of the Family Court Act and is cared for twenty-four (24) hours a day in a family foster home with a foster parent who is a relative within the second or third degree to the parent(s) or stepparent(s) of the child and who is duly approved by an provider in accordance with *Title 18 NYCRR, Part 443.3* and any successor or amended regulation.

(d) An Emergency Foster Home

- 1 Certified Emergency Foster Home: An emergency certified home allows authorized foster care providers (including Children’s Services) to place children who are in the legal custody of the Commissioner of Social Services, on an emergency basis, in the foster home of person who are relatives beyond the third (3rd) degree and non-related persons who had significant prior relationship with the child/family, for up to ninety (90) days. The Provider shall adhere to *Title 18 NYCRR, Part 443.7* and any successor or amended regulation for placement considerations.
- 2 Approved Emergency Foster Home: An emergency approved home allows authorized foster care agencies (including Children’s Services) to place children

who are in legal custody of the Commissioner of Social Services, on an emergency basis, in the foster home of persons who are related to the child up to third (3rd) degree, for up to ninety (90) days or longer in some cases. The Provider shall adhere to *Title18 NYCRR, Part 443.7*. Approval of an Emergency Foster Home shall meet the health and safety standards, and physical plant requirements in accordance with *Title18 NYCRR, Part 433.3* and any successor or amended regulation.

(8) Recertification of Certified and Approved Foster Homes

Providers are encouraged to develop written procedures to guide staff in the annual Certification/Recertification of their foster homes. Every foster home shall be recertified on an annual basis and shall include documentation of an updated home study prior to each recertification in accordance with established Children's Services procedures and *Title18 NYCRR Part 443.10* and any successor or amended regulation. The annual renewal of a foster home's certificate or letter of approval must include the following:

- (1) A written evaluation of the home and family that uses the criteria for certification or approval as specified in this *Title18 NYCRR Part 443.10* and any successor or amended regulation.
- (2) A written evaluation of the care provided children in the home and the working relationship of the foster parents or relatives with the Provider in accordance with *Title18 NYCRR Part 443.10* and any successor or amended regulation.
- (3) A written statement from a physician about the foster family's or relative family's health, if it has been two (2) years since the date of the last medical exam.
- (4) An oral review of the evaluation with the foster parent or relative foster parent before the certificate or approval is renewed.
- (5) The completion of state criminal history record check(s) for the foster parent and all persons over the age of eighteen (18) other than a foster parent certified or approved prior to January 11, 2007, who is currently residing in the home of the foster parent who has not previously had such criminal history record checks completed in the foster home with the Division of Criminal Justice Services in accordance with *Title18 NYCRR Part 443.2* and any successor or amended regulation.

All decisions for recertification shall be reviewed by at least one (1) staff member on a supervisory level and the Provider shall document discussion of the home evaluation with the foster parent(s) in accordance with *Title18 NYCRR Part 443.10* and any successor or amended regulation.

(9) Concurrent Certification /Approval of Foster Parent and Approval of Adoptive Parent

The requirements to approve an individual as an adoptive parent are the same as those for the certification or approval of a foster parent. Concurrent Certification/Approval must be

completed in accordance with *Title 18 NYCRR, Part 443.9* and any successor or amended regulation. An applicant for concurrent foster home certification/approval and adoptive parent approval will not be required to submit dual documentation to the provider.

C. Supports Services for Foster and Pre-Adoptive Parents

1. Key principles to communicate

Providers and foster parents share the common goal to provide a safe, nurturing environment for children in care. When communication is open, it will be easier to accomplish this goal. Providers shall maintain and foster ongoing communication with foster parents/caretakers and pre-adoptive parents. Foster parents and Caseworkers shall:

- Communicate often and effectively;
- Respect each other's roles;
- Make decisions together;
- Solve problems together; and
- Resolve conflicts.

Foster parents shall be encouraged to communicate to case planners and other appropriate Provider staff issues around key events in the child's life. Certain events, including significant childhood milestones, can have a powerful impact resulting in changes in behavior or conduct, sleeping and eating patterns, and temperament. Examples of such events include, but are not limited to:

- First day of school;
- Birthdays, holidays, Mother's Day, and/or Father's Day;
- Changes in visits (parent or siblings) such as the frequency or duration of such visits;
- Meeting with school staff;
- Family court hearings; and
- Service plan reviews and other conferences.

Foster parents shall be instructed to contact Providers when an emergency occurs outside of their normal responsibilities, or any other situation the foster parent feels they cannot handle without assistance. Providers shall be contacted include when the following events occur involving the foster child:

- A Medical emergency;
- A Child runs away;
- Acute problems with a child;
- A Child has problems with the law
- Problems related to a birth parent's visit (e.g.), an unexpected visit from a parent or any unauthorized visitor);
- A Child is kidnapped or taken by his or her parents without consent;
- A Child is truant, expelled and or dismissed from school;
- A Child attempts suicide; or
- A Child is abusing substances, drugs or alcohol.

2. Engagement with child(ren)/youth

- a) Providers must ensure that the foster and adoptive parent engages the child(ren)/youth in the decision-making process regarding their future. Providers must involve the child(ren)/youth in case planning and encourage them to advocate for themselves as appropriate to their age/developmental level. It is important that child(ren)/youth gain the self-advocacy skills they will need to be successful adults.
- b) The provider shall ensure that foster/adoptive parents understand that the engagement process must offer meaningful participation for the child(ren)/youth, and an opportunity for the child(ren)/youth to take responsibility and leadership while working in partnership with the Foster/Adoptive Parent who values, respects, and shares power with them. Child(ren)/youth who are in control of their own destiny will achieve self-sufficiency.

3. Working with foster parents after placement

(a) Concrete supports

Supports for foster parents are the key to recruiting and retaining foster parents, and achieving the critical child welfare outcomes, i.e. stability, safety, and permanency.

1. Provider administrative/supervisory staff shall regularly meet with groups of foster parents to elicit feedback about the quality and effectiveness of the Provider's support systems. Information from those meetings, exit interviews with foster parents who elect to close their homes, the analysis of data on placement disruptions, and input from Children's Services' Offices of Parent Support & Recruitment and Special Investigations shall be used by a group composed jointly of each Provider's administrative /supervisory staff and foster parents to develop a foster parent support plan, which shall be updated at least annually. The plan shall address the role of staff, other resource families, the faith community, the business community and others in supporting foster parents to help them meet the needs of the child(ren)/youth placed in their home. Provider staff shall have the expertise to assist foster parents in dealing with but not limited to: education related issues, physical and mental health, and behavioral related needs.
2. Providers shall make available emergency, on-call support for foster parents twenty-four (24) hours a day, seven (7) days a week. Providers need to ensure that in the case of an emergency, a foster parent's call is returned within a one (1) hour by someone who is capable of giving concrete, effective assistance. This support shall consist of safety planning with the child and foster parent; training in crisis de-escalation; crisis intervention services; counseling and referrals to programs such as Home-Based Crisis Intervention, which can provide intensive, short-term services in the home setting; and other services to be identified jointly by the Provider administrative/supervisory staff and foster parents.

3. Provider staff shall collaborate with the foster family on the development of an emergency/evacuation plan for the foster home. Providers shall encourage foster families to practice that emergency plan with all family members, including the foster child(ren)/youth in the home.
4. The Provider shall provide each foster parent with an emergency wallet card telling them how to reach their Caseworker, their Caseworker's supervisor, the foster care program director and another Provider administrator, and the Children's Services Office of Advocacy by telephone and by email.
5. Providers shall supply each foster parent with a photo-identification card when appropriate, and ensure that options are available for direct deposit of foster parents' monthly stipends for those foster parents who request it.
6. Providers shall develop a procedure to address foster parents concerns. Each Provider shall work with its foster parents to create and sustain a network of foster parent support groups; Providers with multiple sites are encouraged to develop borough or community-based foster parent support groups. Not all foster parents are able to attend support group meetings; Providers shall develop options to work with such foster parents to share information with them that has been provided to other foster parents. Each Provider shall decide, in discussion with its foster parents, whether to hire one or more foster parent advocate(s) and jointly define their role.
7. Foster parents are a part of the foster care team and shall be part of case decision-making through Family Team Conferences (FTCs) and other case conferences.
8. Foster parents need to be meaningfully involved in the Provider's policy development and program planning activities.
9. While the safety of children is paramount, foster parents must be supported and treated with respect when allegations of maltreatment against children in their care are investigated by the Children's Services Office of Special Investigation (OSI). Foster parents subject to an OSI investigation shall be informed of the allegations they are facing, and explained their rights as foster parents.
10. The Provider is encouraged to use foster parent advocates as staff members in their programs in order to enhance outreach to and engagement of birth parents/caretakers. The caseworkers shall utilize the assistance of the foster parent advocates to engage birth parents/caretakers in case planning and permanency planning. This will include ensuring their attendance at and preparation for the FTCs, and general support of birth parents/caretakers in activities necessary to achieve service plan goals. Integrating foster parent advocates into a program is highly effective as a strategy for a foster care provider to achieve these goals and fulfill these responsibilities. Foster parent advocates are not explicitly required in

family foster care programs. However, birth parent advocates are encouraged in all foster care programs.

11. The Provider shall educate foster parents on parental mental health and its impact on Foster Children.

(b) Training needs assessment

Ongoing training for foster parents (after initial orientation) shall take into account individual needs of the foster parents and the population of children served. The Provider shall provide a minimum of six (6) hours of such training annually, either by the Provider or by an outside educational institution, and make efforts to connect foster parents to an additional six (6) hours through community-based supports and/or ACS-provided training. On-going training may take place at each foster parent contact.

(c) In-service training

In-Service training is regularly scheduled training throughout the year. All regularly scheduled foster parents' In-service training must include the following topics:

- Resource parent - being a resource of information on community resources and provide guidance to birth parent;
- Emergency medical procedures/Provider medication administration policy;
- Crisis de-escalation/intervention;
- Trauma, the emotional effects of abuse and maltreatment, and the range of behaviors traumatized children may express and what those behaviors indicate, and how to appropriately intervene;
- Loss and separation;
- Depression;
- Common psychotropic medications used with children, and risks/side effects associated with such medication;
- Normal and abnormal child/adolescent development and behavior;
- Family planning and sexual health, including child(ren)/youth's rights to access confidential services on their own;
- Chemical dependency/use, domestic violence, and sexual abuse and their effects on child(ren)/youth;
- HIV/AIDS;
- The importance of child(ren)/youth getting regular health care, including the administration of prescribed medication and treatments;
- Orientation regarding the health services available in their neighborhood; and
- Supporting lesbian, gay, bisexual, transgender and questioning (LGBTQ) child(ren)/youth in care.

The Provider shall educate prospective foster parents about the types of trauma that can be caused by abuse and maltreatment in addition to the behaviors that can result from such trauma.

D. Training Requirements for Renewal of Foster Parent License

- (a) Children's Services policy requires that participation in training is a condition of the re-certification or re-approval process.
- (b) Children's Services' *Foster Parent Agreement, Form CM-912y* contains the required provision. If providers are not using the Children's Services form (or their own version of it), they must immediately revise their provider-specific form to align with the Children's Services form noted previously. Licensed foster parents who might have signed a previous version of this form must be asked to sign the new version of the form.
- (c) The following training expectations must be met:
1. Regular Foster Care: Twelve (12) hours annually.
 2. Special/Exceptional Care (including Treatment Family Foster Care): In addition to the basic refresher training, foster parents caring for "special" and/or "exceptional" needs children require annual refresher training which includes appropriate time on the specific child's special or exceptional care needs. They are as follows:
 - (d) Special: Twelve (12) hours annually, including training on child's special needs.
 - (d) Exceptional: Fifteen (15) hours annually, including training on child's special needs.

As with initial special/exceptional training, refresher training may be provided or arranged by the professionals treating the child, e.g., doctors, nurses, therapists, etc. The specialized training may be individual or group and the foster parents' attendance must be monitored by the Provider.
 3. Mini-MAPP training must be completed prior to calendar year 2003 for all foster parents who were licensed prior to fiscal year 2000. Accordingly all current foster parents will be required to undergo MAPP training. Providers are required to document in each provider record that MAPP training requirements were met for these earlier licensed foster parents.

(d) Suggested Approaches for Meeting Refresher Training Requirements:

1. While not required, Children's Services recommends that providers offer in their array of refresher training, the following MAPP-based curricula:
 - "Shared Parenting" for recruited foster homes.
 - "Caring for Our Own" for kinship foster homes.
 - "Fostering and Adopting the Child Who Has Been Sexually Abused" for all foster homes.
 - "COMPASS Training" for certified foster parents.
2. Additionally, up to four (4) of the total number of hours for regular care training may be provided via "Circle of Support" attendance. (Foster parents shall provide agencies with written documentation of their attendance at these meetings signed by "Circle of

Support” supervisors.) Providers are also encouraged to offer training collaboratively with other providers serving the same or contiguous CD’s.

E. Recordkeeping and Documentation of Foster Parent Training in CONNECTIONS (CNNX), and in accordance with Title 18 NYCRR Part 443.2 and any successor or amended regulation.

1. All Family Foster Care (FFC) foster parents training must be documented in the CNNX-FAD stage, as Scorecard (formerly EQUIP); other performance measures will now be obtaining training information from this location.
2. Annual training information may be added anytime prior to the next foster home reauthorization date. Note that training information for initial certification must be entered into CNNX prior to certification or approval of a regular family foster care home and within one hundred fifty (150) days of placement for emergency certified or emergency approved family foster care homes.
3. Entries must not be made for each individual *session* completed, but rather for the full training *program* completed, e.g., MAPP/GPS, ten (10) sessions, thirty (30) hours and date completed.
4. The required Orientation shall be entered as such in this orientation window.
5. For initial training of all foster parents, select “MAPP/GPS” from the drop-down in the ‘Type’ field. In the ‘Title’ field, type in “MAPP/GPS”, “MAPP/Deciding Together” or “Mini-MAPP” as appropriate.
6. For the additional hours in the initial Special/Exceptional care training, enter a new training line and specify the type and the number of hours provided.
7. For specific types of “refresher” training, select an appropriate ‘Type’ from the drop-down list and type in the ‘Title’. Trainings such as “Shared Parenting” or “Caring for Our Own” shall be listed as “Other” in the ‘Type’ field and then labeled appropriately in the ‘Title’ field.
 - (a) Special/Exceptional Care Family Foster Care: In addition to the CNNX documentation described above, the Provider must document the foster parents’ training on Form CS-884A, *Agency/Foster Parent Certification* as part of the package for applying for the special or exceptional care rate. See *Procedure No. 97/Bulletin No. 96-1, Special and Exceptional Care, dated 1/9/96*, for details.
 - (b) Providers must also maintain records of invitations to training sessions, attendance records and documentation of efforts to facilitate attendance by both prospective and currently licensed foster parents. Such documentation may take the form of progress note entries, CNNX home study documentation, local Provider (outside source) forms/letters, and attendance sheets, copies of “certificates” of attendance or completion of training programs, (including training provided from outside sources, including the Circle of Support). This information shall be maintained in the foster parent’s record.

F. Adoption Services

1. Recruitment

- (a) Many of child(ren)/youth who are legally freed for adoption can be adopted by their current foster parents; the Provider shall facilitate, where appropriate, foster parents to adopt foster children in their care. In those instances, the Caseworker should complete an adoption home study and have the approved parents sign an adoption placement agreement once the child is freed for adoption.
- (b) If the child legally freed for adoption is not already placed in a home that will adopt, the Provider shall make diligent efforts to recruit and identify a family as the adoptive home. Efforts at recruiting new adoptive families can be categorized as:
- General recruitment;
 - Targeted recruitment, which focuses on specific groups of children/youths in need of families, and tries to match them with the pool of available families (Children's Services Matching Conference and referrals to recruitment organizations); or
 - Child-specific recruitment, which may be aimed at relatives or other individuals who already know the child/youth, or by using various types of media (Wednesday's Child, Heart Gallery, AdoptUsKids) to describe a specific child/youth. Asking a child/youth about their connections to others can help identify a potential adoptive resource.
- (c) The Provider shall comply with the following milestones in the adoption and home recruitment process:
1. Changing the goal to adoption within fifteen (15) months of placement as per ASFA guidelines;
 2. Filing a petition in court for termination of parental rights within sixty (60) days of goal change;
 3. Freeing the child/youth for adoption within twelve (12) months of goal change; and
 4. Placing the child in an adoptive home (signed adoption placement agreement) within ten (10) days of legal freeing or if a new home must be recruited the child must be "photo-listed" or an appropriate "photo-listing" entry must be made within ten (10) days of the legal freeing; and
 5. Finalizing the adoption within twelve (12) months of placement in an adoptive home.
- (d) While an adoptive family is being recruited for a child/youth, the Provider shall provide or arrange for these services:
- (1) Conduct monthly recruitment activities including videotape and media presentations,
 - (2) Use photo-listing as an option for recruiting. Place the child/youth on the Photo-list in the New York State Waiting Children Registry within ten (10) days of termination of parental rights;
 - (3) Participate in community gatherings, churches and schools, and advocate for the child/youth at adoption exchanges and fairs;

- (4) Children/youth who are older members of large siblings groups, or who have special needs shall be referred to specialized adoption recruitment and placement organizations; and
- (5) Participate in Children's Services sponsored recruitment events/strategies.

2. Home Study

Providers that recruit a prospective adoptive family shall make or arrange for an assessment of the family in accordance with *Title 18 NYCRR 421*: this process is called the "home study." A home study is a series of meetings, interviews, and training sessions involving the Provider and the prospective adoptive family. The Home Study shall meet NYS licensing and certification and/or approval requirements, as per *Part II, section B, subsection 5* of these *Foster Care Quality Assurance Standards, Title 18 NYCRR Part 421*, or any successor or amended regulation and all Children's Services Procedures. The Provider shall educate prospective adoptive parents about the types of trauma that can be caused by abuse and maltreatment in addition to the behaviors that can result from such trauma. An Assessment of the family is one of the earliest steps in the adoption process for the worker and the family.

- (a) It is a mutual process by which the Caseworker and a prospective adoptive family determine the family's appropriateness and readiness for adoption. The assessment process shall be strengths-based with the intent to screen in applicants. It often includes:

- Adoption education and development of families;
- Family dynamics and functioning;
- Background checks;
- Child care history and practice;
- Exploration of values, expectations, and motivations;
- Family self-assessment of strengths and limitations;
- Conversations with the child/youth about his/her wishes;
- Preparation of the family for placement;
- Ability of the family to provide safety and permanency for the child/youth;
- Motivation for and expectations of adoption; and
- Willingness to make a lifelong commitment.

- (b) Prospective families shall be assessed within their cultural context. Thus, adoption workers shall strive to be culturally competent, so that they can relate to persons from diverse cultures in a sensitive, respectful, and productive way. To reduce the chance of inaccurate assessment, workers must consider different communication and interaction styles, nonverbal behaviors, differences in the use and meaning of specific words and phrases, family roles and relationships, and home environments.
- (c) Providers shall ensure that prospective adoptive parents have an understanding of the trauma caused by abuse and maltreatment and the behaviors that can result, and a

commitment to do whatever is necessary to maintain the child/youth in their home, including collaborating with service providers who are working with the child/youth.

3. Filing for Adoption in Family Court

The Provider shall require and take steps necessary to ensure that an adoption petition is filed by the prospective adoptive parents or their attorney as soon as practicable from the date of notice that the Foster Child has been legally freed for adoption, subject to the following provisions:

- the child/youth was freed for adoption through an extra-judicial surrender, in which case the petition may not be filed until at least forty-five (45) days after the surrender was executed; or
- the child/youth was freed for adoption through an order of a court committing custody and guardianship of the child/youth to the authorized foster care Provider pursuant to the provisions of *Sec 384-b of the Social Services Law*, in which case, the petition may not be filed until at least thirty (30) days after service of the order of commitment on the birth parent/caretaker(s).
- If the child has been freed for adoption through an extra-judicial surrender or through an order of a court committing custody and guardianship of the child/youth to the authorized foster care Provider, but an adoptive resource has not yet been identified, the foster care Provider shall make diligent efforts to identify an appropriate resource so that the child does not linger in placement.

4. Comprehensive Adoption Report

The adequacy of adoption reports of investigation included in the Adoption Packet plays a key role in insuring that the adoption is completed expeditiously. To make an informed decision that adoption is in the best interest of the child, a judge or surrogate needs objective, comprehensive, and legible reports on the child/youth, the adoptive family and their home, and on the birth parents.

Additionally, the need for comprehensive, up-to-date information on all members of the adoption triad is particularly important where the judge or surrogate who is considering the adoption petition has had no previous experience with the child/youth.

PART III: PERMANENCY PLANNING

A. Service Plan Design and Delivery

A family to family service philosophy and approach must inform the provider's design and delivery of all child welfare services, with particular focus on family foster care.

1. When Children's Services determines that the removal of a child/youth from his/her primary family is necessary to protect his/her health and safety, Providers shall provide foster care placement and supportive services in accordance with all existing Federal, State and City laws, rules, and regulations, and consistent with policies, procedures, and standards promulgated by Children's Services.
2. Before a child/youth is placed in a foster home, Providers must prepare the foster parent with appropriate knowledge and skills to provide for the needs of the child/youth. Such preparation must be continued, as needed, after the placement of the child/youth. Providers shall supply basic information to foster parents about each child. Providers shall adhere to *Title 18 NYCRR 443.2* or any successor or amended regulation.

B. Key Components and Approaches

1. The Provider shall ensure that placement and supportive services are in place and available to promote timely reunification between Foster Children and their families, while ensuring safe and stable foster care experiences for Foster Children in settings that are as familial and least restrictive as possible consistent with the needs of the child. Children's Services shall share with the Provider as soon as possible any current assessment of the child's needs and any identified safety issues.
2. Children's Services shall provide the Provider with all available relevant information regarding the needs of the child and family for children/youth referred to the Provider.
3. The Provider shall operate according to the following principals and practices in efforts to maximize and improve safety, permanency and well-being for Foster Children:
 - Minimized periods of time spent in foster care and timely permanency through family reunification or adoption according to the strengths and needs of each Foster Child and his/her family.
 - Placement stability that minimizes the occurrence of replacements and relocations and provides consistency in care throughout the time that Foster Children remain in care.
 - In the event a Foster Child is removed from family foster care to residential care, the Provider shall make efforts to minimize the length of time spent in residential care,

returning the Foster Child to a family setting as soon as possible consistent with the needs and behaviors of the child as determined at the FTC.

- Except where otherwise indicated for the safety and well-being of a Foster Child, the Provider shall make efforts to place Foster Children in a Family Foster Care setting that is in the same community in which their birth parents/caretaker resides.
- Ensure safety from abuse and neglect while in foster care.
- Implement discharge planning and services to avoid the need for re-entry of a Foster Child into foster care after discharge.
- Implement services and support for Foster Children to develop to their fullest potential and become healthy, educated, and constructive members of the community with successful transitions to adulthood.
- Create and foster permanent adult connections for all Foster Children, including older Foster Children, when they leave foster care.

C. Referral, Intake and Placement

1. Placement

A child/youth is deemed to have been placed with the Provider on the day on which the child/youth enters the Provider's care pursuant to:

- a. The approval of Children's Services.

2. Referral and Intake

- a. Children's Services, pursuant to the Commissioner's responsibility and authority under Article 6 of the Social Services Law and the City Administrative Code, shall, in its sole discretion, refer children/youth in need of service, for placement to a family foster care Provider. Providers shall comply with all Laws prohibiting discrimination in placement on the basis of any factors including, but not limited to race, religion, color, national origin, disability, age, gender identity, sexual orientation, and each child/youth will have access to quality services. Where practicable, Providers should recognize the statutorily permissible desire for in-religion placement, in accordance with *SSL §373* and in a manner consistent with the principles of equal protection and non-discrimination as defined in other applicable Law. Pursuant to *Title 18 NYCRR 441.11* or any successor or amended regulation, Providers shall preserve and protect the religious faith of the child/youth.
- b. If a parent physically appears at the Provider's offices seeking voluntary placement of a child/youth, the Provider shall, in compliance with all Laws and Children's Services Policies, refer that child/youth to the appropriate Children's Services office. Thereafter, Children's Services shall determine whether the child/youth needs placement and, if

necessary, Children's Services shall place the child/youth.

- c. The Provider shall accept all children/youth placed by Children's Services in its care in accordance with these *Foster Care Quality Assurance Standards*.
- d. Providers are responsible for having staff available twenty-four (24) hours a day, seven (7) days a week, to receive intake referrals from the Children's Services' Office of Placement Administration (OPA). An administrative staff person, one (1) primary and a back-up), who can make intake decisions shall be available twenty-four (24) hours a day.
- e. The Provider shall make its best efforts to find a foster family able and willing to provide care for children referred by Children's Services who meet the criteria for family level of placement.

3. Provider's Acceptance of a Children's Services Referral

The Provider shall accept all children/youth referred to it for placement in accordance with these Family Foster Care Quality Assurance Standards except that the Provider may object to a placement in the following circumstances:

1. **Objection Based on Lack of Vacancy:** In the event the Provider is experiencing a legitimate lack of vacancy which is reflected on Children's Services' vacancy report or demonstrated by the Provider to Children's Services' satisfaction that Children's Services' vacancy report is inaccurate; or

2. Objection Based on Therapeutic Grounds

a. The Provider may object to the placement of a child/youth based on therapeutic grounds by providing Children's Services with an explanation in writing articulating what support or special arrangements, if any, the Provider would require in order to accept placement and address the child's/youth's needs and detailing the specific therapeutic reasons for the objection including details relating to whether the child/youth requires services that exceed the scope of their Contract Agreement and whether placement in the Provider's care would not address the child's/youth's needs. The Provider's written objection must be submitted to Children's Services within five (5) business days of the Provider's notice of a Planned Placement or within one (1) business day of the Provider's notice of a Regular Placement. In the event the Provider does not submit its written objection to placement within the time limitations stated here, the Provider shall be deemed to have accepted the placement.

b. After receiving the Provider's written objection, Children's Services may request that the Provider meet with Children's Services at a date, time and location specified by Children's Services to discuss the Provider's reasons for objecting to the placement, the needs of the referred child/youth, the support needs of the Provider as listed in the written objection, if any, and whether placement can be made with the Provider.

3. If the Provider displays a pattern of therapeutic objections to provide services that the Provider is obligated to provide under their Contract Agreement, or if the Provider displays a pattern of objections based on any characteristic(s) that might constitute unlawful discrimination, Children's Services shall investigate the matter. During the investigation, the Provider shall have the right to be heard and to present facts in support of its position. Following such investigation, Children's Services shall, in its sole discretion, take appropriate action including, but not limited to, sending the Provider a letter of admonition, reporting a deficiency on the Provider's annual performance review, requiring the Provider to file a corrective action plan, and/or closing the Provider's intake.

4. Capacity and Vacancy Reporting and Wait List

1. The Provider shall report its capacity, Regular Vacancies, and Planned Placement Vacancies to Children's Services as follows:
 - a. Capacity: The Provider shall accurately report its capacity on a monthly basis or more frequently as requested by Children's Services.
 - b. Regular Vacancy Reporting: The Provider shall report to Children's Services Regular Vacancies that are able to receive placements of Foster Children on a daily basis by 10:00 AM or as soon as possible thereafter, in order to keep Children's Services apprised of changes in vacancies as they occur daily.
 - c. Planned Placement Vacancy Reporting: The Provider shall report to Children's Services its Planned Placement Vacancies every Monday and Thursday by 12:00 pm (noon) or as soon as possible thereafter via the Vacancy Control database. Providers are responsible for maintaining the vacancy control data base with accurate information about the availability of homes they have licensed, which shall be documented and reported to the OPA.
 - d. Back-up Staff: The Provider shall designate one person and an additional back-up staff person from its intake section as a liaison who will report vacancies to Children's Services.
2. The Provider's failure to report vacancies in accordance with this Section shall trigger an immediate review of the Provider's vacancy reporting process and may result in the suspension of the Provider's intake.

5. Waitlist

For Planned Placements, the Provider may place children referred to it on a waitlist in the event the Provider does not have a vacancy. Notwithstanding the Provider's ability to place a referred child/youth on the Provider's waitlist, Children's Services may in its sole discretion place the child/youth with another foster care provider.

D. Case Opening Criteria and Procedures

1. Intake and Admissions

- a. The Provider shall establish policies and procedures that define the intake and placement process and clearly delineate the types and intensity of services provided to meet the needs of the children/youth.
- b. Children's Services shall assign a CIN number to each Foster Child, document eligibility requirements and placement/payment information in CNNX, and document other required systems to support payment to the Provider within three (3) business days of placement.
- c. The Provider shall verify the CNNX information with Children's Services, and shall be responsible for opening a "Child" case record immediately upon admission of all children/youth entering their care (see Part III, Section A, subsection 1 of these Foster Care Standards for more details). The Provider shall maintain a Uniform Case Record in accordance with the Law. The Provider shall have specified procedures for obtaining admission information on children/youth, including receiving information from the OPA and integrating it into the immediate service plan, that demonstrates a direct relationship between the plan goal and the needs of the child(ren)/youth.

2. The First Two (2) Business Days hours after placement:

The Provider shall:

Make contact with foster parents, child/youth and birth family/caretaker; engage kinship foster parents; and share information with foster parents.

The Provider must adhere to the following:

- a. For Foster parents: The Provider shall visit the home within the first two (2) business days after placement of a child/youth in a foster home. Contacts shall be in accordance with *Title 18 NYCRR 443.2* or any successor or amended regulation.
- b. For Child(ren)/Youth: A Provider worker shall visit the home within the first two (2) business days of placing a child/youth in a foster home. An assessment of safety and risk must be part of this initial visit and all subsequent visits and contacts (see Safety and Risk, Section C). Contact shall be in accordance with Children's Services' *Revised Casework Contacts for Families with Children in Foster Care - Implementation Responsibility (Children Services Guidance # 2007/02) dated October 23, 2007*, and Children's Services Memorandum "Family Casework Contact requirement:" Issued 4/7/00.

- c. For Birth Families/Caretakers: Birth parents/caretakers are essential in the lives of their children. Providers are expected to make them a primary focus of their programming and ensure their ability to effectively engage birth parents throughout the planning process. Providers are responsible for initiating contact with the birth parents during the first two (2) business days of their child's placement and maintaining regular contact with birth parents/caretaker, including visits to the birth parent's/caretaker's home or outreach to those in treatment or correctional facilities. Efforts must be made to identify birth fathers, and attempts made to locate and engage these individuals and their extended family or families in case planning. Providers shall refer to *Title 18 NYCRR, Parts 441.21, 423.4 and 443.4* or any successor or amended regulation for an understanding of the complete purpose of casework contacts with parents or relatives. When children enter foster care, parents/caretakers, including non-custodial parents, are required to receive information about which foster care agency and worker is responsible for their child(ren); parents have an early opportunity to meet face to face with child protection staff, foster care agency workers, and foster parents; and children have an opportunity to visit with their parents early in the foster care placement, preferably at the time of the transition meeting. This applies whenever a child is placed into foster care as a result of an abuse/neglect investigation, when parents voluntarily place a child through a Voluntary Placement Agreement, or when a child is placed into the care of Children's Services as a destitute child. It does not apply when children are placed into the care of Children's Services as a Person In Need of Supervision (PINS) or juvenile delinquent. Providers shall refer to *Children's Services policy "Transition to Foster Care Services," Procedure #2010/02 dated February 12, 2010* concerning this guidance.
- d. For Kinship Foster Parents: Providers are expected to engage kinship foster parents within the first two (2) business days. Contact shall be in accordance with *Requirements for Certifying or Approving Emergency Foster Boarding Homes - Implementation Responsibility (Children Services Guidance # 2008/04 dated October 23, 2007) Section IV-A*. Engagement of approved kinship foster parents: Contacts shall be in accordance with *Procedure 98A/Bulletin 92-2A, Referrals and Supervision of Approved Relative Foster Homes (Memorandum dated 04/11/1996)*.

3. Visitation and Establishment of Visitation Plan

Visitation between children/youth in foster care and their family members is crucial to supporting the children/youth's well-being, and helping them sustain relationships with important people in their lives. It also is a critical element in the child welfare system's response to the Federal Adoption and Safe Families Act (ASFA). ASFA's time frames for permanency require that children maintain frequent contact with their families whenever it is safe and/or appropriate for them to do so.

(a) *Responsibility for Visits*

It is always the Provider's responsibility to arrange and facilitate visits and other forms of contact between the child/youth, birth parents/caretakers, and among separated siblings.

When appropriate, phone contact between the child/youth and birth parent/caretaker shall occur throughout the life of the case until permanency is achieved. It is also recommended that the Provider, whenever it is safe and/or appropriate, facilitate visits between the child/youth and other significant adults in their life, when visitation would not compromise the safety of the child(ren)/youth. This responsibility applies to both planning and non-planning Providers. Although foster parents can escort children/youth to visits, or host visits in their homes and actively participate in visitation arrangements, the ultimate responsibility for ensuring that visits take place lies with the Provider, and for these visits to occur in the least restrictive environment.

(b) *Sibling Contact*

New York State laws and regulations require that all siblings and half siblings be placed together whenever possible, unless such placement would be a risk to a child's health and safety, or when geographic distance precludes visiting. When placement together is not possible or appropriate, Providers shall arrange frequent opportunities for sibling visits, communication by telephone, letters, and or other forms of regular and meaningful contact.

(c) *Scheduling*

Visitation arrangements shall take into consideration the schedules and circumstances of all those involved, including the parent, the child/youth, and the foster parent. Youths shall be actively involved in the planning and scheduling process. Providers are required to provide evening and weekend hours for supervised visits to take place, and show evidence of those extended hours in writing. Providers can comply with this requirement by collaborating with community-based partners who offer space in the evening and/or weekend hours. In scheduling visits, Providers should consider issues affecting their satisfactory completion, including travel distance, cost and safety considerations, (such as in cases involving domestic violence where visits must be monitored carefully so as not to compromise the safety of the survivor or children), as well as cultural, religious and language issues. The Provider is expected to facilitate family visits even if the foster family is unavailable.

(d) *Onset of Visiting*

In order to maintain relationships, help in the reduction of trauma, and begin the reunification process, visits shall begin as soon as possible after initial removal. The family and child/youth shall have an initial visit within the first two (2) business days of removal or replacement where appropriate and/or safe, unless prohibited by a court order.

(e) *Frequency and Length*

Children's Services' Visiting Guidelines require that families with a goal of reunification visit at least once (1) a week. Whenever possible, and in the best interests of the child, it is recommended that visits:

1. occur on a weekly basis;
2. be at least two (2) hours (for infants, shorter but more frequent visits can be scheduled) in length; and

3. occur in sites that are outside of the Provider, and identified by participating parties as comfortable, supportive and convenient.

(f) *Activities and Location*

1. When the goal is reunification, child/youth-parent visits shall serve as preparation for reunification, allowing parents to resume as much parental responsibility as possible while maintaining the safety of the child/youth. With this in mind, and whenever possible, visits shall be integrated into the already scheduled activities of children/youth and activities in which the parent will be involved post-reunification, such as medical appointments, school meetings and events. This type of visiting arrangement maximizes the naturalness of visits for children and parents; (re)integrates the parent into the child/youth's life, supports the continuation of the visit activities post-reunification, and eases the burden on foster parents to make special scheduling arrangements for visits.
2. Visits shall take place at convenient times and outside of the Provider facilities as much as possible, to allow families to experience real life situations together. Visits shall be arranged in the evening or weekends, if appropriate, to accommodate parents' and children/youth's schedules. Community Coalitions may be used for visiting support, including the use of community venues for family activities. An increasing number of chemical dependency/substance use disorder-treatment-providers offer on-site visiting for parents in residential care. The Provider shall contact the treatment provider to ascertain if that facility can accommodate on-site visiting. If visits take place at the foster care Provider's site, efforts must be made to provide a private, comfortable space equipped with age-appropriate toys and materials.
3. The Provider sites must comply with the Americans with Disabilities Act and applicable state and local laws make services and service locations accessible to family members with physical disabilities including, but not limited to, developing plans for: making facilities wheelchair accessible, utilizing sign language interpreters and large print informational reading materials.

(g) *Supervision*

Children's Services' policy states that visits will be unsupervised *unless* reasons for supervision are justified and can be clearly articulated and documented. At the beginning of a case, a reasonable justification for supervised visiting is based on an assessment; but once family interaction has become familiar to the Provider, other reasons for supervision must justify its use. If a level of supervision is applied, the Provider staff must be able to articulate the reason for the supervision and the conditions that the parent must meet in order for it to be lifted or lessened. The Provider shall comply with Children's Services Policies regarding visitation between Foster Children and birth parents/caretakers including the *Best Practice Guidelines for Family Visiting Arrangements for Children in Foster Care, August 28, 2006* or any successor or amended guideline. Both Children's

Services and the Provider acknowledge that these decisions are sometimes made by the Family Court.

(h) *Progression of a Visiting Plan*

1. Best case practice dictates that the family's visiting plan will progress and evolve to reflect progression in the parent's ability to meet his/her child/youth's needs and as deemed beneficial to the child's well-being, health, and safety. This may not always coincide with a parent's compliance with other aspects of their individualized service plan; rather this decision shall be based on the Provider's assessment of the parents' progress in changing those behaviors which place the child at risk for abuse or maltreatment. Visits shall not be suspended or limited in a punitive manner solely due to the parent's lack of compliance with the outlined services, unless such noncompliance is directly related to the parents' ability to keep their child safe. As well, prohibiting visits cannot be used as a form of discipline or punishment for the child/youth.
2. When reunification is the permanency goal, it is understood that visitation frequency and length will increase over time, with the level of any supervision deemed necessary decreasing over time as consistent with the well-being and safety of the child/youth. In general, a visiting plan shall evolve from weekly visits to more frequent visits of greater length, to overnight and weekend visits, leading to trial and then final discharge.
3. Although the variation in case circumstance renders it difficult to set forth specific timeframes for the progression described above, it is expected that visiting plans will be evaluated at least on a quarterly basis and shall have significantly progressed between reviews. In addition, Providers shall observe and assess parent-child/youth interactions to understand the parents' progress in modifying their behavior so that they can safely care for their child/youth. For unsupervised visits, providers shall be discussing how the visit went with the child/youth and parents separately, and any other adult such as a foster parent who was a part of the visit to understand same regarding the parents' capacity to care safely for their children. *If a child/youth's visiting plan has not progressed between quarterly reviews, the reasons justifying the lack of change must be clearly documented in the case record.* At a minimum, the visiting plan and level of supervision shall be reviewed at all Family Team Conferences (FTC) (including Parent to Parent Meeting and 20-Day Family Permanency Conferences (FPC)), service plan reviews, dispositional and permanency hearings, and at any other court dates. The Provider and Children's Services acknowledge that court orders pertaining to visiting can only be modified in court. Modifications can be made in between set court dates, however, by requesting a hearing to specifically change a visiting order that has become a barrier to permanency progression.
4. When considering a change in visiting plan, Caseworkers shall arrange to be present at all or part of a visit to assess case circumstances and progress, in order to ensure that the proposed change in visiting plan is appropriate. Also, as a general rule,

children/youth shall not be trial or final discharged from foster care without first having experienced successful overnight and weekend visits with the parent over a period of time. It is essential to have a planned, prepared transition to increase the likelihood of success and to support the children's well-being. In cases where there is a court order for an immediate discharge, the court order must be obeyed and implemented accordingly, regardless of whether or not there have been prior overnight and/or weekend visits. At the same time, Providers shall remain fully involved in assessing and acting as needed to keep the child safe if the order does not preclude such ongoing involvement. Providers do have the ability to recommend appealing court ordered discharges with which they disagree due to safety or risk concerns, by contacting FCLS.

(i) *Visits with Parents who are Incarcerated*

1. Providers are required to arrange for visits at least once a month between children/youth in foster care and their parents who are incarcerated, when the goal is reunification. Parents who are incarcerated retain their parental rights to visits until their rights are terminated or a court has suspended visits. Upon birth parent/caretaker incarceration, the Contractor shall establish a new visitation plan.
2. Providers are responsible for ensuring visits between children/youth and parents who are incarcerated, even if the parent is further than fifty (50) miles away. Such visits can be facilitated through the Children of Incarcerated Parents Program (CHIPP). CHIPP facilitates visits at Riker's Island and at upstate and tri-state State and Federal Correctional facilities.
3. When the whereabouts of a birth parent/caretaker are unknown, the Caseworker shall consider the possibility that the parent may have been arrested and is incarcerated and shall contact CHIPP to help them locate the parent. If after diligent effort the parent is located in a Correctional Facility, then the Provider shall establish a new visitation plan that allows for frequent visits by the child(ren)/youth, and complies with the goals of the family service plan.
4. While visits between children/youth in foster care and their birth parents/caretakers who are incarcerated are mandated to occur once a month, Providers are encouraged to provide visits as often as the child/youth can be escorted by the foster parent, Caseworker, Case Aide, or Parent Advocate.

(j) *Visiting Initiatives*

The following innovative visiting programs and initiatives are available to Provider Agencies to assist them in improving visiting practices:

- CHIPP, and
- Foster Grandparents.

Where available, Providers shall work with the Community Partnership Programs (CPP) to locate Visit Hosts for their families and additional community venues where visits can be held.

E. Engagement and Assessment

Engagement and assessment are core responsibilities that begin when the child(ren)/youth is first placed into care and continues through the entire period of placement. Case planning and other support staff are responsible for ongoing engagement with the child(ren)/youth in care, his/her birth parents and other family, his/her discharge resources, and the resource families with which the child is placed. They are also responsible for documenting this work in the case record. Effective engagement is needed to ensure that assessments are of good quality and responsive to the needs of those involved with the child. Ultimately, these assessments inform planning, service delivery and service coordination. The FTC is the key mechanism for incorporating the assessment information into the plan and it is critical opportunity for on-going engagement with all the key individuals involved in the case. In addition to the assessment requirements set forth below, the Provider shall initiate conversations with appropriate individuals, including Provider staff, other service providers, family members, and foster parents about the needs of each foster child. Furthermore, the Provider shall assist foster children ten (10) and older to articulate their own needs.

1. Birth Parent/Caretaker Engagement

- a. The Provider shall schedule and facilitate an initial meeting with the birth parents/caretakers, ("Placement Transition Meeting"), within two (2) business days of each Foster Child's placement for the purpose of educating birthparents/caretakers about their child's placement and educating them about family foster care (see also the Section of this Part II entitled "Onset of Visiting"). The Provider shall ensure that a staff member is assigned to each Foster Child's birth parent/caretaker for the initial meeting.
- b. The Provider shall ensure that birth parents/caretakers are part of the Foster Child's programming while in family foster care with birth parents/caretakers being engaged throughout the Foster Child's planning process.
- c. The Provider shall ensure that birth parents/caretakers are engaged, appraised and involved with every aspect of the Foster Child's life, including but not limited to decisions regarding the service plan, education, medical issues, development and overall wellbeing. When possible, the Provider shall take measures to facilitate the attendance of birth parents/caretakers at occurrences such as school conferences and medical appointments, and shall update birth parents/caretakers on the outcome of such events when they are unable to attend.

A Provider Caseworker must visit the home within two (2) business days of placing a child in a foster home. An assessment of safety and risk must be part of this initial visit (and all subsequent visits and contacts – see Safety and Risk below). In addition, the Provider shall

initiate its assessment of permanency that assessment shall continue, resources and permanency planning, including concurrent planning at this initial visit and throughout the life of the case. In addition to the safety and permanency areas referenced, the following are the areas for which assessments must be conducted within the first thirty (30) days of placement into foster care in the following areas:

- Medical health and developmental screening;
- Mental health screening [including chemical dependency/use screening for children ten (10) years of age and older];
- Domestic violence screening; and
- Educational status and need.

More detailed descriptions concerning the engagement of and assessment involving child(ren)/youth, birth parents, and resource parents are found in Part V, Section A, B, C, and D. In addition, the key areas requiring on-going assessment and planning are covered in depth in the Planning and Services sections that follow.

2. Safety and Risk Assessment

- (a) The purpose of a safety assessment is to ascertain whether there are any safety factors currently present and to determine if any children/youth are likely to be in immediate danger of serious harm. Safety factors shall be viewed as "red flag alerts" due to present identified circumstances, conditions or behaviors.
- (b) The safety assessment shall reflect the identification of any safety factors present or impending in the child/family behaviors and/or circumstances. This assessment shall cover all minor children in the foster home including those who may be foster children in another case and the foster parents' own children/youth. In cases where the discharge resource family has minor children who may not be foster children or were previously discharge, the Provider staff shall include them in the assessment. Based on the information gathered, it is then determined what interventions, if any, need to be initiated or maintained to provide appropriate protection for the child(ren).
- (c) Providers are responsible for adhering to New York City Children's Services' policies regarding regular casework contacts and safety assessments, including regular visits to the foster home. Providers are responsible for assessing, through these contacts' including the present factors that may impact the child/youth's safety and the quality of the relationship between foster parents and children/youth, and that between the children and their birth parents/caretakers; and domestic violence, in the foster home or discharge resource home environment. Providers' safety assessments of foster homes must be performed in accordance with the *New York State Safety and Risk Assessment Model as specified in OCFS Transmittal: 93.INF-14, Transmittal 95.INF-25, Transmittal 00.INF-05, Transmittal 08.INF-15; Title 18 NYCRR Part 428. 1-6, and Children's Services' Practice Guidelines for Addressing Domestic Violence in Foster Care Settings* or any successor or amended regulation.

- (d) Ongoing assessments of safety and risk in service cases initiated as a result of a substantiated SCR report of abuse or maltreatment must include the following activities:
 - (1) At intake, Intake Supervisor must review the investigation that led to the service referral, and incorporate the results of that investigation into an ongoing assessment of safety and risk and service planning for the child and family.
 - (2) Maintaining adequate casework contacts with the family, as required by *Children's Services Memoranda Issued 6/1/06, and 8/17/06*, and using those casework contacts to assess child safety and risk throughout the life of the case.
 - (3) Supervision of the Caseworker by an administrator, to support, guide, and review the Caseworker's ongoing assessment of safety and risk through contacts with the family, and with collateral contacts throughout the life of the case.
- (e) The Provider staff develops, and implements assessments and service plans, and maintain casework contacts with the family and service providers to assess necessary parental behavior changes in doing so are responsible for monitoring safety and risk throughout the life of a case.
- (f) In reviewing the service plan, the Provider has a continued responsibility to assess whether:
 - (1) a safety response has been initiated or maintained when necessary and whether such a response protects the child/youth from immediate danger or serious harm;
 - (2) services planned and/or provided are likely to reduce the risk related to one or more identified risk elements;
 - (3) the family is engaged and participating in those services, such that there is a reasonable expectation that the services will help to reduce the identified risk(s) to children/youth. If the services have not yet begun, is the family willing to participate;
 - (4) the parental behaviors identified during the investigation or which emerged during the child/youth's time in foster care as creating safety or risk concerns are changing, such that the parents can safely care for them;
 - (5) the needs of all children/youth in the household are taken into consideration when formulating a treatment plan; and
 - (6) the best interests of the child/youth require Family Court or Criminal action.
- (g) The Provider must incorporate the results of subsequent SCR reports, including any changes in the assessment of future risk of abuse or maltreatment, into the family's service plan.
- (h) When a major change in the service plan is considered, the Provider must carefully review the case to determine whether the planned action is consistent with the provider's assessment of child safety and risk. Major changes include:
 - (1) Reunification and/adoption;
 - (2) Foster care placement;
 - (3) Termination of mandated preventive services;
 - (4) Closing of any active service case;
 - (5) Initiating court action under Article 10 to recommend a change in the court disposition for the case; and

(6) Replacement (inter and intra Provider transfer).

3. Permanency Assessment and Planning

During the initial visit to a Foster Home, which is required to be conducted within two (2) business days, Provider staff shall assess the permanency needs of every child individually to determine if a plan is in the child's best interest, with such assessments continuing throughout the duration of each Foster Child's placement. The Provider shall assess the permanency needs of each Foster Child, develop a permanency plan, and work to reach established permanency goals as soon as possible. The Provider shall comply with OCFS guidelines and NYC Children's Services Regulations *Part I: 'Guidelines for Permanency Reviews'*, (issued March 12, 1999) and *Part IV: Guidelines for Choosing a Child's Permanency Plan* (issued May 16, 2001), and *Children's Services Memorandum to ASFA Memo Part V* (issued 1/29/03); and in accordance with *Title 18 NYCRR Part 428 and 430.12* or any successor or amended regulation when making such assessments.

4. Initial Assessment/Evaluation

The Provider shall complete an initial comprehensive assessment/evaluation for each Foster Child within thirty (30) days of placement. The initial comprehensive assessment/evaluation shall incorporate the input of clinical and social work experts and practitioners as appropriate to the needs of each Foster Child, including but not limited to a pediatric/adolescent medicine specialist, a developmental specialist, psychiatrist, psychologist, social workers, and educational, recreational, and vocational specialists. The Provider shall ensure that the comprehensive assessment/evaluation integrates the results of any assessments done prior to the Foster Child's referral to foster care, any assessments done since the Foster Child's placement, and an assessment for past trauma (including incest and other sexual abuse) and presenting trauma symptoms.

5. Assessments and Follow-up

(a) Child and Adolescent Needs and Strengths Assessment (CANS)

The Child and Adolescent Needs and Strengths (CANS) assessment tool assists with identifying a child/youth's needs and strengths and creating a service plan that prioritizes those issues that are most pressing. It helps to promote consistency and thoroughness of decision-making, and maintain a focus on the needs of the child/youth and family. With the use of CANS, Providers are expected to identify child/youth's needs and strengths earlier in their foster care placement, and address these needs more effectively.

(b) Permanency Resources for a Birth Family/Caretaker

Permanency resources are developed by a Provider to respond to the concerns, interests, and needs of families within a community or service area. These resources shall be developed within a geographic community where the birth family/caretaker resides. This will serve to increase the strength and stability of birth families/caretakers (including adoptive, foster, and extended

families), to increase birth parents caretakers' confidence and competence in their parenting abilities, to include adults and organizations that care for the children in the oversight of their safety and well-being, afford children a stable and supportive family environment, and otherwise to enhance child development. Some examples of permanency resources are; social supports, family, religious (spiritual leader) and school supports (teachers, teacher's aides, advocates) that the family will reach out to in times of crisis or for informal respite services.

(c) Vision evaluation: Each child shall receive an age appropriate vision assessment.

(d) Hearing evaluation: Each child shall receive an age appropriate hearing assessment.

(e) Dental evaluation: Each child shall receive a dental screening and/or referrals as appropriate.

(f) Domestic Violence Screening and Assessment:

1. Children's Services requires that all families involved with any part of the child welfare system receive routine screening for domestic violence, regardless of the presenting issues in the case. Routine screening to identify the presence of domestic violence is an important step in supporting and protecting children and adult survivors of domestic violence. The Provider will need to screen and assess for domestic violence, not only in the family of origin, but also in foster homes and in pre-adoptive homes.
2. The Provider must screen every family for domestic violence using the Children's Services Domestic Violence Screening Tool. The screening tool is meant to determine whether further assessment is necessary; its questions are written to be non-threatening and shall be integrated into a private conversation with each birth parent/caretaker. The safety and well-being of the survivor and her children must take the first priority and be considered throughout the case. Suspected abusive partners and birth parents/caretakers shall never be interviewed together when screening or assessing for domestic violence. (It is Children's Services policy that suspected abusive partners and birth parents/caretakers shall always be interviewed separately.) If the birth parent/caretaker answers affirmatively to the screening questions, or the Caseworker suspects that domestic violence is an issue regardless of the outcome of the screening, the Caseworker then completes the Domestic Violence Protocol, which will assist in making informed assessments of the family situation and the risks to the children. When routine domestic violence screening indicates that abuse may be an issue in the family, or when the Caseworker suspects that domestic violence is an issue, the Children's Services Domestic Violence Protocol must be utilized and appropriate interviews conducted. The Domestic Violence Protocol consists of three (3) main sections:
 - (a) The Interviewing the Survivor section includes: Identifying Domestic Violence, Assessment of the Safety/Risk to Children, Victim's Help-Seeking and Supportive Resources and Safety Planning;
 - (b) The Suspected Abusive Partner's Interview; and
 - (c) Overall Case assessment.

3. The Protocol provides further assessment regarding safety of the children and survivor, the survivor's help-seeking measures needed for safety planning. The Provider shall ensure that appropriate staff is fully trained on the use of these tools, including how to engage families and how to assess for seriousness of risk and harm to the children, as described in the Children's Services' "*Guidelines for Addressing Domestic Violence in Foster Care Settings*" which provides general information about domestic violence as well as how to identify and intervene in domestic violence cases within the foster care system. Included is information on screening for domestic violence with survivors and children, interviewing and service planning for all family members including the abusive partners, The Domestic Violence Screening Tool, and the Domestic Violence Protocol. All documents can be found on the ACS Intranet in DocuShare.
4. The Provider shall be aware that domestic violence refers to the intimate context within which one partner is abused by another. Domestic violence occurs in same sex relationships at about the same rate as they do are in heterosexual relationships and men account for about fifteen percent (15%) of survivors of domestic violence. The Provider will also be aware of the co-occurrence of domestic violence and other forms of family violence (sibling abuse, elder abuse, child maltreatment, and child(ren)/youth abusing adult members of the family). Screening and assessment of domestic violence must occur throughout a case but particularly:
 - (a) When a case is first opened;
 - (b) Whenever the worker suspects the presence of domestic violence;
 - (c) Any time the family composition changes or family circumstances changes;
 - (d) Whenever a subsequent case involving domestic violence allegations is called in to the SCR; and
 - (e) Before a case is closed.
5. The Provider shall be aware that while there are protective factors that can mitigate against the impact, children/youth who have lived with domestic violence or are living with domestic violence are at increased risk of experiencing emotional, physical, and sexual abuse, of developing emotional and behavioral problems. The impact of such exposure may endure even after measures have been taken to secure their safety and children/youth exposed to domestic violence are at increased risk of exposure to the presence of other adversities in their lives. The Provider will screen both adults and children/youth for exposure to domestic violence. All members of the family unit are to be interviewed separately. Assistance in engaging and interviewing children regarding domestic violence can be found in the *Practice Guidelines for Addressing Teen Relationship Abuse in Foster care Settings*.
6. The Provider shall also be aware of the significant rates of teen relationship abuse between both heterosexual and same sex teen partners. Youth who have grown up in violent homes are at risk for recreating the abusive relationships they have seen. The Case Planner will screen and assess for teen relationship abuse by using the Abusive Experience Inventory for Adolescents found in the *Children's Services Practice Guidelines for Addressing Teen Relationship Abuse in Foster Care Settings* which can be

found on the Children's Services intranet in DocuShare. The Provider shall be aware of special populations of teen survivors which can include:

- (a) Teen Relationship Abuse - teens in abusive relationships with other teens;
 - (b) Teens in abusive relationships with adults;
 - (c) Pregnant and Parenting teens and relationship abuse;
 - (d) Teens who are trafficked;
 - (e) Teens with disabilities and relationship abuse;
 - (f) LGBTQ – lesbian, gay, transgender, questioning youth and relationship abuse;
and
 - (g) Immigrant Child(ren)/youth and relationship abuse.
7. The Provider shall possess the expertise to: identify the abusive, coercive, and intimidating tactics used by an abusive partner, create a domestic violence safety plan for a teen or adult survivor, recognize the short and long-term impact of exposure to domestic violence on the survivor, on the children/youth and on the abusive partner and utilize the full spectrum of safety interventions available to families experiencing domestic violence consistent with the identified level of safety and risk.
 8. The Provider shall be prepared to assess if any family member is in immediate and impending danger of serious harm because of domestic violence. In some cases, it may not be safe to provide services within the survivor's current community. Some survivors of domestic violence may need an alternate residential or school placement or move to an emergency shelter at residential programs for victims of domestic violence because it is unsafe for them to remain in their current placements. Survivors are often at highest risk of serious injury or death from an abusive partner when she/he makes a decision or first acts upon her/his decision to leave/end an abusive relationship. It is therefore essential that a survivor receive all the support available at this critical time.
 9. When the Provider lacks expertise in domestic violence, it shall consult with a domestic violence specialist or provider. The Domestic Violence Specialist/Consultant shall provide the necessary assistance needed to appropriately engage families experiencing domestic violence. The Domestic Violence Specialist may conduct initial domestic violence assessments, crisis intervention, and provide referrals to nonresidential domestic violence services.
 - (a) The Domestic Violence Specialist may provide ongoing assistance, guidance and support to Caseworkers and other Provider staff as they work with families' experiencing domestic violence. The Domestic Violence Specialist shall be present at case conferences and other service plan reviews when appropriate and/or feasible; e.g.: the Domestic Violence Specialist can assist the Caseworker in properly documenting the survivor's accounts of the abuse by using language that holds the abusive partner accountable for his/her behavior. The Domestic Violence Specialist may also be utilized to provide ongoing domestic violence training to Provider staff.

10. The Provider shall be knowledgeable about the NYC 24 hour DV hotline number 1-800-821-HOPE (4673) which can also be accessed by dialing 311. Hotline advocates provide crisis counseling, safety planning, assistance with finding shelter, referrals to Safe Horizon programs and other organizations, advocacy with the police, and other crucial services.
11. Children/youth's safety shall be ensured through a coordinated community response. The provider shall obtain appropriate releases of information and maintain frequent communication with other key systems and service providers in order to effectively coordinate services to the family.
12. All information pertaining to domestic violence safety planning (i.e. a shelter's business address or an actual address of a survivor of domestic violence) shall be clearly and boldly identified in the case record by preventive staff as "Confidential Information Due To Domestic Violence, Do Not Share". This same documentation is required when a survivor of domestic violence is residing in a homeless shelter, substance abuse program, or other non-confidential location. In these situations, it is still imperative that the abusive partner does not learn of the survivor's location, directly or indirectly, from ACS or from preventive staff. The address and name of the location shall be clearly and boldly identified in the case record with "Confidential Information Due to Domestic Violence, Do Not Share."
13. Similarly, Article 10 petitions shall not include the survivor's address. The address shall be listed on the face of the petition as "Confidential". The survivor's address and the address of any service providers shall be redacted from any records provided to parties in court proceedings.

Please find specific instruction on engagement, assessment, safety planning, intervention and documentation regarding domestic violence cases in the Children Services' Preventive Practice Guidelines: Domestic Violence. For specific instruction on engagement, assessment, safety planning, intervention and documentation regarding teen relationship abuse see Children's Services Practice Guidelines for Addressing Teen Relationship Abuse in Foster Care Settings.

6. Services Related to Abuse and Neglect

- (a) Providers shall ensure that their staff are trained in and carry out their responsibilities to report alleged child abuse or maltreatment in accordance with the Law.
- (b) When an allegation of abuse or neglect is filed, the Provider shall cooperate in any steps deemed necessary by Children's Services to ensure the safety of the Foster Child, the Foster Child's siblings, or other children/youth in care. Where necessary, Children's Services shall, in cooperation with the Provider, establish a plan for responding to the alleged abuse or neglect, and the Provider shall carry out such plan.

7. Other needs

During the first two business days of contact with the birth parents/caretakers and foster parents the Provider shall initiate conversation about other needs that may impact the placement. If the child is between the ages of ten (10) and twenty-one (21) years, the Provider is responsible for assisting the child/youth to articulate his or her other needs.

F. Family Team Conference Model and Child Safety Conferences

1. Family Team Conference Model

A. The Provider shall utilize the FTC model as a fundamental approach to case planning. The FTC model is designed to engage families, foster families, community members, relatives and other adults who care about the child/youth in open, honest, critical child welfare decisions related to child safety, risk, well-being, placement stability, well-being, permanency, and service planning. Decisions are made jointly, and service plans are developed by the family, the social supports, community supports and service providers. Weaving together the family's expertise and the knowledge of professionals produces a partnership that designs more effective plans and services and offers the family a continuing network of support.

B. Across all program types, the FTC model is at the core of service provision. Children's Services expects that the FTC model will serve as the main practice tool for encouraging and supporting decision making for each case, as well as a central mechanism for organizing and facilitating the Provider's work with children and families, while focusing on safety, and maintaining a spotlight on achieving permanency.

C. The Provider shall partner with Children's Services in the FTC model, and the Provider's foster care program shall incorporate the principles and guidelines of the FTC model, and ensure that FTCs promote practices that reflect Children's Services' core principles, thus enhancing children's safety and well-being.

D. The Provider staff shall conduct and/or participate in all FTC conferences as required by and in accordance with Children's Services Policies. The Provider shall arrange for quarterly FTCs to provide a regular forum to discuss the family's progress toward the service goals, and adjust the service plan as is deemed necessary.

2. Family Team Conference and Domestic Violence

Domestic violence is a pattern of coercive, abusive and intimidating behaviors perpetrated by one partner over another to establish and maintain power and control. Given the significant overlap between domestic violence and child maltreatment, and the fact that domestic violence may not be known before a conference, care must be taken during the conference to ensure the safety of all participants.

When domestic violence has been identified prior to a conference, it is Children's Services policy to hold separate conferences for the victim and the abusive partner. FTCs shall be scheduled in such a way as to reduce the likelihood of contact between the partners, and an "exit" strategy shall be developed beforehand with the survivor. In addition, the allegiances of any child(ren)/youth attending a FTC need to be assessed prior to discussion of any safety planning. A child/youth who is aligned with the abusive partner shall not participate in safety planning discussions for the survivor and for the children.

When domestic violence has not yet been identified, and partners attend the conference together, no direct line of questioning shall be asked that would disclose domestic violence. The victim would most likely deny any abusive, coercive and/or intimidating tactics used by the partner out of fear or it could be dangerous if the victim disclosed in the abusive partner's presence. If domestic violence is suspected, the facilitator shall initiate a private discussion with the survivor/victim away from the abusive partner to complete a domestic violence assessment, discuss appropriate immediate safety planning and arrange for appropriate services.

When domestic violence is identified during the conference, and both the survivor/victim and the abusive partner are present, the facilitator may stop the conference if continuation would create an unsafe situation because of the dynamics between both parties. The reason for ending the conference shall also be kept confidential if disclosure would create an unsafe situation. Appropriate safety planning with the suspected survivor should be initiated before the survivor leaves the conference. Assessment of domestic violence shall never take place during a FTC with both partners present.

When a birth parent/caretaker attends a conference and the survivor/victim or abuser is not present, if domestic violence is suspected, the issues may be discussed depending on the parent/caretaker's comfort level with the group. If the birth parent/caretaker is unwilling to discuss the issues with the group, staff must initiate a follow-up discussion after the conference. A domestic violence assessment, appropriate safety planning and arrangement for appropriate services must be initiated if one has not yet been completed.

3. Requirements for FTC Facilitators

An FTC Facilitator must have, at minimum, a MSW or equivalent human service graduate degree or two (2) years casework experience and one (1) year group work experience and/or one (1) year supervisory experience. The Facilitator is responsible for helping identify any safety issues that may threaten the safety of the child in the foster care setting, during family visits, or at home, as well as the status of behaviors or conditions that present risk of abuse or maltreatment to the child and to help family members create a plan that will address them. The Facilitator is a person who helps a group reach consensus; is responsible for bringing the team together; and has had no ongoing involvement with the family. The Facilitator is positioned to be completely independent of the case.

The role of the Facilitator is to:

- Guide the FTC process, but does not have decision-making authority;
- Focus participant's attention on identifying and building on strengths;
- Focus participants' attention on the child's need for permanency and the urgency of developing a family-based "exit strategy" from foster care;
- Negotiate/develop a collaborative service intervention and permanency plan that will ensure the safety and well-being of the child;
- Help participant's present discuss concerns about risk to the child without making family members defensive; and

- Be knowledgeable of best case practice, and apply such practice to the FTC and the conference participants' subsequent work with the child and family.

4. Types of Family Team Conferences

A. There are four (4) types of FTCs:

- (1) Permanency Conference is to be facilitated by the Provider and are held at three, six, and twelve month intervals, during the first year of the child's initial removal into foster care, and every six months thereafter (in sync with SPR). Children's Services will be available to assist with facilitating conferences or will attend in the role of Permanency Specialist. The FTC conference model addresses the three "critical decisions" described below in number 4(i), (ii) and (iii).
- (2) Placement Preservation - critical decision-making conferences facilitated by Children's Services' Office of Family Permanency Team Conferencing (OFPTC) in the Division of Family Permanency Services (DFPS).
- (3) Goal Changes (Adoption, Alternative Planned Living Arrangement (APLA), Discharge to Adult Residential Care)- critical decision-making conferences facilitated by Children's Services' Office of Family Permanency Team Conferencing (OFPTC).
- (4) Reunification/Discharge- critical decision-making conferences facilitated by Children's Services' Office of Family Permanency Team Conferencing (OFPTC).

B. Role of FTC

Critical Decisions:

- (i) **Placement Preservation** - Prior to a child/youth moving from one placement to another, a FTC conference shall be held to determine whether it is possible to support the child in his/her current placement. If an emergency removal is inevitable, then a conference shall be held within twenty-four (24) hours from the time of the removal.

- Foster parents are strongly recommended to attend and assist in making a decision that will best meet the child/youth's needs.
- The goal of the conference is to decide if a child/youth can remain in their current placement, possibly with additional supports/services to stabilize and maintain that placement.
- If the child/youth must move to another placement, the foster parent's assistance is crucial in ensuring that the Team has all the information to support the need for the child/youth's movement, and how to make the change with as little trauma as possible.
- The overall goal is to minimize the number of moves that a child/youth experiences before permanency is achieved.

- (ii) **Goal Change** - Prior to a having a goal change, a FTC needs to be held. The following are three specific goal change conference types:

- Adoption: A goal change conference is needed to make an alternative permanency plan if child/youth cannot return to his/her own family. The preferred alternative if a child/youth cannot return to his/her family of origin is adoption.
- APLA: Is to determine a permanency goal that shall be used only with discretion, and it may not be assigned without an FTC. Prior to an APLA goal change FTC, the Caseworker will work in close collaboration with a youth to explore possible connections the youth may have to caring adults parents, extended family members, parents of friends, former foster parents, provider staff members, acquaintances from school, work, or the community) so that these adults can be invited to participate in the FTC as possible permanency resources. As mentioned previously, any youth given a goal of APLA must also be involved in developing a family-based concurrent plan for reunification, adoption, guardianship or custody to ensure that the youth has permanent connections, a permanent support network, and housing stability.
- "Adult Residential Care": This shall only be made the goal when the child/youth's physical and/or developmental disabilities are severe enough to require life-long care in a non-family-based setting, such as those provided through the New York State Office of Person with Developmental Disabilities (OPWDD) or the New York State Department of Health (DOH). Adult Residential Care is not an appropriate goal for children/youth that are being referred to supportive housing upon discharge from foster care. A FTC conference needs to be held when a child/youth's goal is being changed to Adult Residential Care (PPG-06). Reunification needs to be explored before the goal change is made; that decision shall be made in collaboration with one's birth family/caretaker, and/or extended kin. Additionally, there must be a thorough investigation of all the caring adults who have ever touched the child/youth's life. If there is a decision change a child's goal to "Adult Residential Care," the Provider needs to ensure that that child/youth has a significant and positive adult relationship as he/she grows up. It is important to note that a goal of "Adult Residential Care" is not a necessary requirement for referring children/youth to long-term facilities. Children/youth with goals of reunification or adoption can also be referred to adult residential programs if such a facility is necessary to meet their physical and/or developmental needs.

(iii) *Discharge/Reunification*

Trial Discharge

To decide if a child can safely return to his/her own family, a FTC shall be convened at which the team:

- determines whether the parental behaviors or other circumstances that caused child/youth to come into care, or emerged while the child/youth was in care have been corrected such that the parents can care safely for their children/youth;
- determines what support services need to be in place to support the discharge;
- discusses a transition plan, such as school, medical records, continued contact with friends and ongoing contact with the foster family; and
- discusses any concerns or misgivings the foster parent or other parties, including service providers, law guardians or other caring adults may have regarding reunification.

Discharge to Parent with Court Ordered Supervision

To decide if a child can safely be discharged to his/her parent with court-ordered supervision, a FTC must be convened at which the team:

- determines what support services need to be in place to support the discharge;
- discusses the of a transition plan, such as school, medical records, continued contact with friends and ongoing contact with the foster family;
- discusses any concerns or misgivings the foster parent may have regarding reunification; and
- discusses a planned joint home visit between the Provider and Family Support Unit (FSU) (which will serve as a transition visit).

Discharge to Relative/Other Permanent Adult Resource

To decide if a child/youth can safely be discharged to a relative/other permanent adult resource, a FTC shall be convened at which the team:

- determines whether the barriers that caused child/youth to come in care have been corrected as well as assess any risk factors;
- determines what support services need to be in place to support the discharge;
- discusses the transition plan, such as school, medical records, continued contact with friends and ongoing contact with the foster family; and
- discusses any concerns or misgivings the foster parent may have regarding the particular discharge.

Discharge to APLA

To decide if a child shall be discharged to "APLA," a FTC shall be convened at which the team:

- determines whether the barriers that caused the youth to come into care have been corrected as well as assess any barriers to services or risk factors;
- determines what support services need to be in place to support the discharge. Prior to an APLA goal change FTC, the Caseworker will work in close collaboration with the youth to explore possible connections the youth may have to caring adults (parents, extended family members, parents of friends, former foster parents, provider staff members, acquaintances from school, work, or the community) so that these adults can be invited to participate in the FTC as possible permanency resources). Any youth given a goal of APLA must also be involved in developing a family-based concurrent plan for reunification, adoption, guardianship or custody to ensure that the youth does not have to face homelessness or discharge into the community without having permanent connections to one's birth family/caretaker, a resource family and/or extended kin. The plan needs to be reviewed and updated with information on current and future services and supports);
- discusses a transition plan, such as school, medical records, continued contact with friends and ongoing contact with the foster family; and
- confirm that the child(ren)/youth will have the supportive services they need, including housing, educational/vocational services and employment, to support themselves independently.

5. Other Types of Required Conferences

(a) Parent-to-Parent Meeting

A Parent-to-Parent meeting is a required meeting between birth parents/caretakers and foster parents to allow them to meet each other and for the foster parent to get to know the needs, likes and preferences of the child/youth. These meetings are scheduled immediately following the Placement Transition Meeting. The goals of the Parent-to-Parent meeting are to:

- Bring together (face-to-face) key parties who are involved in the process of reuniting the family when a child/youth has been removed from the birth parent and enters foster care.
- Facilitate an informal, positive relationship-building session between the birth and foster parents.

(b) Initial Child Safety Conference

In the Children Services Division of Child Protection (DCP), placement decisions are made through Child Safety Conferences (CSC). CSC is an innovative concept in the DCP at Children's Services, designed to produce optimal decision-making, where all the people who can have an impact and/or can contribute to the safety of a child/youth, including community members, meet and work together in order to arrive at the most appropriate, yet least intrusive and least restrictive safety intervention for a child/youth who may be in imminent danger, while empowering the parents in the decision-making process. The CSC process establishes a forum to share ideas and opinions and to identify accessible, wraparound resources available as immediate supports in a family's neighborhood, while supporting and strengthening the family.

When DCP schedules an Initial-CSC, either because an emergency removal took place the night before, because the Child Protective Services (CPS) is considering removal of a child/youth, or when other legal intervention (such as Court Ordered Supervision) is deemed necessary to keep a child/youth safe, it will be the responsibility of the provider who already has a relationship with the family, (because they have either been responsible for the fostering of a member of the family in the past or because a child/youth of the family is in foster care,) to be present at that initial conference, and bring with them all the information pertaining to the history of the members of the family with Children's Services and with the provider. Through their participation at these critical decision-making conferences, the providers will assist the group with the recognition of the existing barriers to reunification, identification of permanent placement possibilities (e.g. known relatives, etc.), and reunification of siblings. The conference takes places always before the initial court hearing as participants work towards reaching a consensus decision that best meets the children's safety needs.

The triggers for the Initial Child Safety Conference are:

1. When the child protection specialist (CPS) and her supervisor have determined that safety concerns are serious enough that a removal or other legal intervention (COS) may be necessary to keep a child safe;

2. Within 24 hours after an emergency removal and **before** the filing of an Article 10 petition. In these instances the conference must be held first thing on the next working day.
3. To determine whether to accept a voluntary placement request for a child.
4. On behalf of a newborn in the following circumstances:
 - If the parent(s) has a child who is currently in the custody of Children's Services, and the mother is expecting or has already given birth to another child.
 - If the parent tests positive for an illegal substance during the third (3rd) trimester of pregnancy or at the time of the child's birth and there are safety concerns.
 - When there are other indicators that the mother may not be able to care for her child at birth;
5. Fatality cases where there is a surviving sibling.

(c) Follow-up CSC (20-day Conference (Previously known as 30-Day Family Permanency Conference))

The Follow-Up CSC is a collaborative process through which families, their support system, various Children's Services staff, Caseworkers, foster parents, service providers and other involved community partners participate in the review of the family's initial engagement, the appropriateness of the child/youth's placement and the initial safety plan developed at the Initial CSC to define a more comprehensive service plan for the family and permanency plan for the child/youth.

The Follow-up CSC is held approximately twenty (20) calendar days after the Initial CSC. The Follow-up CSC follows-up on the action plan developed at the initial CSC and the recommendations made at the Parent-to-Parent meeting. The Provider to which the case has been referred to, or that has been working with the family must attend this meeting. The Caseworker is expected to notify the foster parents about the CSC, explain their role at the CSC and prepare them for the CSC. It is expected that by this point safety and risk have been assessed, kinship resources have been identified and a service plan has been initiated.

Children's Services participants and the foster care staff, if available, must meet before the Follow-Up CSC to review the case, the identified service needs and any existing service plans, any special circumstances and the roles of each participant and presentation sequence. Efforts shall be made to answer any questions about the case and to explore service and placement options suggested by Children's Services staff before the conference.

PART IV: PROGRAM SERVICES

A. Coordination and Delivery of Services

1. Service Planning

The five (5) permissible ASFA permanency plans, pursuant to the Adoption and Safe Families Act (ASFA), *ASFA Regulations 6-30-09* and *Title 18 NYCRR 430.12*, in order of consideration are:

- a) Return to parent
- b) Adoption upon the filing of a petition to terminate parental rights
- c) Referral for legal guardianship
- d) Permanent placement with an appropriate and willing relative
- e) Another planned living arrangement (APLA) [but only in the event there is a compelling reason why none of the other ASFA permanency plans is in the child(ren)/youth's best interests.]

2. Service Plan Reviews

Service Plan Reviews (SPRs) shall be conducted for each foster child in accordance with *Title 18 NYCRR Part 428.9* and *430.12* or any successor or amended regulation. OCFS requires SPRs to be done every six months; however, Children's services requires that an FTC, in this case the QCC, to be done every quarter (for the first year only, depending on case circumstances). While sometimes the two meetings may coincide, they often do not. Providers must conduct SPRs and FTCs, but they are not required to do SPRs at every FTC.

3. Family Assessment and Service Plan (FASP)

Providers shall create and maintain written service plans for each child(ren)/youth in care, which are documented in the FASP in the New York State CONNECTIONS (CNNX) system, and which are created in conjunction with and provided to birth parents/caretakers, child(ren)/youth, foster parents, and others in accordance with *Title 18 NYCRR Part 428* or any successor or amended regulation.

Individualized Family Assessment Service Plans FASPs will include specific steps and services to reinforce identified strengths and meet family needs. The FASP shall incorporate the findings from the Child and Adolescent Needs and Strengths (CANS) assessment, if one was done before the child was placed into the foster home/ residential care or at any other point in time. The Provider will assess the birth family/caretaker for domestic violence, chemical dependency/use, mental/behavioral health issues, etc., and ensure that service goals address the needs of the family. (Assessments for chemical dependency/use that go beyond observable behaviors can only be done by an OASAS- Credentialed Alcohol and Substance Abuse Counselor (CASAC); when appropriate and necessary, referrals shall be made to licensed providers.)

Plans will specify steps to be taken by each member of the team, timeframes for accomplishment of goals, and concrete actions to monitor the progress of the child and family. The Provider will create these service plans utilizing the FTC model.

4. Permanency Planning

It is crucial to the child(ren)/youth's well-being that their adult caretakers engage in positive interaction. To that end, the Provider shall facilitate the development of respectful and supportive relationships between birth parents/caretakers and foster parents. The Provider shall work with appropriate individuals in each Foster Child's life to develop a plan to successfully discharge the Foster Child with the preferred goal being reunification. The Provider shall conduct all such permanency planning efforts in accordance with the provisions of the Law.

The first and foremost obligation of all those involved with foster care is to ensure that child(ren)/youth are safe. Child(ren)/youth shall not grow up in foster care. From the day a child(ren)/youth enters care, it is the responsibility of the Provider to work with the parent and the foster parent to develop an "exit strategy" from care. For most child(ren)/youth, reunification is the preferred "exit strategy" up until the point at which the child(ren)/youth has been in care for fifteen (15) months.

If, however, a child(ren)/youth has not been reunified after a foster care stay of fifteen (15) months, ASFA requires that the child(ren)/youth's goal be changed to adoption and steps be taken to begin a "termination of parental rights" (TPR) proceeding, unless there is a "compelling reason" why filing a TPR proceeding is not in the child(ren)/youth's best interest. Reunification may be maintained as the child(ren)/youth's concurrent goal, but concrete steps to move toward adoption need to be put in place after the child(ren)/youth has been in care for fifteen (15) out of the last twenty-two (22) months.

Delaying the filing of a TPR petition on the grounds of "compelling reasons" is not to be undertaken lightly. The reason for the delay must be truly "compelling", such as

- The parent(s) have made substantial progress in eliminating the problems that necessitated the child(ren)/youth's placement into care and there is a very strong likelihood that the child(ren)/youth can return home safely within the next six (6) months.
- The child(ren)/youth have been placed with an approved relative who is able to provide the best available care for the child(ren)/youth. The relative strongly prefers that parental rights not be terminated but is committed to providing a non-adoptive but safe, permanent home for the child(ren)/youth.
- The Provider has failed to provide the services necessary for the safe return of the child(ren)/youth to the parent.
- A parent is incarcerated but has maintained involvement in planning and it is expected that they will be available to provide for the child(ren)/youth within an appropriate timeframe.

Provider shall carefully track their decisions to delay filing TPR proceedings to make sure that "compelling reasons" exceptions do not dominate their caseloads.

Children who stay in foster care longer than two (2) years are considered to have a long length of stay. Their cases need special scrutiny by the Provider's foster care director at regular quarterly intervals at the FTCs. Provider shall institute accountability mechanisms to track the lengths of stay of children on the caseload of each worker, supervisors and program director.

5. Concurrent Planning

The Provider will engage in concurrent planning, (unless it is determined to be inappropriate in a particular case), in which planning for adoption or other custodial arrangements begins at intake, though the formal service goal may be reunification. The goal of concurrent planning is to reduce the time to adoption or other permanency in situations where reunification with birth parents/caretakers is ultimately determined not to be the appropriate plan and the circumstances result in the termination of the birth parent/caretaker's rights. Older children shall receive concurrent planning and services that support the goal of family-based permanency and the goal of leaving foster care as young adults who are emotionally and physically able to succeed as adults and to pursue healthy and productive futures. Children's Services' guidelines on the ASFA, permanency planning and concurrent planning may be found on www.nyc.gov/html/acs/html/about/asfa_guidelines.shtml. The Providers shall review ASFA timelines for setting goals for permanency: family reunification, adoption, legal guardianship, and legal custody with a relative or placement in another planned permanent living arrangement.

6. Planning for Teens

Permanent, nurturing family connections are as important for youth as they are for younger children.

Many teens know best who the caring, committed adults are in their life. Permanency for teens requires a partnership with young people to identify the key people in their lives, including but not limited to parents; members of their extended family such as grandparents, older siblings, godparents, aunts, uncles, cousins; family friends and neighbors; current and former foster parents and group home staff; school and after-school personnel; and other responsible adults whom the child/youth trusts and with whom the child/youth feels safe.

It is the Caseworker's responsibility to ensure that child(ren)/youth are active participants in their plans for permanency.

The goal of APLA is a permanency goal that shall be used only with discretion. It may not be assigned without a FTC and only if a concurrent family-based plan for reunification, discharge to relatives, adoption, guardianship or custody or [for youth eighteen (18) years of age and older only] another ongoing supportive permanent relationship has been documented in writing in the service plan.

There is no "age limit" for adoption. Adoption remains a viable option for adolescents and young adults, who have a critical role to play in identifying their own potential adoptive resources.

- No child/youth in foster care may be asked to sign an across-the-board adoption waiver or to sign a general statement that they do not wish to be considered for adoption.
- Youth eighteen (18) years of age and older shall be informed by their Caseworker that they can consent to their own adoption without a TPR.
- Adolescents who are ambivalent about adoption or who state that they do not wish to be adopted need support and exploration of their concerns, feelings and reasons; as well as provided other supports, e.g. discussion of the availability of an "open adoption" which allows for post-adoption contacts with birth parents, introduction to other adopted teens and to adoptive parents of teens, and other peer supports in accordance with *Title 18 NYCRR Part 421.8* or any successor or amended regulation.

Bridges to Health (B2H) Waiver program is available to support reunification for teens and to support foster parents caring for teens and shall be accessed.

Foster parents who have strong relationships with child(ren)/youth but who are reluctant to adopt the child(ren)/youth shall be offered counseling and peer supports to address the feelings and concerns that may underlie their reluctance to proceed with an adoption, including counseling to address financial concerns, availability of post-adoption services, and kinship issues.

B. Casework Contacts

The Provider shall provide casework contacts in accordance with *Title 18 NYCRR 441.21, 423.4, and 443.4* or any successor or amended regulation.

1. Child(ren)/Youth

The purpose of casework contacts with the child(ren)/youth is to "assess the child(ren)/youth's current safety and well-being, to evaluate or re-evaluate the child(ren)/youth's permanency needs and permanency goal, and to guide the child(ren)/youth toward a course of action aimed at resolving problems of a social, emotional or developmental nature that are contributing towards the reasons why such child(ren)/youth is in foster care." Providers shall also adhere to *OCFS Regulations* issued August 15, 2006, and *Children's Services Memorandum Guidance #2007/02*, titled "*Revised Casework Contacts for Families with Children in Foster Care*," dated 10/23/07 and revised 3/30/10 which describes Children's Services minimum casework contact requirements for children in their placement location (*formerly known as home-based casework contacts*) and for face-to-face contacts for all parents/relatives.

During the first thirty (30) days of placement, casework contacts are to be held with the child(ren)/youth as often as is necessary, the Provider shall conduct (two) 2 contacts. At

least (one) 1 of the (two) 2 contacts must be held at the child/youth's placement location, within the first (seven) 7 days. After the first (thirty) 30 days of placement, casework contacts are to be held with the child at a minimum of one (1) a month. At least (two) 2 of the monthly contacts every (ninety) 90 days must be at the child/youth's placement location.

When conducting casework contacts with the parents or relatives, the Provider shall continue to assess "whether the child(ren)/youth would be safe if he or she was to return home, and the potential for future risk of abuse or maltreatment if he or she was to return home" in accordance with *Title18 NYCRR Part 441.21* or any successor or amended regulation.

Providers have express authority to direct an assigned Caseworker to conduct casework contacts as necessary.

2. Family

As defined in *Title18 NYCRR 441.21* casework contacts with the child(ren)/youth's birth parents/caretakers is defined as individual or group face-to-face contacts between the Caseworker, or assigned Caseworker, as directed by the Caseworker and the child(ren)/youth's birth parents/caretakers for the purpose of assessing whether the child(ren)/youth would be safe if he or she was to return home, and the potential for future risk of abuse or maltreatment if he or she was to return home. Such contacts are also for the purpose of guiding the child(ren)/youth's parents or relatives towards a course of action aimed at resolving problems or needs of a social, emotional, developmental or economic nature that are contributing to the reason(s) why such child(ren)/youth is in foster care in accordance with *Title18 NYCRR 441.21* or any successor or amended regulation.

In the case of child(ren)/youth with the permanency planning goal of APPLA placement arrangement with a permanency resource or Adult Residential Care, such contacts are for the purpose of mobilizing and encouraging family support of the child(ren)/youth's efforts to function independently, and to increase his/her capacity to be self-maintaining; evaluating the ability of the birth parents/caretakers to establish or reestablish a connection with the child(ren)/youth and serve as a resource to the child(ren)/youth; and, where appropriate, encouraging an ongoing relationship between the birth parents/caretakers and the child(ren)/youth.

During the first thirty (30) days of placement, casework contacts are to be held with the child(ren)/youth's birth parents/caretakers as often as is necessary, but at a minimum, must occur at least twice unless compelling reasons are documented why such contacts are not possible. After the first thirty (30) days of placement, casework contacts are to be held with the child(ren)/youth's birth parents/caretakers at least once every month unless compelling reasons are documented why such contacts are not possible.

3. Foster Parent

As defined in *Title 18 NYCRR 441.21* casework contacts with the child(ren)/youth's foster parent is defined as face-to-face contacts by the Caseworker as directed by the Caseworker with those persons immediately responsible for the child(ren)/youth's day-to-day care for the purpose of obtaining information as to the child(ren)/youth's adjustment to foster care and for facilitating the foster parent's role in achieving the desired course of action specified in the child(ren)/youth and family services plan.

During the first thirty (30) days of placement, casework contacts are to be held with the child(ren)/youth's foster parent as often as is necessary, but at a minimum must occur at least once at the child(ren)/youth's placement location.

After the first thirty (30) days of placement, casework contacts must be held with the child(ren)/youth's foster parent at least monthly, and at least one (1) of the monthly contacts every ninety (90) days must be at the child(ren)/youth's placement location.

4. Discharge Resource

Best case practice dictates that discussion of discharge resource must be part of the case planning process. The Provider is responsible for discussing and reviewing all changes of identified discharge resource during any and all casework contacts with the child(ren)/youth and parents/caretakers.

C. Treatment Team Meetings

The Provider shall establish a Treatment Team for each child(ren)/youth, led by provider staff, to determine the most appropriate treatment plan for each child and to review service plans and determine changes necessary to improve the emotional and physical well being of the child(ren)/youth, birth family/caretaker, and foster family. The team members shall include but not limited to the following, as appropriate for each child(ren)/youth's service needs and plan: birth family/caretaker, foster parent, a medical professional [Medical Doctor (MD), Registered Nurse (RN) or Licensed Professional Nurse (LPN)], developmental specialist, psychiatrist, psychotherapist, psychologist, program director, social workers (including clinical social workers), child(ren)/youth skills trainer, Caseworker who has daily contact with the family and educational, recreational, and vocational specialists. Additionally, the team shall provide support and consultation to the foster parents.

D. Transfer of the Foster Child

A. Transfer within the Provider's Care

It may be necessary in order to meet the needs of a Foster Child to transfer the case within the Provider's family foster care or residential care program. Transfers within the Provider's care shall be made in accordance with Children's Services Policies, and following the standards outlined in the qualifying sections below.

B. Transfer Out of the Provider's Care

It may also be necessary in order to meet the needs of a Foster Child, to transfer the case to another foster care provider. When a child(ren)/youth is transferred from one Provider to another as the result of a FTC, the discharging Provider is responsible for ensuring that the child(ren)/youth's health care is up to date, and that health records, including the child(ren)/youth's Medical Passport, are fully updated, and that such information is shared with the Provider to whom the child(ren)/youth has been transferred. Discharge health summary and updated Medical Passport shall be provided to the new Provider within fifteen (15) days of transfer.

In the case of a planned transfer of a child(ren)/youth to another foster care Provider, the Provider shall enable the child(ren)/youth to participate in the plan, including a discussion with the child(ren)/youth about the reason for transfer, exploration of child(ren)/youth's feeling about the move, and a visit by the child(ren)/youth to new facility prior to transfer (after acceptance of the child(ren)/youth by the receiving facility).

Case planning responsibility for Foster Children who are transferred to residential care shall be retained by the Family Foster Care Provider or transferred to the Residential Care Provider in accordance with ACS Policies.

If the Provider maintains case planning, the transferring Provider shall be responsible for performing all adoption, legal and recruitment activity in a timely fashion. If the child is being transferred to another foster care Provider, the discharging Provider is also responsible for completing the FASP if due within forty five (45) days of transfer.

1. Removal of Child(ren)/Youth from Family Foster Care Homes

Whenever a Provider proposes to remove a child(ren)/youth from a family foster care home, a Placement Preservation Conference (PPC) shall be held before pursuing the removal. If a decision is made at the FTC to proceed with the removal, the Provider shall comply with all Children's Services Policies regarding such recommendation. The Provider shall notify the foster parents, in writing, in the form of the Notice For Removal Of Child(ren) From a Foster Home (Form CS-701D) of the intention to remove the child. Such notification shall be given at least ten (10) days prior to the proposed effective date of the removal, except where the health or safety of the child(ren)/youth requires that the child be removed immediately from the family foster home. The written notification shall further advise the foster parents that they may request a PPC conference by Children's Services' Office of Advocacy – Independent Review Unit at which time the foster parent(s), with or without a representative, may appear to have the proposed action reviewed, advised of the reasons for the removal and be afforded an opportunity to submit reasons why the child shall not be removed.

In the event the Foster Child must be removed immediately from the Foster Home due to health or safety issues, the Provider shall conduct an FTC in accordance with Children's Services Policies. Providers must comply with a family court order to discharge a child/youth;

as such, an FTC should be held if possible or during the Trial Discharge period to assess the safety of the child(ren)/youth's adjustment to discharge.

For emergency removals, Form CS-701D shall be given at the time of the removal or as soon as is practicable thereafter. A Form CS-701D is not provided to the foster parents when the removal is done pursuant to a court order or State Fair Hearing decision.

2. Removal from a Residential Care Facility

- i. An FTC must be held prior to the removal of a Foster Child from a Residential Care Facility in accordance with ACS Policies, except where the health or safety of the Foster Child requires that the Foster Child be removed immediately from the Residential Care Facility. If a decision is made at the FTC to proceed with the removal, the Provider shall comply with all ACS Policies regarding such recommendation.
- ii. In the event the Foster Child must be removed immediately from the Residential Care Facility due to health or safety issues, the Provider shall conduct an FTC in accordance with ACS Policies.

(a) Placement Stability

Providers are responsible for ensuring stable placements for foster children. Movements of children/youth while in foster care can be harmful and must be made only when in the best interest of the child/youth for reasons of safety, reunion with siblings/kin, or other serious concerns. Providers shall work to maintain placement continuity for child(ren)/youth that are pregnant or parenting while in care, so they can remain in their same family foster homes with services and supports to ensure their own health and that of their babies.

(b) Lifebooks and Continuity

Unnecessary disruptions of school placements and attendance shall be minimized to ensure continuity of educational services and preserve relationships with familiar school personnel, religious affiliations and cultural connections. Children/Youth in foster care shall be supported in maintaining a sense of continuity and their own personal histories as they transition into and through foster care. This is especially important as children/youth experience movements in care and have a variety of people and events that are important to them. Providers shall be creative in helping children/youth to track and remember these people and events, including the creation of Lifebooks for children/youth in care. Lifebooks are put together by the Provider and contain pictures of the child/youth and his/her birth family/caretaker, foster family, friends, and other important people in the child/youth's life. Lifebooks are also used to document childhood milestones, including certificates, awards, high-scoring exams, ticket stubs, and other important memorabilia. For more information on Lifebooks, please reference the following Lifebooks resource document from Casey Family Services:

http://www.caseyfamilyservices.org/pdfs/sel_lifeskill_resources.pdf

E. Case Closing Criteria and Procedures

1. Discharge from Foster Care

The Provider is responsible for ensuring safe, timely, and appropriate discharges of children/youth from foster care. An FTC must be held before the Provider can discharge a Foster Child from foster care. When children/youth are being reunified with their families, the Provider is responsible for determining that the birth parent will be able to provide a safe and nurturing home for the child/youth prior to discharge, including linking the birth family/caretaker with community-based services, such as after school programs, child care, support groups, in-home supports (e.g., New York State Office of Mental Health Home (OMH) and Community Based Waiver program, the New York State Bridges to Health Waiver program, services through the New York State OMH or New York State Office of Persons with Developmental Disabilities (OPWDD) services, case management services, school based services, alcohol and other drug prevention services, and preventive services). During the trial discharge period, the Provider is responsible for:

- monitoring the home to assess the parent's interactions with the child(ren)/youth;
- continuing conversations with key service providers regarding the parents' ongoing ability to care safely for their children; and
- for bringing the child/youth back into foster care if the child cannot safely remain with his/her parents.

When a child/youth that has been reunified can no longer remain safely at home, the Provider shall put forth its best efforts to facilitate the child/youth's placement with the foster parent who had been caring for the child/youth prior to discharge, whenever possible and appropriate.

2. Discharge to Adoption

Once a decision has been made to change the goal to adoption, a conference shall be held with the child/youth's foster parent concerning their desire to adopt the child/youth and what adoption entails. If the foster parent does not wish to adopt, or if the child is not in a foster home setting, prior to freeing the child, the Provider shall carry out recruiting efforts specifically directed at communities of populations which have ethnic, racial, religious, or cultural characteristics similar to those of the child/youth desiring to be adopted.

When a child/youth is being discharged to adoption, the Provider is responsible for providing a healthy transition of the child/youth into the adoptive family through visiting, monitoring of the placement, and other means. The Provider is responsible for ensuring that, prior to discharge, both the child/youth and adoptive family have the support they need to remain together as an intact family, including physical and mental health services, support groups, chemical dependency/use education and prevention, educational advocacy and assistance and other services. The Provider shall help families to engage with community-based programs, and this may include referrals to Children's Services preventive services programs for post-adoption services. For more information see *Children's Services Guidance: 2008/01 "Post Adoption Services"* dated January 23, 2008. Adoptive families are entitled to receive post adoption services from their Provider.

3. Discharge to Another Planned Living Arrangement (APLA)

When youth are being discharged to APLA, the Provider is responsible for providing, prior to discharge, that:

- The youth has been connected to a caring adult who has made a commitment to the youth's emotional well-being beyond the age of twenty-one (21), including a demonstrated willingness to provide a place to live (if necessary to prevent the youth from becoming homeless) and financial assistance;
- the youth has safe and stable housing;
- the youth is in possession of needed government documents such as birth certificates or and social security cards and any immigration issues have been resolved to the extent possible;
- the youth is in possession of any other necessary documents as required;
- the youth is enrolled in an educational or vocational program, and/or is employed and receiving a stable income;
- the youth is referred to community-based medical care, mental health care, chemical dependency/use treatment, aftercare, and other clinical services as needed;
- the youth has health insurance, and all paperwork for transitioning into community Medicaid has been filed; and
- request conferences for non-engaged youth twenty (20) years old and younger.

For young people who will require clinical supports as adults, Providers are responsible for guiding them through the application process for supportive housing or other services available through adult social service, health, and mental health systems.

4. Discharge to Adult Residential Care

When children/youth are being discharged to Adult Residential Care, the Provider is responsible for:

- Commence planning for that discharge at or before the child(ren)/youth's sixteenth (16th) birthday;
- Refer the child/youth to a facility and/or program that will be able to begin serving him/her upon discharge; and
- Make best efforts to connect the child/youth to a caring adult who is willing to make a commitment to the young person's future well-being beyond the age of (twenty-one) 21, even though the child/youth will not be living in their home.

Providers are responsible for facilitating the child/youth's enrollment in Medicaid, Social Security, and other government assistance programs as early as possible/appropriate.

5. Unplanned Discharges

For unplanned discharges [see *Title 18 NYCRR, Part 431.8*], the Provider with case planning responsibility is responsible for documenting all unplanned discharges, including children/youth missing from foster care, parental removal of voluntarily placed children, and court ordered discharges that are effective immediately. In addition, Providers shall act to the full extent of their authority to ensure safety through continued oversight, assessment,

prudent decision-making and service planning until the final discharge. Documentation requirements include:

- a. Assessment of circumstances under which child/youth was discharged before anticipated date, e.g., unexpected court order;
- b. Assessment of current situation and identification of needed services to prevent replacement; and
- c. Diligent efforts to locate a child/youth that is missing from foster care.

F. Discharge Planning, Aftercare and Final Discharge

1. Establishing Necessary Aftercare Services

As part of the discharge plan, the Provider shall ensure that children and their families are connected to services and supports needed to maintain safety and stability and to continue progress made during the foster care placement. The Provider shall develop and maintain linkage agreements with community based service providers in order to assist families and facilitate a smooth transition for Foster Children that are returning to their community of origin upon discharge. Among the services that should be considered are the OCFS Aftercare Service Program and B2H Waiver Program.

(a) Referrals to OCFS Aftercare Services Programs

All referrals must be in accordance with each of the OCFS-appointed aftercare provider's assigned intake areas. Referrals may be made via telephone. It is strongly recommended that the referral be made at the point that discharge of the child/youth is being considered, and that the family be involved in the decision-making process. It is suggested that the aftercare provider be invited to any formal trial/final discharge conference that may be held.

(b) Bridges to Health (B2H) Waiver Program Services

B2H services can follow a child/youth after discharge from foster care back to his/her birth family/caretaker, into adoption, or into Another Planned Permanent Arrangement as long as the services began while the child/youth was legally in foster care. For children/youth that are enrolled in B2H while in care and will continue to receive these services upon discharge, the provider must ensure that the B2H Health Care Integration Provider is familiar with the discharge plan and working with the discharge resource to ensure smooth continuity of services. The Provider, and if applicable the preventive services provider that will be working with the family upon discharge from foster care, shall actively participate in any B2H team meetings related to discharge planning. Children/youth who will continue to receive B2H services upon discharge from foster care must have their CNX case remains open. Please see "Services for Families and Children" for more information on the B2H program.

(c) Discharge Grants

Discharge grants are a useful tool in planning for the discharge of a child/youth from foster care. In order to be eligible for a discharge grant, the child/youth must meet the following criteria:

- (c) The child must have been in continuous care and custody of the Commissioner for six (6) months or more.
- (c) The child must have a permanency planning goal of either:
 - i. discharge to parents,
 - ii. discharge to relatives, ,
 - iii. discharge to adoption,
 - iv. discharge to a primary resource person, or
 - v. discharge to APLA.
- (c) The child must have a discharge plan that is either approved by the Children's Services case manager or ordered by the court.
- (c) The child must not have received a discharge grant within (two) 2 years of the date of the current discharge.

(e) Community Based Services

Providers are responsible for developing and maintaining linkage agreements with Community Based Services in order to plan appropriately for children/youth and families to allow for smooth transition when returning to their community of origin upon discharge from care.

(f) Medicaid Transition

The Provider shall ensure medical coverage by assisting with Medicaid transition or linking the child/youth to low-premium health insurance options, such as Family Health and Child Health Plus.

(g) Health Care

The Provider shall ensure that all children/youth's health care is up-to-date and all referrals are followed up prior to discharge, including filing all paperwork for transitioning into community Medicaid. The Provider shall ensure that health services are available to all children/youth discharged from placement and help children/youth obtain medical coverage by assisting with the Medicaid application process or linking the child to low-premium health insurance options, such as Child or Family Health Plus. The Provider shall ensure that health records are up-to-date and all records are transferred to the discharge resource person and the post-discharge health services provider, as appropriate.

The Provider shall work with the discharge resource person and/or the child/youth, as age appropriate, to identify and establish a linkage with the child/youth's post-discharge primary care provider and mental health provider, if indicated. Where

appropriate and available, the post-discharge provider shall be located in the child's discharge neighborhood.

2. Monitoring during Trial Discharge

Discharge Planning & Aftercare (With legal custody retained by the NYS OCFS Commissioner).

The Provider must also ensure that Caseworkers commit to an appropriate level of continued casework contacts and home monitoring during the trial discharge to assess the birth/caretaker family's interactions with the Foster Child; continue conversations with key service providers regarding the ongoing ability of the birth parents/caretakers to care safely for their child; and shall be responsible for returning the child/youth back into foster care if the child/youth cannot safely remain with his/her birth parents/caretakers. The Provider shall continue to provide a minimum of one (1) face-to-face casework contact and one (1) home monitoring visit per month during this period in accordance with Children's Services policies. However, more than the minimum numbers of home visits may be required if:

- more than one child/youth is returning home;
- one or more children/youth has special needs;
- one or more children/youth is under the age of six (6) years old;
- one or more children/youth had previously been returned home and then re-entered foster care after a prior trial or final discharge; and
- parents need advocacy and assistance in securing community-based services for themselves and/or their children.

For trial discharges where children/youth are reunified with a parent or relative in cases where the Family Court has made a finding of abuse/maltreatment, the case planning Provider must ensure that an enhanced level of casework contact and/or monitoring is scheduled during the trial discharge period for a minimum of six (6) months. Enhanced monitoring shall include conferences with school or day care personnel, with medical providers, with other service providers, and family members and supporters.

In the event a Foster Child that has been reunified with his/her birth/caretaker family can no longer remain safely in the home, the Provider shall make efforts to place the Foster Child with the foster parent that cared for the Foster Child prior to discharge when possible and appropriate.

3. Final Discharge

The Contractor may not final discharge a Foster Child without Family Court approval.

4. Post Discharge Supervision

The Provider shall provide post-discharge supervision in accordance with the Law and ACS Policies. The Provider with planning responsibility for the child shall provide post-discharge services for a minimum of three (3) months and a maximum of six (6) months

with extensions provided when necessary and/or appropriate, including youth between the ages of eighteen (18) and (21) that are discharged to APLA.

PART V: SERVICES FOR CHILDREN AND YOUTH IN CARE

A. Educational Services

1. Educational Plan

Educational Plan

Providers shall provide for or work in collaboration with an educational provider for the provision of an educational plan that is appropriately based on an assessment of the child's/youth's educational level. Plans for young children will include early childhood education and, when indicated, Early Intervention Services, New York City Department of Mental Health and Hygiene, and services provided through the Committee on Special Preschool Education and City of New York Department of Education (DOE). School-aged child(ren)/youth will have a plan that promotes their developmental, social, emotional, and academic growth and prepares them for high school. This includes services provided through the DOE Committee on Special Education, if indicated. High school students will have a plan that prepares them for graduation with a diploma, post-secondary education, and/or skills for adulthood. Provider staff, foster parents, and family members will work with school personnel to develop and monitor plans for the child(ren)/youth's educational achievement.

The Provider shall work with birth parents, foster parents, and children to ensure that key transitions in child(ren)/youth's educational progress receive adequate attention. These include referral to Head Start and/or Pre-Kindergarten for children age three (3) to four (4) years of age; application to Kindergarten for children age four (4) to five (5) years of age, application to middle school for fifth (5th) graders, application to high school for eighth (8th) graders, and application to higher education or vocational training for youth leaving high school.

Children's Services' Scorecard will measure provider compliance, and the Division of Quality Assurance will work with Providers whose educational interventions with children are in need of improvement.

Education and Child and Adolescent Development

Educational deficits form barriers to child(ren)/youth served by the child welfare system from developing to their fullest potential. Children placed into foster care need to maintain educational continuity; existing educational deficits should be identified and remediated. Education shall be a focus for all members of the FTC, and school personnel shall be encouraged to contribute to service planning.

2. Educational Liaison (Required)

Each Provider shall identify at least one (1) Educational Liaison who shall have experience in education programming or a related field. The identified staff shall:

- i. Have an ability to make use of DOE data; any education performance data provided by Children's Services throughout the year (at least three times per year); and educational information obtained by the Caseworker in support of best practice and case planning.

- ii. Work with the Caseworker and foster parent, birth parent/caretaker to address any educational concerns; build and maintain collaborative relationships with the schools; provide advocacy on behalf of the child(ren)/youth; negotiate with the DOE staff to ensure the implementation of recommended and appropriate educational services; and monitor on-going performance.
- iii. Make contact with each child's school within a short time of the child's entering foster care to track areas in need of improvement and develop educational plans.
- iv. Give particular focus to helping children achieve the best possible educational outcomes, including school stability, attendance, access to appropriate assessments and services, and academic progression.

3. Special Education Planning

Providers are responsible for engaging in special education planning when needed.

- i. Providers shall obtain copies of Individualized Education Plans (IEP) and evaluations conducted by the DOE, and incorporate the IEP goals into the child(ren)/youth's overall service plan.
- ii. Providers shall advocate with the DOE for the provision of needed educational services; obtain legal assistance from education advocacy programs; and make use of technical assistance from Children's Services and community resources when needed.

4. Communication with Child(ren)'s/Youth's School

- i. Provider staff shall meet regularly with school guidance counselors, teachers, and other school staff to determine that child(ren)/youth are developing at sufficient competency levels in both Reading and Math.
- ii. Staff shall ensure that adolescents are receiving appropriate educational services placing them on track to achieve a Regent's high school diploma, (except for situations where this standard is deemed unrealistic by an assessment of the particular child(ren)/youth's capacity).
 - In situations that this standard is deemed unrealistic, then staff shall assist the child(ren)/youth and family in the development of an alternative educational plan to maximize the child(ren)/youth's Reading and Math competency.
- iii. The Provider is encouraged to secure and/or provide tutorial services to all child(ren)/youth whose Reading or Math scores are two (2) or more grades below their age-appropriate levels.
- iv. The Provider shall engage the birth parent/caretaker and foster parent as active participants in the child(ren)/youth's education, and work to facilitate the birth parent/caretaker's involvement with the child's school.

B. Mental Health Services

- 1. Initial Mental Health Screening

- (a) A formal developmental screening shall be provided for all children under five (5) years of age, and older children who are suspected of having a disability or developmental delay. Early diagnosis and treatment of developmental delays offers an opportunity for children/youth to achieve their maximum potential. Developmental screenings identify children who need more thorough evaluations for potential developmental delays.
 - Children, ages zero (0) to three (3) years that are at-risk for developmental delays shall be screened with the suggested Ages to Stages Questionnaire (ASQ), a parent developmental screening tool used to collect information from parents about their child's progress at various stages of development.
- (b) A mental health screening shall be conducted for all children age two (2) years and older, and for any younger children who are suspected of having an emotional disability. These screenings shall incorporate the findings from the CANS assessment, if one was done before the child was placed into the foster home. All mental health screenings shall include an assessment of past or present trauma.
- (c) For children who are suspected of using or abusing alcohol and/or other drugs, the mental health screening process shall also cover chemical dependence/use in accordance with ACS Policies and the Section of these *Family Foster Care Quality Assurance Standards* entitled "*Substance Abuse Services*."
- (d) The Provider shall develop a strategy for completing or obtaining current age appropriate mental health screenings within fifteen (15) days of placement but in no event shall the mental health screenings be completed later than thirty (30) days from the date of placement and at least annually thereafter. . If the Provider is unable to complete a Foster Child's mental health screenings within fifteen (15) days of placement, the Provider shall document in CNNX, the case record, and the medical record the reasons the mental health screenings were not completed within that fifteen (15) day period. These screenings shall use validated instruments, and the Provider shall inform Children's Services' medical auditors which instruments they are using at the time of audit.
 - If indicated by the initial screening, or the child's history of maltreatment, physical abuse or sexual abuse, the provider shall ensure that a full psychological and/or psychiatric evaluation is/are done by qualified staff, and provide follow-up for recommended services. Children who have severe developmental and/or mental health needs shall be referred to the B2H program or appropriate OMH services.

2. Assessment/Evaluation

- (a) If the psychological and/or psychiatric evaluation indicates a need for further mental health or behavioral health services, provider staff shall arrange for follow-up treatment for the child(ren)/youth. Treatment plans for mental health or behavioral health services shall be written and included in the child's case record.

- (b) When deemed appropriate by a qualified mental health professional, the Provider shall ensure that a mental health or behavioral health service treatment plan is developed, a copy of which shall be included in the case record of the Foster Child.
- (c) The Provider shall ensure that mental health services are delivered by qualified licensed mental health providers, and that services are documented.
- (d) If the Provider is unable to offer a comprehensive array of such services to their foster care population, they shall establish a formal referral and treatment arrangement with at least one (1) neighborhood-based children/youth's mental health provider, and one (1) adult mental health provider, (to the extent that such local providers exist within the geographic location).
 - The provider shall seek to establish referral linkages with mental health providers having specific expertise in the treatment of trauma, attachment disorders, depression, loss and other conditions relevant to the child welfare population, and make referrals when possible and appropriate.
- (e) Support Services
 - i. The Provider shall develop relationships with parent and family support programs and parent advocacy programs within the mental health network, and link their birth parents, foster parents and parent advocates with these resources.
 - ii. The Provider shall be familiar with and develop linkages with preventive programs, and home and community-based clinical services providers, such as Early Intervention Programs for eligible children zero (0) to three (3) years of age; mental health Case Management programs for adults, child(ren)/youth; and B2H and NYS Office of Mental Health Waiver services for children with serious emotional disabilities.
 - iii. The Provider shall also provide birth parents/caretakers and foster parents with basic information about children/youth's mental health, including but not limited to:
 - trauma and the emotional impact of the abuse/maltreatment experienced by the children/youth;
 - the range of behaviors traumatized children/youth may exhibit, including substance use/abuse, and how to appropriately intervene;
 - common children/youth's mental health issues and treatments;
 - the importance of mental health screening and early intervention; and
 - Psychotropic medications and how they are used within a mental health treatment plan.
 - iv. The Provider shall make best efforts to ensure that birth parents/caretakers and foster parents are meaningfully engaged in the child's mental health treatment, including participating in family counseling if recommended. The Provider shall follow-up to determine that the mental health services are being utilized by the birth parents/caretakers and foster parents, that the mental health and foster care service plans are coordinated, and that the services are accomplishing the treatment goals.
 - v. Parents shall also receive education about parental mental health (including maternal depression) and its impact on children.

C. Health Services

1. Continuum of Care

The Provider shall develop a strategy for creating a continuum of care to adequately meet the full range of health needs of the children being served through participation in community-based health coalitions, consortia, and networks, including the Children's Services Coordinated Initiative and coordination with borough-based family support service providers in the mental health system. If the Provider operates its own health clinic, it shall utilize its on-site medical and mental health services with modifications or accommodations, to ensure that services are provided within a neighborhood-based context. The Provider shall ensure that children in their care have access to a full range of specialty, sub-specialty, dental, ancillary, and hospital services. "Specialty medical services" includes general mental health services, chemical dependency/use services and specialty services for mental retardation and developmental delays.

All medical services shall be provided, either directly or through linkage agreements, with hospitals and specialty networks, and/or through primary care physicians who are affiliated and/or have admitting privileges with a hospital network. The Provider shall establish linkages including, but not limited to, service provider contracts, formal service agreements, "letters of linkage," and "memoranda of understanding." The Provider may establish linkages with health providers outside the community for services not available within the community. These agreements shall include provisions for information-sharing and collaborative service planning. If the child already has an established relationship with a specialty health care provider, every effort shall be taken to ensure that the child continues to receive services from that Provider. Both the Provider's services and those from external sources shall be neighborhood-based. The Provider shall monitor and coordinate all services.

2. Medical Services

All Primary and Sub-specialty Care for foster children shall be coordinated through a coordinated network referred to as a 'medical home'. This includes the sharing of health information with and referrals to other healthcare facilities and professionals if and when appropriate. The medical home shall:

- offer health care services that are delivered or directed by a licensed medical professional;
- explain diagnoses and treatment modalities to others;
- be accessible in the child's/youth's community;
- ensure that the same primary pediatric health care professionals are available from infancy through adolescence and young adulthood; and
- maintain a private and accessible centralized system in which a comprehensive record of the child's health information is stored and maintained.

To ensure geographic proximity, each child must have the option of having a primary care provider and access to the full range of health services within thirty (30) minutes of travel

from his/her foster care placement location if quality services exists in the neighborhood to meet his/her health service needs.

3. Initial and Comprehensive Health and Development Screening

Each child shall receive an immediate health screening and receive a comprehensive examination, preferably by a neighborhood-based medical provider, within thirty (30) days of placement; children who are in specialized family foster care must receive a screening and assessment earlier than thirty (30) days of placement. The comprehensive examination shall be performed by the child's identified primary care provider, thereby commencing the medical home approach. The Provider shall ensure that the examination meets guidelines in content and in periodicity as established by the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the New York State Child-Teen Health Plan, and the American Academy of Pediatrics and *Title 18 NYCRR, Parts 441.22 and 507.2* or any successor or amended regulation as adopted by Children's Services. The screening shall include a nutritional assessment.

To reduce the number of missed opportunities to vaccinate, healthcare professionals shall review the immunization status of children/youth in foster care, and ensure that all vaccines currently due are up-to-date. Immunizations shall be administered as part of the comprehensive child health care plan along with other preventive health care.

The provider shall develop a protocol for relevant health care staff to ensure review of the Children's Services triage medical package prepared for each child entering placement. Children who have more severe health needs shall be referred to the B2H program.

4. Referral to Bridges to Health Waiver Program

The Provider shall refer eligible Foster Children who are emotionally disturbed, developmentally disabled or medically fragile to the B2H Medicaid Waiver program.

5. Referral to Specialized Services

As indicated by the initial and ongoing assessments of the child's needs, the provider shall facilitate the child's enrollment into community-based clinical services such as mental health case management services, day treatment programs, Nurse Family Partnership, and/or Early Intervention.

When the Provider does not operate such services itself, the Provider shall develop formal referral linkages with other organizations, such as mental health clinics, parenting programs, HIV specialized programs, pediatric AIDS hospital units, infectious disease specialists, and maternity and mother/child service providers. Additionally, the Provider shall link with community-based chemical dependence/abuse programs to address the full range of child and family chemical dependency/use prevention, counseling, education, treatment and aftercare needs. All children and family members with chemical dependency/use disorders shall receive referrals to NYS OASAS-licensed treatment programs.

6. Emergency Medical Services

The Provider shall arrange for on-call availability (twenty-four (24)-hours-a-day, seven (7)-days-a-week basis) of a primary care physician or appropriate coverage for any urgent medical and mental health consultations sought by a Caseworker, Child Care Worker, or foster parent regarding a child(ren)/youth. The Provider shall develop a protocol to ensure that all emergency care information is shared with foster care staff, social worker, foster parents, and all relevant medical and health care providers in a timely fashion.

7. Medication Management

The Provider shall develop a medication management plan to guide health services providers and the child's foster parent/residential care provider. The Provider shall have policies/procedures in place and provide adequate training to staff, foster parents, and birth parents/caretakers to assure proper and safe medication administration. The Provider shall develop a specialized medication management plan for child(ren)/youth requiring medication for chronic conditions, to ensure appropriate monitoring of dosage, dispensing, and duration.

All medication shall be kept in well-lit, locked storage areas that provide sufficient privacy for uninterrupted handling of medication. In foster homes, medication shall be stored in locked cabinets or labeled containers out of reach of children in care.

8. Consent

In accordance with Federal, State and City laws, regulations, and policies, and *Children's Service Procedure No. 102/Bulletin 99-1, 'Guidelines for Providing Medical Consents for Children in Foster Care'* as amended, informed consent for medication provision to children/youth must first be sought from the birth parent/caretaker, unless their rights have been terminated or surrendered.

9. Psychotropic Medication

In addition to the elements of informed consent described earlier, informed consent prior to the administration of psychotropic medications shall include the following information from the prescribing psychiatrist:

- reasons for prescribing the medication;
- name and dosage of medication and the date prescribed;
- previous non-pharmacological interventions; and
- expected results of the medication and potential side effects.

Psychotropic medication shall be a separate section of the overall treatment that includes psychotherapy (i.e., "talk therapy") unless otherwise indicated by the child's diagnosis. The psychiatrist shall communicate regularly with any other clinicians providing mental health services to the child. Based on a "targeted symptom" approach, every effort must be made to limit the number of psychotropic medications prescribed for each child, and the dosage of

each medication. The decision to start and/or add a certain medication shall be based on clinical review of the child's progress and response to treatment, known adverse reactions, and potential pharmacologic interactions.

Every child shall be cleared medically with appropriate indicated lab tests performed in the twelve (12) week period preceding the administration of psychotropic medication. Thereafter, the prescribing physician or an equivalent shall observe the child(ren)/youth receiving psychotropic medication at least once a month, and document the observations in the case record.

All children on psychotropic medication shall be given a physical examination and appropriate indicated lab tests at a minimum of every six (6) months or based on the frequency required by accepted New York State health standards. It is also the provider's responsibility to maintain an up-to-date list of all current medications, a current treatment plan, and copies of medication consent forms for each child receiving such treatment.

The psychiatrist on the clinical team shall assume responsibility for medical aspects of mental health care provided by the provider in all phases of intervention. All children/youth prescribed psychotropic medication are required to receive concurrent non-medical mental health treatment, unless indicated by the child's condition or treatment needs; frequently, family treatment may be needed and shall be explored. As is the case with all medical and mental health treatment, continuity of care with a single clinician shall be the standard.

D. Substance Abuse Services

The mental health screening process shall include questions/instruments related to the child's/youth's history of use or abuse of alcohol and/or other drugs. Under New York State law, chemical dependency/use risk behavior assessments of the child(ren)/youth cannot include random urinalysis drug screening of the child, nor is such screening permissible at any other time during a child's stay in foster care. Drug tests have been deemed to be a "search," and such testing is now deemed to be a violation of the Social Services regulation which governs foster children's privacy rights, regardless of the presence or absence of consent by the child(ren)/youth in accordance with *Title 18 NYCRR Part 441.8* or any successor or amended regulation. The very limited circumstances in which drug testing of foster children is allowed are as follows:

- a. A parent or guardian signs a consent for a school related testing in accordance with *NY Education Law 912-a*;
- b. There is a medically necessary need as determined by a doctor, and the parent or provider, if authorized, consents;
- c. The child(ren)/youth is in an OASAS program, and the drug tests are part of that program. The results of testing may only be used for treatment purposes, and the child(ren)/youth must give his/her informed consent to participate in a drug testing program; and
- d. Pursuant to a court order.

The Provider shall ensure that children/youths experimenting with substances receive alcohol and other drug education and counseling either on-site or by referral to community-based OASAS-licensed programs. If a child(ren)/youth is regularly using, abusing, or is chemically dependent, this young person requires treatment. Treatment is different than counseling or education, and can only be provided on-site if the provider holds an OASAS license to provide treatment and has a CASAC to deliver it. Otherwise, chemical dependency/use treatment of children/youths and family members must be provided through a referral to OASAS-licensed chemical dependency/use facilities. When specialized chemical dependency/use treatment is offered in the program, a licensed physician shall be a member of the clinical team.

When there has been chemical dependency/use in the child's family, children shall be referred to a chemical dependency/use prevention program unless otherwise indicated.

Parents who need chemical dependency/use treatment shall also be offered services when needed. For more information refer to the section on "Support Services for Parent/Caretakers" in Part VI.

E. Enrichment/Recreational Activities

The Provider shall ensure that Foster Children are provided recreational opportunities pursuant to the Law including 18 NYCRR 442.20 or any successor or amended regulation. Recreation shall be provided in accordance with *Title 18 NYCRR Part 442.20* or any successor or amended regulation.

Planned recreational programs/activities shall be provided for all child(ren)/youth in foster care including special populations of children (e.g., mother-baby, special needs).

In Residential Care Settings, planned recreation programs shall be discussed in the Provider's Operational Manual. Recreation schedules shall reflect the availability of more than one type of recreation. Both indoor and outdoor activities, trips, and other events from outside sources shall also be included. In the case of the mother-baby population, the provider shall offer recreational opportunities for the mother that permits respite from child care responsibilities, and provide opportunities for child-bonding/relationship building. Recreation schedules shall be posted in all Residential Care settings.

Child(ren)/youth shall be involved in planning special events, e.g. dances, parties, and talent nights. These events shall be recorded in logs and reports. There shall be adequate supervision during *all* recreational activities (a minimum of one (1) staff member for every nine (9) children).

Where possible, the community shall be utilized for recreational events (e.g., YMCA, pools, movies, concerts). Children shall be encouraged to participate in community programs such as scouts, little league and school clubs. All foster care programs must offer children/youth opportunities to develop safe and age-appropriate hobbies.

The Foster Parent Handbooks shall discuss the importance of recreational expectations for foster parents; these include encouraging appropriate recreational activities (i.e., services related to personality development, socialization skills, and enhancement of cultural horizons through participation in sports, camping, arts and crafts, games, outings), and programs that promote one-to-one relationships.

F. Financial Literacy

Providers shall provide children/youth in foster care with financial literacy training, which shall include, but not be limited to:

1. Financial Literacy – What does it mean to child(ren)/youth?
2. Provide access to information on financial management.
3. Understanding money in our society.
4. Practicing money management: saving, spending, budgeting, investing, and debt.
5. Importance of paying bills on time; role of credit cards; role of credit scores.
6. Strategies for minimizing debt.

G. Employment/Training

Providers' vocational activities/supports shall offer opportunities for children/youth in foster care to receive employment-related training, including but not limited to the:

1. Assessment of the child(ren)/youth's abilities to find employment and keep a job; assess a child(ren)/youth's social and interpersonal skills, and self-awareness to develop a plan to improve and maximize the child(ren)/youth's skills.
2. How to prepare for the world of work, whether paid or unpaid; including how to interview, conduct a job search, grooming, dress, punctuality, follow instructions, complete tasks, and obtain actual referrals to neighborhood businesses for employment. Assist child(ren)/youth in obtaining documents required for employment.
3. Provide and/or make referrals for career counseling, vocational assessments, and for training to identify appropriate placements and supports needed to secure and sustain employment.
4. Develop job leads in the private sector and work with businesses who are potential employers. Develop linkages with local merchants, trade unions, and trades people to arrange possible apprenticeships, summer jobs, and other opportunities for young people.

H. Legal Services

The Provider shall complete timely and complete permanency reports; attend Family Court proceedings; and comply with all Court orders. Provider staff with substantive knowledge of

the case situation must be ready to testify in court as to the provider's safety and permanency assessments, and the provider's position related to the current placement and permanency when necessary.

The Provider shall provide Children's Services' Family Court Legal Services (FCLS) attorneys with updated information including child status, location, assigned Caseworker and supervisor. The Provider shall maintain contact with FCLS attorneys to review any important developments, and communicate with lawyers for respondents and children as necessary, pursuant to communications protocols. Provider staff must cooperate with FCLS attorneys in preparing court cases for trial.

The Provider will retain counsel for TPRs as well as other situations where representation is needed at no additional costs to Children's Services OR the cost of which is covered under the MSAR.

The Provider shall inform Foster Parents of their role in court proceedings, especially during adoption.

I. Sexual Health Education and Services

The Provider shall reference the *Children's Services' "Policy Guidelines for Family Planning and Pregnancy Related Information and Service"* dated 11/8/07, and any subsequently released policies, that describes activities foster care providers must take to ensure that children in their care receive timely and comprehensive sexual health information and services. The Provider shall assure that all children in care aged twelve (12) years old and over, and younger children who are known to be sexually active, receive comprehensive information about family planning and sexual health issues, and have access to the full range of services including contraception (including but not limited to condoms, emergency contraception, and prescription methods), options counseling (including abortion and adoption services), and education and treatment related to sexually transmitted diseases ("STDs") and HIV/AIDS within thirty (30) days after placement and every six (6) months thereafter, and provide them with such services upon request.

1. The Provider shall ensure that such notification is made both in writing and verbally and must be recorded in each Foster Child's medical record and in CNRX as part of the Foster Child's health history. The Provider shall ensure that such notice complies with the Law including *Title 18 NYCRR Part 463.2* or any successor or amended regulation. The notice must inform the Foster Child of the Foster Child's rights to confidential sexual and reproductive health services and social, educational, health, and medical family planning services.
2. The Provider shall notify the foster parents of all Foster Children twelve (12) years and older and Foster Children younger than twelve (12) years old who are known to be sexually active of the availability of family planning services within thirty (30) days after placement and every six (6) months thereafter.

3. The Provider shall ensure that religious beliefs are not be conveyed to any Foster Child with regard to family planning during initial or semi-annual written or verbal notification of the availability of family planning services nor shall it be included in the curriculum of structured family planning programs.

J. Transportation:

The Provider shall ensure that transportation services are readily available to transport Foster Children to the hospital, medical and mental health appointments and other sub specialty providers as necessary.

K. Preparing Youth for Adulthood (PYA)

The Provider is responsible for youth development services; this work shall be incorporated into all aspects of practice and shall be a central and integral aspect of case planning activities. For youth who are age fourteen (14) and older, regardless of permanency plan, particular attention must be paid to their development into adulthood. Such services shall be considered an integral component of the permanency planning continuum. They may include the use of classes, extra-curricular activities, individual instruction, or other methods, and must be aimed at achieving the following six (6) goals:

1. Youth will have permanent connections with caring adults.

Youth shall leave care with the presence of and some measure of continuity in a caring relationship with an adult, who can include a network of family and friends that the youth can rely on for guidance and support. At least one (1) person in this network shall be identified as a primary caring, responsible adult who can provide financial, moral, and emotional support to the youth.

2. Youth will reside in stable living conditions.

Youth living in foster care shall be living in a safe and secure environment. While in care, the youth shall be living in the least restrictive setting possible. As the youth prepares to leave care, he/she shall reside with a permanent, caring adult. In situations where this is not possible, youth shall be assisted in finding and maintaining housing that will be safe and stable, including support for the youth in accessing appropriate supportive housing services and subsidies prior to their exit from care.

The Provider shall develop relationships with existing housing providers and, whenever possible, develop its own housing resources. The Provider shall be creative in its approach, seek and utilize a variety of funding sources, including but not limited to Children's Services housing subsidy program, and other subsidy and supportive housing programs. The Provider shall help youth identify appropriate roommates and apartment sharing arrangements.

3. Youth will be afforded opportunities to advance their education and personal development.

Youth will be afforded the same educational and interest development services regardless of their living situation. Youth shall be encouraged to begin planning for their educational track as early as middle school.

Each youth leaving care shall have attained at minimum, a high school diploma, unless otherwise indicated. If the youth is unable to complete high school he/she shall be enrolled in and shall complete a General Equivalency Diploma (GED) program.

Whenever possible and appropriate, youth shall be encouraged, assisted and engaged in post-secondary education programs. In planning for post-secondary school, youth shall be encouraged to prepare for and take the Preliminary Scholastic Assessment Test (PSAT), Scholastic Assessment Test (SAT), and/or other college entrance exams.

Youth shall be supported in pursuing their personal interests and encouraged to participate in school and extra-curricular activities including but not limited to the arts and athletics.

4. Youth will be encouraged to take increasing responsibility for their work and life decisions and their positive decisions will be reinforced.

Youth shall be provided with opportunities to develop the appropriate skills such as basic literacy, computer literacy, analytical abilities, conflict resolution, and team work to enable them to navigate the current job market while working toward financial independence.

Youth shall receive early exposure to work and career exploration, which shall include participation in employment readiness programs, internships, volunteerism, career fairs, and vocational trainings. When appropriate, youth shall be referred to Vocational and Educational Services for Individuals with Disabilities (VESID). Youth shall also receive vocational assessments to identify appropriate placements and supports needed to secure and sustain employment. In addition to these activities, youth shall develop basic financial literacy skills, as discussed earlier in the Financial Literacy section.

The Provider shall make an assessment of each youth's social functioning. This assessment shall include identification of services required to ensure appropriate educational and vocational adjustment.

In addition to these responsibilities, the Provider shall make diligent efforts to:

- identify and assist youth in linking with all available community employment and training resources to the maximum extent possible, and help youth to access them;
- develop job leads in the private sector and work with businesses who are potential employers of discharged youth;
- assist youth in obtaining documents required for employment;

- train youth to function in a standard work environment, addressing topics such as punctuality, grooming, dress, following instructions, and completing tasks; and
- have foster parents understand and support the youth's career goals.

5. Youth's individual needs will be met.

Physical health, mental health, and positive development are fundamental to a youth's ability to maintain stable housing, secure a job, and form healthy relationships. The Provider shall link youth to needed treatments during their time in foster care, and educate youth both on responsible preventive health measures and about their own health and mental health status prior to discharge from care. In addition, the Provider shall support youth in addressing specific needs to support their positive development and safety while in care and when they exit.

6. Youth will have ongoing support after they age out of foster care.

The Provider shall meet all mandates of the trial discharge, including the ninety (90)-day notice to all foster children that they will soon be leaving care. The Provider must ensure that a complete and comprehensive discharge plan is in place for every youth leaving care, and that planning for discharge begins at least a year before the anticipated discharge date. The Provider shall establish linkages with the community in which the youth will be residing after discharge. Prior to discharge, the Provider shall provide the youth with a contact person to call with aftercare issues, needs, or problems. The Provider shall develop a booklet for every youth which provides a listing of the services available in the community in which the youth will be residing after discharge. This booklet shall list emergency phone numbers, health, mental health and dental clinics, legal service providers, and answers to common aftercare problems.

The Provider shall maintain contact with and monitor the status of discharged youth to the extent possible and appropriate, until the youth turns twenty-one (21) years of age. The Provider shall encourage foster parents about the value of a life-long connection to youth who leave their home on final discharge.

For youth exiting foster care to Independent Living, the Provider shall ensure that each youth receives an original (when possible) copy of her or his social security card, birth certificate, immigration documentation, and medical history records upon discharge. The Provider shall also make available sufficient funds to assist with the payment of the first month of rent and security, household items, transportation, work clothes, utilities, and other daily living items as deemed appropriate. Discharged youth shall be provided with carfare for Preparing Youth for Adulthood (PYA) support sessions held at the site of the providing organization or in the community.

Every youth discharged from foster care with a goal of Independent Living in the community shall have a job or be enrolled in a full-time higher education program, offered specific educational skills (all adolescents shall have an educational plan that supports their developing sufficient English language and math skills necessary to achieve a high school diploma), appropriate medical coverage with an identified "medical home", and adequate housing. Each Provider shall have a program to support youth to

develop positive social relationships and linkages with people and institutions located in the communities in which they will be living after discharge.

(a) Life Skills Development

Foster/adoptive parents and child care staff shall provide structure and daily activities in their homes designed to promote the individual physical, social, intellectual, spiritual and emotional development of the children.

Foster/adoptive parents and child care staff shall offer each child(ren)/youth techniques by stressing praise and encouragement.

The child(ren)/youth shall participate in daily activities that include responsibilities for chores or tasks that are age appropriate and developmentally on track.

Tasks and chores include activities which aid in developing future self sufficiency, e.g., cooking, cleaning, laundry, repairing items.

L. Housing Services

(a) Youth Transitioning Out of Care: On the behalf of Foster Children returning to birth parents/caretakers or transitioning to APLA or out of foster care, the Provider will provide training and assistance to staff in the following areas:

- (1) Training youth on community characteristics, resources, and needs, and on how to successfully negotiate services for youth within a neighborhood-based environment.
- (2) How to help youth find adequate and affordable housing upon discharge from foster care.
- (3) Ensure that all young people have an appropriate and stable living arrangement available prior to discharge. Under no circumstances, may a youth be placed in inappropriate housing, even on a temporary basis. If appropriate housing cannot be found, the Provider planning Caseworker MUST arrange for the youth to be returned to foster care in an appropriate setting suitable to the youth's needs.
- (4) Develop relationships with existing housing providers and, whenever possible, the Provider shall develop its own housing resources. The Provider shall be creative in its approach and seek to utilize a variety of funding sources, including but not limited to Children's Services housing subsidy program, and other subsidy and supportive housing programs. Providers are encouraged to help young people identify appropriate roommates and apartment sharing arrangements.
- (5) "Stable Housing" is defined as housing in which there would be reasonable expectation that the residence will remain accessible for the first twelve (12) months after discharge.

(b) The Provider shall be responsible for monitoring the housing situation of each youth for up to two (2) years after discharge from foster care, when deemed possible and appropriate, and report the findings to Children's Services on a regular basis.

PART VI: SUPPORT SERVICES FOR BIRTH PARENTS/CARETAKERS

A. Various Support Services

The Provider shall facilitate supportive services for birth parents/caretakers, including but not limited to day care, parent training, support groups, advocacy, legal assistance, housing assistance and/or financial assistance where indicated through active referral and case planning by a caseworker, in accordance with *Title 18 NYCRR 421*. The Provider shall provide birth parents/caretakers and other significant family members of the Foster Child with referrals and access to services to meet identified needs related to their medical and mental health, chemical dependency, domestic violence, and educational and/or vocational services in efforts to accomplish FASP goals. The Provider shall support additional needs and presenting circumstances of birth parents/caretakers and extended family members to achieve successful reunification, including, but are not limited to:

1. Assistance with job training and finding employment;
2. Cultural and linguistic barriers to services;
3. Connections to community supports and services;
4. Immigration status services;
5. Education and information regarding the impact of incarceration on permanency plans;
6. Information regarding legal status pertaining to family court proceedings, including PINS petitions; and
7. Support for responding to children's/youth's sexual orientation and/or gender identity/gender expression.

B. Parenting Skills Education

The Provider shall provide birth parents/caretakers with parenting skills training that are culturally sensitive and in a manner that is responsive to the needs of specific parent categories, such as Non-English speaking teen parents, Non-English speaking parents and/or terminally ill parents. For the terminally ill parent the provider must provide a curriculum where emphasis is placed on the family bonding and the separation and loss to be associated with the impact of continued permanency planning. The curriculum shall be detailed for such services.

The Provider shall provide individualized parenting skills training in cases where group participation is not appropriate.

C. Domestic Violence Services

Every family involved with Children's Services shall receive timely and appropriate domestic violence assessments. Family members shall be provided with appropriate and responsive interventions including but not limited to ongoing safety planning in accordance with Children's Services Office of Clinical Policy: Practice Guidelines for Addressing Domestic Violence in Foster Care Settings. The Provider shall obtain appropriate releases of information and maintain frequent communication with the agencies providing services to the family member.

All non-abusive birth parents/caretakers shall be referred to appropriate services when appropriate, including domestic violence programs. Referrals must be made to law enforcement agencies or the courts for legal intervention when appropriate.

Every birth parent/caretaker who is a survivor of domestic violence shall be engaged in developing a strategy for increasing their safety and preparing in advance for the possibility of further violence.

A family's history of domestic violence must be taken into account when planning or making recommendations about visitation between parents and children, to ensure that such arrangements do not endanger the child or the non-abusive birth parent/caretaker. Children's visits with an abusive birth parent/caretaker shall be planned with the non-abusive birth parent/caretaker to minimize risk.

Abusive partners must be held accountable for their actions. Mechanisms for holding abusive partners accountable may include criminal justice and law enforcement interventions, and required participation in batterer intervention programs. Non-abusive birth parents/caretakers must not be held accountable for the violence committed by others.

Each individual involved in a child's care must be treated with respect and viewed as an integral part of the process. Children shall be ensured of enhanced safety through a coordinated community response. This coordinated community response shall engage domestic violence programs, the police, family and criminal courts, and other key systems and providers.

Families shall receive consistent and appropriate judicial responses fostered by a partnership between NYC Children's Services and the family and criminal court systems. Whenever possible, given legal and ethical standards governing client confidentiality, families shall be more comprehensively served through the sharing of information among agencies and providers.

D. Alcohol and Substance Abuse Services

A risk behavior assessment of the birth parents/caretakers shall be completed and shall include the history of use/abuse/or dependence upon alcohol or other drugs. Substance abuse/chemical dependency services shall be made available, either in the Provider program if they are licensed by OASAS to do so, or by referral to a community-based OASAS licensed treatment provider, for any parent who abuses alcohol or any other dependency-inducing substance. When possible, Providers shall make referrals to substance abuse treatment programs that have received training on how to work with parents when they have children in foster care; information about such treatment programs is available from Children's Services or on DocuShare. Once a referral has been made and contact information shared, the Provider and the receiving substance abuse treatment provider will communicate regularly about the birth parent/caretaker's compliance and progress in treatment; participate in FTCs together; and coordinate the delivery of services, aftercare, and discharge planning to ensure child safety and a supportive transition for reunification or other appropriate permanency goals.

E. Mental Health Services

The Provider shall recognize indicators of mental health issues in birth parents/caretakers and provide or arrange for assessment, diagnosis, testing, psychotherapy, specialized therapies and interventions to birth parents/caretakers that require them. Birth parents/caretakers will be assessed and recommended for services by the Provider and services shall be delivered by qualified licensed mental health providers and documented in a written treatment plan developed, signed and dated by the individual members of the treatment team. Birth parents/caretakers will be assessed and recommended for services by the Provider and services shall be delivered by qualified licensed mental health providers and documented in a written treatment plan developed, signed and dated by the individual members of the treatment team. If the Provider lacks capacity to provide mental health services to birth parents/caretakers directly, the provider shall establish referral agreements and treatment arrangement with neighborhood-based adult mental health providers having specific expertise in the treatment of Post-Traumatic Stress Disorder, and other conditions relevant to the to the child welfare population.

Birth parents/caretakers that need more intensive mental health services will be referred to programs including mental health case management programs, Assertive Community Treatment Teams, etc.

The Provider shall also be familiar with and develop linkages with home- and community-based clinical service providers; mental health Case Management programs for adults and children; and OMH Home and Community-Based Services Waiver programs for children with serious emotional disturbance.

The Provider shall also provide birth parents/caretakers with basic information about children's mental health, including but not limited to trauma and the emotional impact of abuse/maltreatment on children; the range of behaviors traumatized children may express, what they mean and how to appropriately intervene; common children's mental health issues and treatments; the importance of mental health screening and early intervention; and psychotropic medications and how they are used as part of an overall mental health treatment plan. Birth parents/caretakers shall also receive education about parent mental health (including maternal depression) and its impact on children. As needed, birth parents/caretakers shall be educated about the importance of being meaningfully engaged in their children's mental health treatment, including participating in family treatment as recommended.

The Provider shall obtain appropriate releases of information and maintain frequent communication with the mental health service provider, in order to effectively coordinate services to the family.

F. Housing and Housing Subsidy Services

The Provider shall assess the need for and arrange for individuals and families to improve their housing conditions. This includes:

- helping individuals and families to obtain necessary repairs;

- to be protected from abuse or exploitation by landlords or other tenants;
- to identify and correct sub-standard rental housing conditions or code violations;
- to find suitable and adequate alternative housing, and to obtain needed assistance; or
- relief from public agencies that regulate housing, including arrangement for legal services when necessary.

Mentally ill birth parents/caretakers that need supportive housing in order to reunite with their children shall be referred to New York-New York III and other supportive housing programs as appropriate.

The Provider shall provide a housing subsidy as a preventive service whenever the provider determines that a lack of adequate housing is the primary factor preventing the discharge of a youth from foster care.

Children's Services administers locally the Preventive Services Housing Subsidy program to which the Provider refers appropriate client families. The referral process will include making an assessment of the client's needs and eligibility for the Preventive Housing Subsidy, and assisting the client in assembling required documentation in order to complete the referral process. Families must be eligible for mandated preventive services and have a need for at least one preventive service in addition to housing assistance. The Provider shall promote and monitors its staff's appropriate use of housing subsidy services.

In cases where adequate housing is located, provided and, if necessary, renovated such that a child could be discharged from care pursuant to this Part, the child must be discharged within two months from the date such housing is made available. Discharge may occur on a trial basis. Where adequate housing is made available and the child is not discharged within the two month period, the reason for the child remaining in care will be deemed to be due primarily to a factor other than housing and housing services will be terminated in accordance with *Title 18 NYCRR Part 423.4 (2) (V)* or any amended or successor amendment.

G. Support Services for Birth Parents/Caretakers of Children with Serious Health and Mental Health Needs

The Provider shall make support services available, directly or by referral, to foster parents and birth parents/caretakers caring for children with serious health and mental health needs. Such support services may include, but are not limited to: twenty-four (24)-hours-a-day, seven (7)-days-a-week crisis hotline services; caretaker support groups; birth parent support and advocacy, which can be accessed through the Department of Health and Mental Hygiene's Family Support Programs; home visits; planned and crisis respite; education and information about community-based resources and services, including crisis services; informational mailings; and specialized trainings.

H. Bridges to Health Wavier Program

The New York State Office of Children and Family Services' Bridges to Health (B2H) Waiver Program provides community-based health care services and supports to children in foster care

who are seriously emotionally disturbed, developmentally disabled or medically fragile. Children have to be in foster care when enrolled in B2H, but can continue to receive B2H services after discharge from foster care or adoption if they remain clinically eligible for the services. This service provides enhanced services to children with disabilities, allows children to live in less restrictive settings, helps to expedite permanency, and can be a critical support service for foster parents and/or caretakers.

The eligibility criteria for children to enroll in the B2H Waiver Program are as follows:

- Placed in the custody of the Commissioner of Social Services;
- Medicaid eligible;
- Have an appropriate and documented qualifying diagnosis of serious Emotional; Disturbance (SED), Developmental Disability (DD) or Medical Fragility (MedF); and
- Eligible for admission to a medial institution and assessed to meet the level of care criteria for one of the waivers.

Services provided by the waiver program are:

1. Health Care Integration;
2. Family / Caretaker Support and Services;
3. Skill Building;
4. Day Habilitation;
5. Special Needs Community Advocacy and Support;
6. Prevocational Services;
7. Supported Employment;
8. Planned Respite;
9. Crisis avoidance, Management and training;
10. Immediate Crisis Response Services;
11. Intensive In-home Supports;
12. Crisis Respite;
13. Adaptive and Assistive equipment; and
14. Accessibility Modifications.

I. Health Education

Providers shall give child-focused health education to birth parents and caretakers.

J. Foster Parents as Resources to Birth Parents

Whenever appropriate, foster parents shall become actively involved with a child's primary family before, during, and after placement. Foster parents shall be resources to birth parents to support the development of stronger and reunified families. In using this approach, Providers shall seek to create a "community of care" for the child which is comprised of those individuals most central to and concerned about the child's well-being: the birth parent or caretaker, foster parent, and Caseworker. This community of care is based within a context of neighborhood

resources, and involves team decision making (not just Caseworkers and foster parents, but also birth families, service providers and community stakeholders) to the extent possible.

K. Birth Parent Advocates

The Provider is encouraged to use birth parent advocates as staff members in their programs in order to enhance outreach to and engagement of birth parents/caretakers. The caseworkers shall utilize the assistance of the birth parent advocates to engage birth parents/caretakers in case planning and permanency planning. This will include ensuring their attendance at and preparation for the FTCs, and general support of birth parents/caretakers in activities necessary to achieve service plan goals. Integrating birth parent advocates into a program is highly effective as a strategy for a foster care agency to achieve these goals and fulfill these responsibilities. Birth parent advocates are not explicitly required in family foster care programs. However, birth parent advocates are encouraged in all foster care programs.

L. Transportation

Providers shall provide birth parents/caretakers with transportation to office and family visits.

M. Involvement of Birth Parents/Caretakers in the Provision of Foster Care Services

The Provider shall encourage involvement of birth parents/caretakers in the provision of services to their child/youth and document the Provider's efforts to encourage birth parents/caretakers involvement as well as the actual involvement of the birth parents/caretakers in the provision of services to their child/youth. The Provider shall ensure that the birth parents/caretakers are trained in applicable special needs curriculum and is involved in the case planning for their child/youth.

PART VII: REQUIRED PERSONNEL & PERSONNEL POLICIES AND PROCEDURES

The Provider shall set forth written plans ("Program Manual of Standards, Policies and Procedures") that detail all management systems and the manner in which they are designed to ensure proper planning and implementation of programmatic operations and fiscal administrative policies and procedures. The Provider's Program Manual of Standards, Policies and Procedures shall include the records and maintenance of: personnel management systems; fiscal management systems, including procurement and cash management systems; facility management systems; program management systems; and parents' decision-making systems.

The Provider, when requested, shall make available for Children's Services review a copy of all Program Manual of Standards, Policies and Procedures related to the implementation of programmatic operations and fiscal administrative policies and procedures. The Program Manual of Standards, Policies and Procedures shall include:

1. Personnel policy practices including such matters as job descriptions and qualification requirements, hiring and selection practice, personnel grievance procedures, benefits and leave, salary increases, holiday schedules and other related matters;
2. Management practices and procedures;
3. Purchasing policy and procedures;
4. Fiscal Policies and Procedures;
5. Intake and Planning Procedures; and
6. Completed Safety Plan that provides specific and detailed procedures for responding to a range of incidents.

If, in response to a request by Children's Services the Provider believes they had previously submitted a copy of its Program Manual of Standards, Policies and Procedures, the Provider shall give written notice to Children's Services of the date of submission and shall certify that the Program Manual of Standards, Policies and Procedures stated therein are currently in effect. ACS may review, in whole or in part, or decline to approve the Program Manual of Standards, Policies and Procedures of the Provider. ACS may direct the Provider at any time, and from time to time, to rescind, modify or add to its Program Manual of Standards, Policies and Procedures to bring the Program Manual of Standards, Policies and Procedures into compliance with their signed Family Foster Care Contract, the Law, and/or ACS Policies.

The Provider shall notify ACS in writing within thirty (30) days of any changes in its Program Manual of Standards, Policies and Procedures.

A. Staff Qualifications

1. Social Work Services

Director of Social Work Services:

MSW or equivalent human services graduate degree and a minimum of three (3) years of documented administrative and supervisory experience in the field of child welfare.

Supervisor of Social Work Services:

MSW or equivalent human services graduate degree (preferred), with at least two (2) years documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. (May be shared across multiple programs).

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) years casework experience and one (1) year group work experience and/or one (1) year supervisory experience.

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Adoption Specialist:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience. (May be shared across multiple programs).

Homefinder:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. (May be shared across multiple programs).

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field. This staff is 'recommended' to help Providers enhance their recreational services.

CASAC:

Bachelor-level CASAC.

2. Mental Health Services

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human

services graduate degree with at least two (2) years documented relevant experience.

3. Health Services

Physician:

Licensed and currently registered to practice medicine in New York State.

Nurse:

New York State-registered professional nurse or licensed practical nurse.

4. Educational Services

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

5. Paraprofessional Services

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year of relevant experience. This staff is 'recommended' to help Providers enhance their support services.

Foster Parent Advocate:

High school diploma or associate degree in human services with three (3) years foster parent experience. This staff is 'recommended' to help Providers enhance their support services.

6. Consultants

Providers may utilize consultants that include, but are not limited to:

- Psychologist: certified as a psychologist in New York State.
- Psychiatrist: licensed physician with a specialized rating in psychiatry.
- Physician: licensed and currently registered to practice medicine in New York State.
- LCSW (preferred) or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.
- CASAC Bachelor-level CASAC

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided. These staff may be shared across multiple programs).

To the degree possible, the Provider shall supply on-site speech, occupational and physical therapy when ordered by the primary care provider.

Staffing and Staff Qualification shall be in accordance with *Title 18 NYCRR Part 442.18* or any successor or amended regulations.

B. Staffing Requirements

Providers shall ensure that programs are operated with understanding and respect for community needs and cultures. Culturally and linguistically competent services shall be provided by a staff that is representative of the community served and fluent in the languages spoken by children and family members. To the extent possible the provider shall recruit and hire appropriately qualified staff from the community served. When it is not feasible to hire bilingual/bicultural staff from each different ethnic/cultural group in the community served, the provider shall have a Memorandum of Understanding (MOU) with community-based organizations or have access to interpreter and translation services needed to serve non-English speaking children/youth, birth parents, kinship resources, and foster parents.

The Provider shall have staff, professional consultants, or close linkages with resources that are qualified to address the full range of medical, clinical, and developmental needs presented by children and adolescents in foster care. Whenever possible, the Provider shall employ social work staff with at least a BSW or equivalent level of education and/or experience. Staff shall be skilled at engagement of children and their families, and have a thorough understanding of child and adolescent development. The Provider shall ensure staff are experienced and qualified to support child(ren)/youth to obtain the skills and resources necessary to live healthy, productive, and self-sufficient adult lives. Social work staff shall be familiar with the practice and concept of family treatment, and receive training/have experience as well as experienced in screening for domestic violence and chemical dependency/use issues and making referrals to appropriate providers for further assessment and services. Experience and qualifications shall include previous work experience with similar populations and credentials in the specific areas of expertise (e.g. CASAC for chemical dependency/use counselors).

The Provider shall assure that all clinical staff including physicians, nurse practitioners, psychologists, nurses, etc. are licensed professionals and meet the qualifications as described here. All staff and neighborhood-based medical and mental health professionals working with the Provider shall have demonstrated experience and skill with, and commitment to, the practices and concept of effective health care management, as well as knowledge and experience with issues affecting health care provision, coordination, and integration.

The Provider shall establish a procedure to review and evaluate the backgrounds of and information supplied by applicants for employee or volunteer positions according to *Children's Services Guidance #2009/01 conducting Criminal History Checks on prospective employees*, *New York State Social Services Law § 371(10), 378-a(1), and 390-b*, and *OCFS Memorandum 03-OCFS-LCM-12 "Criminal History Records for Candidates for Employment (Prospective Hire)" dated August 15, 2003*. All applicants shall complete employment applications which shall include inquiries relative to the applicant's most recent employers and prior criminal convictions. The use of this information in the applicant's evaluation shall be consistent with Article 23-A of the New York State Correction Law or any successor or amended Law.

In accordance with *Title 18 NYCRR Parts 442.18, 447.2, and 448.3* or any successor or amended regulations and *NY CLS Soc. Ser. 424-a*, the Provider shall adhere to all codes prior to hiring staff.

1. Staff Workload Ratios and Coverage

Providers must recruit and hire appropriate and sufficient staff to meet their program's needs. The ratio of children to workers in all types of foster care settings shall not exceed the standards set by OCFS and shall follow the established guidelines for each level of care and program type, e.g. group homes, hard-to-place, etc.

C. Screening Prospective Staff

The Provider shall be responsible for the verification of credentials and references and screening of all current and prospective employees. Such screening shall include but not be limited to 1 through 5 below.

1. New York State Central Register Clearance (SCR)

Prior to employment, the Provider shall clear with the NYS Central Register of Abuse and Maltreatment all staff members who are to have contact with children (including administrative staff, supervisors, social workers, Child Care Workers, cooks, drivers, and any other appropriate staff) in order to determine whether the applicant has been or is currently the subject of an indicated child abuse/maltreatment report. The Provider shall provide written notice to each prospective employee of its intention to make inquiry of the SCR.

2. Criminal History Record Check

Providers shall obtain a fingerprint supported criminal history background declarations indicating criminal conviction records, if any, and conducting a record review through the DCJS, in accordance with above reference for all prospective employees who will have the potential for direct contact with children. Fingerprinting of all prospective employees must be conducted in accordance with SSL § 378-a and all other Laws. The fingerprinting processing fee may be paid either by the prospective employee or by the Provider. In either case, the fee **will not** be paid or reimbursed by Children's Services.

When there is indication in either and/or both the Provider shall adhere to *Title 18 NYCRR 443.8* or any successor or amended regulations. The Provider shall make employment decisions concerning prospective employees with a criminal record in accordance with the Law. In the event the Provider hires a candidate with a criminal record, the Provider shall document the basis for the decision to hire such employee, which shall be signed and approved by the Provider's executive director. The Provider shall inform Children's Services of decisions to hire employees with criminal records.

3. Applicant's Employment History

Providers shall obtain a statement or summary of each applicant's employment history, including but not limited to any relevant child welfare experience, must be submitted before hiring. For prospective employees, the summary of the employment history must include written inquiries to

at least three (3) of the applicant's most recent prior employers, if applicable. The Provider shall use its best efforts to obtain a response to such inquiry prior to placing the prospective employee on the payroll.

4. References

Providers shall obtain from all prospective staff the names, addresses and, telephone numbers of three (3) references who can verify the applicant's employment history, work record and qualifications is required. Providers shall request written statements from three (3) references including previous employers. When written statements are not received, the Provider shall follow up by telephone. These statements shall become part of the individual's employment record.

5. Physical Examination

A physical examination shall be required of all staff as a condition of employment, which shall include an intradermal tuberculin test, with chest x-rays where such test result is positive. The candidate needs to be certified in writing for fitness of employment. Such certification shall be retained by the Provider and kept available for inspection.

See *Title 18 NYCRR Part 442.18* or any successor or amended regulations for additional information regarding institutional personnel requirements.

D. Probationary Employment

The Provider may retain an employee on a probationary basis in accordance with Children's Services' Policies, pending the results of the record review conducted by DCJS and the SCR. For such probationary hires, the Provider shall keep in confidential personnel files documentation describing supervision and measures taken to ensure the safety of children with whom such staff is working, pending background clearance. The Provider shall notify Children's Services of decisions to hire employees on a probationary basis pending the results of a criminal background check.

E. Suspected Abuse or Maltreatment of Children/Youth by an Employee

1. If the Provider has reasonable cause to believe that an employee has abused, maltreated, neglected, assaulted or endangered the welfare of any child/youth, the Provider shall, immediately report such belief to the SCR, and take appropriate action to remove the employee from the proximity of all children/youth while the matter is being investigated. The Provider shall immediately notify Children's Services of any Provider reports made to the SCR regarding employees of the Provider.
2. Children's Services reserves the right to conduct its own investigation with regard to any employee of the Provider for which the Provider has filed an SCR report. The

Provider and its program staff is required to fully cooperate with any such investigation.

3. If there is a finding of indicated abuse, maltreatment or neglect by the Provider's employee, the Provider shall immediately take action to ensure the permanent removal of the employee from the proximity of all children/youth, and Children's Services and/or the Provider may take appropriate legal action or disciplinary action, if necessary, to accomplish such removal.
4. If, notwithstanding the SCR finding of indicated abuse, maltreatment or neglect by the Provider's employee in question, the Provider believes that there are special mitigating circumstances in the matter, the Provider shall promptly submit a written request to the Commissioner for a review of the matter. This request shall contain a complete explanation, including all pertinent documentation, and the actions the Provider intends to take, in regard to the employee. During the review process, the employee shall remain removed from proximity to all children/youth. The Commissioner or his/her designee shall review the matter and may meet with the Provider and/or the employee and shall promptly notify the Provider of the Commissioner's decision concerning the permanent removal of the employee from the proximity of all children/youth.

F. Children's Services' Request for an Employee Review

Children's Services reserves the right to request that the Provider review the performance of any employee who has direct contact with children and/or families referred by Children's Services pursuant to their contract. Upon completion of the review, the Provider shall take appropriate action with respect to the employee, and thereafter notify Children's Services of such action.

G. Staff Training and Development

Providers shall continually assess the training needs of the Provider staff based on the population of Foster Children in the Provider's care and tailor the training to ensure that its staff receives appropriate training,

Providers shall have an annual training plan, which describes the specific trainings and hours of each that are required of and offered to each staff level. Providers shall be able to track and monitor staff compliance with annual training requirements.

All staff shall receive the MAPP and Parenting Skills Training: Teaching and Learning with Children in Care, which are critical to understanding the needs of foster and birth parents. Staff shall also receive training covering, but not limited to, the following topics:

- ASFA;
- Safety and Risk Assessment;
- Critical Thinking and Case Decision-Making;
- General Child Welfare Training (legal and regulatory standards);
- Emergency medical procedures;
- Crisis de-escalation;

- Trauma, the emotional effects of abuse and maltreatment, and the range of behaviors, including substance abuse, that traumatized children may express what they mean, and how to appropriately intervene;
- Loss and separation;
- Depression;
- Common psychotropic medications used with children, and risks/side effects associated with such medication;
- Normal and abnormal child/adolescent development and behavior;
- Domestic Violence
- Family planning and sexual health, including child's/youth's rights to access confidential services on their own;
- Chemical dependency/use, domestic violence, and sexual abuse and their effects on children;
- HIV/AIDS;
- Supporting lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth in care; and
- Cultural Competency.

The Provider shall ensure that all staff receive training specific to the provision of neighborhood-based services, including training on community characteristics, resources, and needs, and negotiation of services for children within a neighborhood-based environment.

The Provider shall make every effort to ensure that training incorporates and encourages the participation of community-based service providers, such as local hospitals, mental health providers and family support programs, police precincts, and drug treatment centers, as well as community residents and leaders. Staff shall be provided with concrete information on the range of services that are available to children and parents involved with the foster care system and how to make referrals to service providers. All staff shall be trained about the B2H Waiver program and the B2H referral process.

The Provider shall designate a staff person to be the Domestic Violence (DV) Services Coordinator. This person will schedule and document staff training in domestic violence, and participate in Children's Services-organized forums for domestic violence education and information on issues such as chemical dependency/use and domestic violence, immigration, working with abusive partners, the effects of domestic violence on children, etc. The DV Service coordinator shall receive on-going regular training and education, including case conferencing, on an as needed basis. The DV Services Coordinator monitors provision of domestic violence assessments with birth families and foster families, and the use of the Children's Services DV Screening Tool and Children's Services DV Protocol at intake and periodically afterwards, receives reports of indicated domestic violence from Children's Services CPS and other referring organizations, and conducts outreach and liaison to establish a network of services for domestic violence.

The Provider shall designate a staff person to be the LGBTQ Point Person to serve as a source of support to youth and as a resource to staff on LGBTQ issues. This person will schedule and document staff training in LGBTQ issues, and participate in Children's Services-organized

forums for education and information on LGBTQ issues. The LGBTQ Point Person will work with the Provider's homefinding department to identify LGBTQ-friendly and affirming homes. The LGBTQ Point Person shall receive on-going regular training and education, including case conferencing, on an as needed basis. The LGBTQ Point Person is responsible for conducting outreach and liaison to establish a network of services for LGBTQ youth and their families.

The Provider shall ensure that all appropriate staff receives training about the FTC, including training on facilitation of the foster parent's role as mentor to the birth parents/caretakers in appropriate areas of child behavior and management, as well as in various aspects of daily living.

The Provider shall train staff and foster parents about the importance of PYA services, including the provision of appropriate PYA services within foster care facilities and family foster homes. The Provider shall develop and provide an enhanced PYA training module, which shall address, but not be limited to, topics such as the role of self-sufficiency in adolescent development, education, employment, housing, health care, basic life skills, healthy intimate partnerships, relationship abuse, preparation for community living, and preparation for discharge.

Providers shall provide training regarding quality visiting to Caseworkers, supervisors, resource parents, and parent advocates. Children's Services OFVPE will provide training on improving visiting practices, including visit coaching, for Provider Caseworkers, supervisors and foster parents, which Providers will be encouraged to attend. Providers may also attend non-Children's Services sponsored trainings but must provide documentation of attendance as well as a description of the content of such trainings to Children's Services.

Supervisors shall have the ability to assess the professional development needs of their staff, and support those needs and provide opportunities for growth. Supervisors shall conduct quality assurance case reviews with staff, and provide staff with reflective supervisory support and regular evaluations.

Staff Training – Providers of Health and Mental Health Services

The Provider shall develop a strategy to ensure that health and mental health services providers who are working with children in their care receive orientation or training in foster care issues such as:

- The foster care Provider's responsibility for overseeing the health care provided to children in its care, the need for documentation of provided health services, and how HIPAA applies to the foster care system;
- the relationship of the Provider and foster parent to the child, to the birth parent, and to each other, and the importance of engaging both parents and foster parents in health care services;
- how the health care provider will interact with the child's caretakers and other service providers; and
- common health, emotional and behavioral issues affecting foster children, including the trauma that often results from abuse, maltreatment and separation from one's parents.

- All health service providers shall be trained in the B2H Waiver program and the B2H referral process.

In addition to the standards and expectations set forth above, the Provider shall ensure that all Provider staff providing both direct and indirect care shall receive training each year to enhance their understanding of the needs and characteristics of the population in care and their skills to provide emotional support and care, and appropriately manage the behavior of Foster Children. Such training shall include the following:

1. Training on trauma, the impact of abuse/maltreatment on children/youth, and the steps the Provider's staff can take to mitigate past trauma and prevent additional trauma;
2. Training on the complex social, medical, developmental, nutritional and emotional needs of Foster Children, the effect of those needs on their normal growth and development, and demands and skills required in caring for Foster Children;
3. Education on the importance of initial and ongoing medical and mental health treatment and the importance of keeping scheduled appointments as well as compliance with treatment;
4. Education on basic pharmacology as needed for Foster Children, including but not limited to the actions, side effects, and possible adverse reactions of medications that such Foster Children may be taking and basic information about administering medication and the dangers that can result from missed or improperly-administered doses of medications;
5. Training on behavior modification and management;
6. Training on youth development and permanency practice; and
7. Training on the Family Court process.

Residential Care

Residential Care Providers must provide comprehensive training for residential staff to equip them with skills to deal positively and effectively with problem behavior; assist them in meeting the needs of a diverse population of youngsters in their care; receive information on techniques in identifying trauma and addressing trauma triggers, managing behavior and preventing abuse/maltreatment, and meeting the contractual requirements of the service provider. Residential training shall consist of both on-the-job and classroom training. In addition to covering the specific topics listed below, the training shall provide a common language and open communication about behavior challenges and solutions for staff – including social service staff, child care staff, therapists, educational specialists, potential step-down foster parents, birth parents and child(ren)/youth. The training required is significantly different and progressively more intense than training provided in regular foster care services.

Specific Training for Residential Care Staff

Residential Care staff require more specialized training due to the behaviors that the child(ren)/youth being served are displaying. Residential Care Providers shall provide training geared towards the following situational definitions:

1. Emergency Situations:

An emergency situation is defined as a situation in which it is immediately necessary to restrain, seclude, or administer emergency medication to a child to prevent imminent: probable death or substantial bodily harm to the child because the child overtly or continually threatening or attempting to commit suicide or serious bodily harm to self; or physical harm to others because of threats, attempts, or other acts the child(ren)/youth overtly or continually makes or commits, and preventative, de-escalate, or verbal techniques have proven ineffective in defusing the potential for injury. These situations may include aggressive acts by the child, including serious incidences of shoving or grabbing others over their objections.

Prior to these situations, de-escalation and defusing strategies shall always be utilized in an effort to avert the emergency situations.

Note: Verbal threats or verbal attacks shall not be considered an emergency situation.

2. Restraint:

Restraint is the containment of acute physical behavior by physical, mechanical, or pharmacological intervention, or room isolation, except that room isolation shall only be permitted in institutions as specified in *Title18 NYCRR Part 442.2*. Restraint does not mean time out, confinement of a child to his own room for treatment or disciplinary reasons or use of a locked unit. The Provider shall adhere to *Title18 NYCRR Part 441.17* or any successor or amended regulation:

- Acute physical behavior means only that behavior which clearly indicates the intent to inflict physical injury upon oneself or others or to destroy property.
- Physical restraint means the use of staff to hold a child(ren)/youth in order to contain acute physical behavior.
- A mechanical restraint refers to restraining devices used to contain acute physical behavior.
- Pharmacological restraint means the use of a chemical agent to contain acute physical behavior by causing an immediate radical suppression of such behavior.
- Room isolation means confinement of a child in a room specifically designed and designated for such use in order to control acute physical behavior of that child.
- Restraint shall be used without purposely inflicting pain or harm, and only when other forms of intervention are either inappropriate or have been tried and proved unsuccessful.
- Restraint, including room isolation, will never be used for punishment or for the convenience of the Provider staff.

3. Seclusion:

Seclusion is defined as the placement of a child, for any period of time, in a room or other area where the child is alone and is physically prevented from leaving by a locked or barricaded entryway. Seclusion/Isolation is prohibited except in institutions specified in Title 18 NYCRR Part 441.1 and 442.2 or any successor or amended regulation.

4. Time Out:

Time out is the removal of a child from a situation that is too threatening or emotionally overwhelming for the child or where the child may lead other children into an uncontrollable state or where the child has exceeded the reasonable limits set by the Provider staff.

Required Notifications to the Child

Allowable Discipline Practices

At the time of placement, a Residential Care Provider must provide each child with a copy of the discipline practices allowed in the facility.

Use of Restraints

Age-appropriate explanations of the use of restraints must be provided to each child at time of placement. The explanations must include:

- who can use restraint;
- methods used by staff to avoid the use of restraint;
- types of restraints used;
- the specific kinds of situations in which restraint may be used;
- when a restraint must cease;
- actions a child must exhibit to be released from a restraint; and
- how to report an inappropriate restraint.

Right to Provide Comments

Children must be notified of their right to voluntarily provide comments on any restraint or seclusion that is used. The notification must include an explanation of the process for submitting such comments. The process must be easily understood and accessible.

Allowable Forms of Discipline

Residential Care Providers are requested to develop procedures regarding discipline that must suit the child's age, circumstances, and developmental needs. Methods of discipline may include:

- establishing routines;
- setting reasonable limits;
- modeling appropriate behavior;
- offering choices;
- giving explanations;
- repeating instructions;
- using time out;
- enforcing or permitting logical or natural consequences; and
- reinforcing desired behavior.

Prohibited Forms of Discipline

The Provider shall adhere to the following prohibited methods of discipline in accordance with *Title 18 NYCRR Part 441.9* but not limited to the following:

- Deprivation of meals, snacks, mail or visits by birth family/caretaker/sibling
- Room isolation
- Corporal punishment
- Solitary confinement

Discipline shall be prescribed, administered and supervised only by the Provider staff. Such responsibilities shall never be delegated to child(ren)/youth.

Documentation of Restraints and Seclusions

Residential Care Providers must keep a written record of all restraints or seclusions. This written record must include the:

- date and time of the restraint or seclusion; and
- the circumstances or specific behaviors that led to the restraint or seclusion.

1. Supervision

All Caseworkers must receive at least one hour per week of individual supervision for the purpose of professional development from an MSW, or equivalent human services graduate degree, level supervisor. In the event of extended absences/vacancies in a supervisory position, the Director of the program shall arrange for coverage and maintain the provision of weekly individual supervision and case reviews.

It is recommended that supervisory case reviews occur in the context of supervision (individual and/or group) with the Caseworker(s), child care staff and supervisor(s) and that the case reviews include thorough discussion of the preceding and current case issues and dynamics; careful monitoring of the quality of the casework provided; and clear support and guidance to staff in making critical case-related judgments and decision.

Supervisors are responsible for maintaining a record, outside of the CNX case record, of weekly supervision meetings with each of their staff. Weekly occurrences of supervision for professional development shall be documented at minimum in a monthly summary of the key aspects of supervision bulleted above. Supervisors shall also keep records of all performance reviews.

2. Performance Evaluation

Performance evaluations of all staff shall be conducted annually at a minimum. For new staff, the first review is conducted within six (6) months and annually thereafter. Performance evaluations shall be based on information from direct observation of job performance on an ongoing basis during weekly staff supervision and monthly social worker/foster parent contact and includes observed interaction with the child and/or birth families/caretakers. Results of

performance evaluations shall be incorporated into the performance plan for the coming year. Performance evaluations shall result in the Provider's effort to strengthen constructive behavior and reward positive performance. Performance evaluations shall also be used to develop training objectives for staff.

3. Cultural Competence

The Provider shall provide culturally and linguistically competent services through staff that is representative of the community/ies served and fluent in the languages spoken by participating children and family members. Such staff shall reflect that the Provider is able to assess the needs of the local community and is meaningfully linked to local community/ies resources, and that the program is led and operated with understanding and respect for community/ies needs and cultures. The Provider shall make diligent efforts to recruit and hire qualified staff that reflects the ethnicity/race of the community served. When it is not feasible to hire bilingual/bicultural staff from each different ethnic/cultural community group, the provider shall have "letters of linkage," memoranda of understanding, or other written agreements with community-based organizations or have contractual arrangements with interpretation and translation services needed to serve non-English speaking children and family members.

4. Political Activity/Religion

Provider staff may not engage in or promote partisan political activity or religious worship, instruction or proselytizing during the conduct of their employment. The religious affiliation of the Provider or individual staff members shall not influence the delivery of services.

5. Community Board of Directors Participation

Providers who receive funding from Children's Services shall ensure that members of the communities they serve have the opportunity to contribute to and be informed about policy-making processes. In doing so, they shall actively solicit family members' involvement in services provided to their children. Providers will encourage consumer involvement in the foster care Provider.

6. Linkages to and Participation in Community Partnerships

Community Partnerships will work to develop and support holistic, seamless local networks of service providers, community members, families, and other stakeholders with the goal of assisting families and offering safety and support where they reside. Community Partnerships will identify community needs and draw upon community resources to address those needs and will work to identify and overcome obstacles to child welfare system success. Relationships and partnerships formed within the Community Partnerships shall significantly impact core child welfare outcomes of safety, permanency, and well-being. The Partnership shall seek to close the divisions between Children's Services, contract providers, other neighborhood organizations, and residents of neighboring communities.

Providers shall participate in local Community Partnerships if one exists in their local community. Family Foster Care providers shall participate in the Community Partnership where a substantial proportion of their clients reside. Residential Providers shall participate in the Community Partnership nearest to their residential facility. Residential Care Providers are encouraged to connect discharged child(ren)/youth and their families to a Partnership if one exists in the community to which the child(ren)/youth is returning.

PART VIII: RECORDKEEPING

A. Documentation of Case Records

The Provider shall maintain adequate case files and fiscal records, and shall ensure that its staff follows appropriate record-keeping and retention practices and procedures, in a manner that is in compliance with and supports all existing federal, State, and City laws, rules, and regulations, and is consistent with policies, procedures, and standards promulgated by Children's Services. The Provider shall keep separate files and records for each Recipient of Service so that they may be readily identifiable from those relating to other activities of the Provider. In addition to information normally kept by the Provider in individual files, such as basic information about the individual, describing and recording each use of the services by the individual, and the individual's progress, the Provider shall include such other information in individual files as Children's Services may require. The files and records of each recipient shall be made available to Children's Services at reasonable times upon reasonable notice and request.

The Provider shall upon reasonable notice and request by Children's Services, provide information and records relating to Foster Children in the custody of Children's Services. Children's Services shall have access to information and records including, but not limited to, information and records pertaining to programs, birth parents/caretakers, foster parents, Foster Children and compliance with legally mandated activities. The Provider shall collect and maintain all information and records requested by Children's Services.

The Provider shall cooperate with Children's Services assessment and evaluation systems, including the new Scorecard system, and shall provide all information necessary to allow Children's Services to fulfill these responsibilities. Appropriate Provider staff shall be trained in the use of electronic data entry record systems, including CNNX, Legal Tracking System (LTS), CCRS, and SSPS and any subsequent tracking systems or databases as required by ACS, OCFS or the Law.

The Provider shall ensure that its staff, consultants and subcontractors shall at reasonable times and upon reasonable notice, be made available to Children's Services or its Counsel upon request for consultation either at the office of the Provider or at the offices of Children's Services.

The Caseworker (and Child Care Worker, where appropriate) shall have primary responsibility for the development, documentation and maintenance of all case records within his/her caseload. Provider policies and procedures shall clearly define the requirements of the Caseworker and Child Care Worker in documenting and maintaining case records, including required forms, content and format of other documentation, and storage.

Primary documentation of case record information will be maintained in CNNX. Hard copies of all other information unable to be captured in CNNX shall be kept in physical case records. In general, case records shall contain: demographic and contact information; the reason for a

request or referral for services; up-to-date assessments; copies of all signed consent forms; a description of services provided by referral; and documentation of routine supervisory review.

A Provider's documentation procedures shall also define the documentation requirements for all service providers, e.g. medical, psychiatric, chemical dependency/use prevention, and treatment and after care providers as well as education professionals.

Please see *Title 18 NYCRR Parts 428.8(2) and 428.10, Children's Services Procedure No. 198/Bulletin No. 05.01 and Procedure 1008/03, Connections Build 18.9, and NYS Standards of Payment for Foster Children, Chapter 1* or any successor or amended regulation for details.

1. Family Case Record 'aka' Child Case Record

A case record is to be maintained for all children in foster care and all services and treatment provided to the child and family shall be documented in the case record. The Provider shall maintain appropriate case files and supportive records e.g., application for services, assessments, evaluations, education and medical reports, legal documents and collateral contacts. The case record is to be indexed reflecting the organization and documentation in the record.

The Provider shall adhere to *Title 18 NYCRR Parts 428.1 and 441.7* or any successor or amended regulations.

2. Foster Family Case Record

(please also refer to Part II E. "Foster Parents – Recordkeeping").

A current, detailed and accurate foster parent case record must be maintained by Provider staff and shall be updated as needed in accordance with the Law including *Title 18 NYCRR 443.2(f)* or any successor or amended regulation. Such record shall include but not be limited to:

- a) A face sheet listing all members of the household and their relationship to the foster parent.
- b) Child-specific training and problem solving during foster home visits.
- c) Respite care provided to foster parents. The face sheet shall be updated as needed.
- d) Assessment of safety issues.
- e) Goal setting and planning.
- f) Observation/assessments of family interactions.
- g) Impact of cultural issues on foster child and foster family.
- h) Description of the relationship between the birth family/caretaker and the foster family.
- i) Emotional support and relationship building.
- j) Crisis Counseling provided and effects/outcomes; nature and extent to crisis calls and methods of resolution.
- k) Participation in meetings/conference, i.e., FTCs, treatment team meetings, sessions with Mental Health providers etc.
- l) Discussion of permanency and interest in adoption or discharge resource to the identified child.
- m) Documentation of all training provided, including pre-service and in-service.

- n) Documentation demonstrating efforts to secure consent from birth parents/caretakers.

The Provider shall adhere to *Title 18 NYCRR Part 443.2* or any successor or amended regulations.

B. Incident Reporting

The Provider shall notify Children's Services immediately in the event of a situation, which presents an imminent danger to the health or welfare of any Foster Child. For purposes of this clause, 'immediate notice' shall mean providing notice to Children's Services as soon as practicably possible without placing the Foster Child in any further danger.

Provider staff are mandated to report fatalities, serious accidents and incidents, and injuries of any child to both the SCR and Children's Services, and to do so within twenty-four (24) hours of receiving notice. The reporting of a fatality shall first be made to the SCR. For fatalities, serious accidents and incidents, and injuries, an e-mail notification must be sent immediately upon knowledge of the incident to the Children's Services Shared Response Team with a comprehensive follow-up report on the initial notification within twenty-four (24) hours. The Provider shall adhere to *Title 18 NYCRR Parts 441.7 and 441.8* or any successor or amended regulation.

For full guidance on this issue please refer to *Delegation and Centralization of Case Management Responsibilities: Revised Foster Care Casework Action Requirements for the Improved Outcomes for Children Initiative/Phase I Implementation*, dated November 5, 2007.

In addition to the above, and in accordance with the procedure in place since 1997, the provider shall submit a copy of each Critical Incident Report to its commercial general liability insurance carrier with a copy to the City of New York Law Department Affirmative Litigation Division.

C. Authorization for Release of Health Information and Consent Form

A signed authorization from the child/youth's parent(s) or guardian(s) must be obtained for the release of medical information from health care providers who have previously treated the child/youth and for copies of medical records from such health care providers. If written authorization for the release of such records cannot be obtained from the parent(s) or guardian(s), the Provider may be able to sign the authorization as the Provider authorized to be the child/youth's personal representative under HIPAA, and obtain copies of medical records from the Providers. Whether the provider may act as the child/youth's personal representative varies depending on the type of legal authority for the placement.

At the time of placement for cases where the foster child/youth is voluntarily placed, or within ten (10) days after admission into care in emergency or court-ordered placements, written authorization from the child/youth's parent(s)/legal guardian(s) must be requested for medical care including medical and/or psychological assessments, immunizations and medical treatment, and for emergency medical or surgical care in those cases when the parent(s)/legal guardian(s) cannot be located at the time the care is necessary. In those instances when parent(s)/legal

guardian(s) are unable, unavailable, or unwilling to sign a release, the Caseworker/Case Manager must follow existing State law and Children's Services policy and procedures in regard to medical consent at the time the treatment is needed. Providers are required to make a diligent effort to contact parent(s)/legal guardian(s) for consent whenever there is a significant change in the health status of the child/youth requiring non-routine medical attention, surgery or administration of psychotropic medication. All consent forms must be retained in the Medical Record and CNNX 'Health Narrative' as part of the child's health history. In those instances when parent(s)/legal guardian(s) are unable, unavailable, or unwilling to sign a release, the planner/case manager must follow existing State law and Children's Services policy and procedures in regard to medical consent at the time the treatment is needed. Medical consent protocols are described in detail in *Children's Services Bulletin 99-1 (10/18/99)*.

D. Health Records & Documentation

Providers are also responsible for maintaining complete health information in each child's CNNX case record, per Children's Services policies and CNNX Build 18.9. In addition to the requirements for the medical documentation contained in CNNX Build 18.9, the Provider shall establish a comprehensive health history for each child/youth by working with the birth family/caretaker and known previous health providers for the child/youth. The medical record shall include, but not be limited to: a complete medical history, dental history, immunization record, an admission physical exam and all subsequent physical exams, records of all medical treatment, consent(s) for treatment, and any other appropriate documentation related to medications and procedures (diagnostic and therapeutic). Providers shall adhere to all timelines for collection of such information as required by Children's Services.

All child welfare health service providers responsible for a child/youth's care shall have health information about the child/youth's health status and history on a "need to know" basis, as appropriate to maintain the child/youth's confidentiality, so as to maximize the opportunity for effective care and coordination. The Provider shall maintain each child/youth's individual medical history in a user-friendly, readily transferable manner that details all critical information regarding the child/youth's health status and history, including achievement of major medical milestones.

The following forms and notices must be included in the child/youth's Medical Record and in the medical section of the FASP and/or CNNX Health screen, where appropriate. Additional details regarding documentation appear in the subsequent sections.

1. The initial health examination;
2. All periodic health examinations (as recommended by the American Academy of Pediatrics/CTHP schedule) and well-child examinations;
3. A list of all of the child's health-related needs, including special healthcare needs, with a corresponding plan to address each need;
4. All on-going medical treatment (including medications, see below) and corresponding reason for treatment;
5. The child's treatment progress, including response to treatment and non-compliance shall be documented;

6. All specialty and subspecialty referrals, including referrals to home-and community-based health, mental health and substance prevention/use programs;;
7. All hospitalizations and corresponding summary discharge notes;
8. Copy of an updated Medical Passport;
9. All laboratory results and results of diagnostic examinations and procedures;
10. Prenatal and birth-related information for all preschool children, and for older children when available;
11. Documented evidence that initial and semiannual risk assessments are performed for HIV, STDs and Family Planning (Form CM 1036);
12. Documentation that a Family Planning Services Notice was given to the youth twelve (12) years of age and older and the child/youth's foster parents, within thirty (30) days of placement and semi-annually thereafter;
13. Documentation of strategies to keep the child's CIN number/Medicaid number readily available when needed by a health care provider; and
14. Documentation of all mental health-related treatment and diagnostic procedures.

1. Physical Examination

Providers shall document the results of a child/youth's physical examinations using the Child's Health Record or a comparable form. This form is used to include the results of the initial and periodic health examinations given to the child/youth. The record shall contain a section describing a plan for the child/youth's health needs being met and document on-going medical treatment. The record shall include information on all specialty referrals, copies of laboratory results, and summary discharge notes from any hospitalizations. The health record must also indicate any evidence that the child/youth's CIN number is readily available when needed by a health care provider.

All records of complete physical examinations shall include documentations of vision screens, hearing screens and dental screens [for children over two (2) years old]. The Child/Teen Health Plan (CTHP) is New York State's version of the Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. It describes the State's plan for ensuring the provision of the full range of CTHP Services as recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics. Subsequent evaluations, procedures and therapies related to significant findings from the required screens shall also be documented in the Medical Record in accordance with *Title 18 NYCRR Part 441.22* or any successor or amended regulation with regard to health and medical services for children/youth.

2. Continuing Health History

The Provider must keep a hard copy of the child's medical history and other relevant health documents that are not scanned or recorded in CNNX.

3. Health Summary Form

The Provider will maintain a Health Summary Form for each child in care. The summary form will be completed during the first six (6) months of placement with the results of the initial comprehensive health and mental health examinations. The form will be up-dated every six (6) months the child remains in care in conjunction with the FASP. The Health Summary will include information on health, mental health and substance use/abuse status; health care providers; dental, vision and hearing test results; current immunization history and any follow up referrals that are necessary in accordance with *Title 18 NYCRR Part 441.22 C(1)* above or any successor or amended regulation.

4. Medical Passport

The Provider shall have a Medical Passport for each child/youth and updated by health service providers at each visit. The Medical Passport shall not be used as a substitute for the full medical record. A copy of the child/youth's most up-to-date Medical Passport shall be kept in the medical record. The passport shall be updated as often as possible and at minimum every six (6) months. An acceptable Medical Passport is available free upon request from the City of New York Department of Health and Mental Hygiene.

5. Medical Consent Forms

Within ten (10) days of admission into care, authorization in writing must be requested from the child's birth parent/caretaker for routine medical and/or psychological assessments, immunizations and medical treatment, and for emergency mental health, medical or surgical care in the *event* that the birth parent/caretaker cannot be located at the time such care becomes necessary. Please see Part IX: Documentation for more information. Such authorization must become a permanent part of the child/youth's medical record.

Informed consent for non-routine medical treatment shall be sought from the child/youth's birth parent/caretaker, unless their rights have been terminated or surrendered per *Children's Services' Bulletin 99-1 (10/18/99) "Guidelines for Providing Medical Consents for Children in Foster Care."* Providers can consent for medical treatment when the parent is unavailable. In situations where the time necessary for seeking parental consent would present a danger to the child/youth's life, health, or immediate welfare, the child's physician has the authority to grant consent if he/she deems the situation to be an emergency as defined by law.

Informed consent for the release of confidential information implies that the following information has been obtained/explained or sent in writing to the consenting party:

- Risks and benefits of the treatment;
- Treatment alternatives;
- Expected outcomes;
- Time frame to observe expected outcomes;
- Proposed length of treatment; and
- Names and contact phone numbers of the clinical provider of proposed procedure/treatment.

E. Mental Health Screening and Treatment Documentation**1. Medication-Related Documentation**

All information related to all medications given to children/youth while in care shall be documented in the Medical Record. For each medication, this includes (but not limited to):

1. The name of the medication(s) currently being taken by the child/youth (including dose and dosage schedule);
2. The purpose of the medication(s) or condition/diagnosis being treated or managed;
3. The name and credentials of the prescriber;
4. Documentation of appropriate consent [e.g., Provider consent for "freed child," parental/guardian consent, consent from a youth over eighteen (18)] and consent procedures followed by the provider;
5. All associated health facility visits, specialty and subspecialty care associated with the medication;
6. Documentation that the Provider has provided appropriate administration of the medication;
7. Documentation of non-compliance to prescribed medications;
8. Documentation of any allergies or adverse reactions that the child may have had to any past medication(s), and the incident report associated with each adverse reaction (while the child was in the provider's care); and
9. Documentation of Model Approach to Partnerships in Parenting (MAPP) training on medication administration for all foster care parents.

For Residential care Settings, there must be documentation that staff has been trained in medication administration/supervision of self-administration. Medication sheets are also reviewed for those in Residential Care.

Care must be taken to ensure that all consents for treatment were obtained and documented appropriately. Specifically, the designated Consent for the Release of Confidential Information Officer (or other personnel with an equivalent title) shall not be the prescriber for the same medication and shall not administer the same treatment for which the consent was obtained.

2. Psychotropic Medication Documentation

In addition to the required documentation above, for children/youth receiving psychotropic medications, the following shall also be documented:

1. Documentation of appropriate informed consent procedures (i.e. consent was given information on alternatives, risks, benefits, expected outcomes, length of treatment) followed by the Provider prior to initial administration of the medication;
2. Documentation of appropriate initial and follow-up laboratory exams;
3. Documentation of recent one (1) month physical exam prior to initiation/change of treatment regimen;
4. Documentation of monthly evaluation (or appropriate reason for exception of this requirement) by a child psychiatrist (or other appropriate health care provider); and

5. Documentation of appropriate monitoring of the child's reaction to any treatment or medication must be provided.

Psychotropic medications may be prescribed by a Pediatrician, a Neurologist, or a Pediatric Psychiatric Nurse Practitioner under specific circumstances. Formal requirements for waiving this condition will be released in the future.

F. Family Planning Services

1. Notice to Adolescents

The Provider shall ensure that the notification of the availability of family planning services pursuant to Part V,(L) entitled "Family Planning Services" is recorded in each Foster Child's medical record and in CNNX, as part of the Foster Child's health history. CNNX reviews for the Family Center site visit. See *Children's Services' Guidance "Family Planning Services -6/8/06"* for details.

2. Notice to Foster Parent

A copy of the family planning services must be kept in the child/youth's health history file to indicate that the required notice of family planning services has been sent within thirty (30) days of placement to all foster parents caring for youth twelve (12) years and older. This notice, which must also be sent semi-annually to such foster parents, informs them of the availability of minor's rights to confidential sexual and reproductive health services and social, educational, health, and medical family planning services for the youth in accordance with *Title18 NYCRR Part 463.2* or any successor or amended regulations.

G. Court Documents

The Provider shall furnish documents to Children's Services attorneys as requested by them for their work on cases under the Provider's care. These documents may include, but not be limited to, case records, FTC and other conference summaries, family assessment and service plans, notes, medical records, and evaluations, as well as written reports prepared specifically for the Court. All documents shall be furnished, whenever possible, at a reasonable time in advance of the Court hearing, so that the attorney can discuss the use of the documents with the provider.

Additionally, Permanency Hearing (PH) reports must be submitted to the Children's Services attorneys by the Provider according to applicable procedures, within firm timeframes.

H. Disposal of Confidential Data

The case record and any documents contained therein are confidential. Other confidential items include, but are not limited to, documents containing: child and family names, addresses, social security numbers, case information, details of allegations of abuse, confidential employee information, medical information, and other personal information. Providers must comply with

New York State law and regulation regarding record retention and disposal. Please reference OCFS' document - 05-OCFS-ADM-02 dated April 19, 2005.

PART IX: LITIGATION, GRIEVANCES, AND DISPUTES

A. Litigation Claims Involving Foster Children

1. The Provider shall notify Children's Services of all litigation and ACS shall notify the Contractor of same concerning a Foster Child within a reasonable time of acquiring this information and shall provide Children's Services with all pertinent papers and documentation in advance of any pending court hearings or litigation. The Provider shall provide its own legal representation when requested to do so by Children's Services. The Provider shall, within three (3) business days, notify Children's Services in writing of the results of such court hearings or litigation.
2. In cases involving a Foster Child who is the subject of litigation, including writs of habeas corpus, Children's Services, after consultation with the Provider, reserves the right to make an independent evaluation of the matter, including, but not limited to review of the Provider's records and contacts with the Foster Child and/or the birth family/caretakers, foster family and significant others. The decision of Children's Services shall be binding on the Provider in accordance with Article 4 of Part IX of their Foster Care Contract Agreement entitled "Responsibility and Authority of Children's Services and Resolution of Certain Disputes."
3. In a court proceeding involving a Foster Child, the Provider may, with the consent of Children's Services, make such appeals as are provided by Law.
4. The Provider shall expeditiously pursue appropriate legal action for the appointment of a guardian ad litem to protect the rights of a Foster Child with respect to all monetary benefit claims, including but not limited to tort, contract or inheritance claims. The Provider, when appropriate, shall arrange for or assist a Foster Child in retaining legal counsel. The Provider shall forthwith notify Children's Services of all circumstances necessitating legal representation of the Foster Child in all such instances, including but not limited to matters of a criminal nature or juvenile delinquency.
5. If a Foster Child commits an act in a Foster Home in which he/she is a resident which is a crime, or if committed by an adult would constitute a crime, the Provider may report such act to the appropriate law enforcement officials. The Provider shall report such acts in writing to the appropriate Children's Services personnel prior to taking any affirmative action with respect to such acts or as soon as possible thereafter.

B. Client Grievance Procedures

1. The Provider shall establish procedures through which Recipients of Service may present complaints and grievances about the provision of any service by the program, parent agency or Provider staff. The Provider shall advise Recipients of Service of these procedures and of

their right to appeal thereafter to Children's Services.

2. If the Provider is unable to resolve the problem and the Recipient of Service initiates an appeal to Children's Services, the Provider shall forward a summary of the relevant information to Children's Services. Children's Services shall confer with all the parties, either separately or jointly, and may request such additional information and material, as it deems necessary.
3. If the Recipient of Service and the Provider can not come to an agreement concerning the Recipient's complaints and grievances, Children's Services shall have the right to make a final determination pursuant to Part 'I' above.
4. In circumstances where the Law or due process requires, the Provider shall advise the Recipient of Service of his/her right to request a fair hearing by OCFS.

**C. Responsibility and Authority of Children's Services
and Procedures for Final Decisions on Issues Related to Services provided to the Client**

1. The Commissioner of Children's Services has the ultimate responsibility for the protection and preservation of the welfare of each child receiving services under the Family Foster Care Contract Agreement. The Commissioner has the ultimate authority for making all decisions relative to the welfare of any foster child, and that the management and supervisory staff of Children's Services carries out such responsibilities on behalf of the Commissioner and in accordance with the authority vested in the Commissioner. The Provider's Board of Directors shall have responsibility and control of its day to day affairs and programs.
2. Resolution of Disputes between ACS and the Contractor:

In the event of a dispute between the Provider's staff and Children's Services' staff relating to case planning, case practice and service planning, and positions to be taken at any court or administrative hearing, Children's Services and the Provider shall follow the steps below to resolve such disputes expeditiously, and cooperate with each other in such situations and/or inquiries to the fullest extent possible. If the Provider fails to report the presence of any dispute or submit an appeal within the time frames indicated below shall constitute a *waiver* of any such dispute.

1. If after the performance of an internal review of its position, the Provider's Executive Director disagrees with Children's Services on a decision relating to case planning, case practice and service planning, and/or a position to be taken at any court or administrative hearing, the Provider shall present its position and recommendation in writing ("Notice of Dispute") within five (5) business days of the occurrence of an event giving rise to the dispute to the appropriate Children's Services Assistant/Associate Commissioner for the Children's Services organizational unit involved. The Notice of Dispute shall include all the facts, evidence, documents, or other basis upon which the

Provider relies in support of its position. The Children's Services Assistant/Associate Commissioner will make every reasonable and good faith attempt to resolve the dispute after due consideration of the opinion, expertise and professional judgment of the Provider, and render a written decision within five (5) business days from the date the dispute was referred to him/her. If the Children's Services Assistant/Associate Commissioner is unavailable to meet or unable to render a decision within such five (5) business days, the time for decision-making may be extended at the sole discretion of Children's.

2. If the Children's Services Assistant/Associate Commissioner fails to act or if the dispute remains unresolved after the decision of the Children's Services Assistant/Associate Commissioner, the Provider, within five (5) business days of receipt of such decision may appeal the decision by submitting its appeal in writing to the Children's Services Deputy Commissioner responsible for the Children's Services organizational unit involved. A copy of Provider's appeal must be submitted simultaneously to the Children's Services Assistant/Associate Commissioner making the initial decision. The written appeal must contain the following information and documentation (i) a brief statement of the substance of the dispute and the reason(s) the Provider contends the dispute was wrongly decided by the Children's Services Assistant/Associate Commissioner; (ii) a copy of the decision of the Children's Services Assistant/Associate Commissioner, and (iii) a copy of all materials submitted by the Provider to the Children's Services Assistant/Associate Commissioner. The Children's Services Deputy Commissioner will make every reasonable and good faith attempt to resolve the dispute after due consideration of the opinion, expertise and professional judgment of the Provider, and render a written decision within five (5) business days from the date the dispute was referred to him/her.

3. If the dispute remains unresolved after the decision of the Children's Services Deputy Commissioner or his/her designee, the Provider, within five (5) business days of receipt of such decision, may present a final appeal to the Commissioner. The written final appeal must contain the following information and documentation:

- (i) a brief statement of the substance of the dispute and the reason(s) the Provider contends the dispute was wrongly decided by the Children's Services Assistant/Associate Commissioner and the Children's Services Deputy Commissioner; and
- (ii) a copy of the decisions of the Children's Services Assistant/Associate Commissioner and Children's Services Deputy Commissioner, and (iii) a copy of all materials submitted by the Provider to the Children's Services Assistant/Associate Commissioner and the Children's Services Deputy Commissioner.

The Commissioner will make every reasonable and good faith attempt to promptly resolve the dispute after due consideration of the opinion, expertise and professional judgment of the Provider.

- 4. The decision of the Commissioner shall be binding upon all parties.

5. At any stage during the above described procedure, where a decision is made which the Provider does not wish to present to the next level of supervision such decision shall promptly be carried out by the Provider to the extent that it is required to do so and to the extent that it is not required to carry out such decision, the Provider shall not impede the carrying out of such decision.

6. During the pendency of the appeal procedure described above, the Provider shall take no action which may undermine or impede the then current decision of Children's Services.

PART X: MONITORING, EVALUATION and QUALITY IMPROVEMENT**A. Standards and Procedures**

A. The Provider shall set forth written plans ("Standards and Procedures") that detail all management systems and the manner in which they are designed to ensure proper planning and implementation of programmatic operations and fiscal administrative policies and procedures. The Provider's Standards and Procedures shall include the records and maintenance of: personnel management systems; fiscal management systems, including procurement and cash management systems; facility management systems; program management systems; and parents' decision-making systems.

B. Unless previously submitted, the Provider shall submit to ACS for its review a new/revised copy of all Standards and Procedures related to the implementation of programmatic operations and fiscal administrative policies and procedures at the time of signing their Family foster Care Agreement. The Standards and Procedures submitted must include:

- i. Organizational papers such as a true copy of the Certificates of Incorporation filed with the New York Secretary of State, by-laws, and any other related documentation reasonably requested by Children's Services;
- ii. Personnel policy practices including such matters as job descriptions and qualification requirements, hiring and selection practice, personnel grievance procedures, benefits and leave, salary increases, holiday schedules and other related matters;
- iii. Purchasing policy and procedures;
- iv. Fiscal Policies and Procedures;
- v. Intake and Planning Procedures; and
- vi. A Completed Safety Plan that provides specific and detailed procedures for responding to a range of incidents.

C. If the Provider has previously submitted a copy of its Standards and Procedures, the Provider shall give written notice to Children's Services of the date of submission and shall certify that the Standards and Procedures stated therein are currently in effect.

D. Appropriate Children's Services personnel/staff may review, in whole or in part, or decline to approve the Standards and Procedures of the Provider. Children's Services may direct the Provider at any time, and from time to time, to rescind, modify or add to its Standards and Procedures to bring the Standards and Procedures in compliance with these *Foster Care Quality Assurance Standards*, the Law and Children's Services Policies.

E. The Contractor shall notify ACS in writing within thirty (30) days of any changes in its Standards and Procedures.

B. Quality Assurance Plan, Ongoing Data Collection and Program Evaluation

A. The Provider shall have a quality assurance plan in place that describes how it will provide quality assurance, planning and program evaluation for Foster Children placed in its care.

B. Provider Participation in Collection of Information for Review Procedures: The Provider shall participate in on-going Children's Services assessment, evaluation, and monitoring review procedures on the performance of Foster Care services and provide all information appropriate to allow Children's Services to conduct these review procedures and complete a full review of the Provider's family foster care program.

C. All records kept by the Provider pursuant to their Foster Care Contract Agreement shall be subject at all reasonable times to inspection, review or audit by City, State, or Federal personnel and other personnel duly authorized by Children's Services.

D. Children's Services' will supervise, monitor, audit and review the activities of the Provider in providing the family foster care services in accordance with their Foster Care Contract Agreement. The Provider staff should be aware that a program and facilities review, including unannounced visits, meeting with Foster Children and birth/caretaker families and foster families, review of service records, review of service policy and procedural issuances, review of staffing ratios and job descriptions, and meetings with any staff directly or indirectly involved in the provision of services, may be conducted at any reasonable time by Children's Services staff, State and Federal personnel, or other persons duly authorized by Children's Services. The Provider shall provide the information required for any review or evaluation requested by Children's Services.

E. Children's Services Data Collection and Program Evaluation:

1. Children's Services shall collect and monitor data as part of a full evaluation process and monitor program performance indicators as appropriate and as needed.
2. Children's Services will establish and notify the Provider of evaluation standards prior to their implementation. Standards will be established in advance of the evaluation period. The Provider will be afforded the opportunity to rebut an evaluation before it is made final by Children's Services.
3. Children's Services shall at its sole discretion:
 - a. Implement monitoring methods including, but not limited to, direct contact with Recipients of Services including Foster Children and birth/caretaker families and foster families by telephone or mail to assess the sufficiency, efficiency and adequacy of the services performed.

- b. Have Children's Services personnel visit the Provider to enable Children's Services to assess and determine the effectiveness of the Provider's staff on a regular basis. During site visits, Children's Services personnel may provide technical assistance in solving problems affecting the provision of family foster care services.
- c. Review all program activities, procedures, records, and records recording, and conduct other evaluatory activities as Children's Services deems necessary and appropriate, including, at reasonable times, unannounced and unscheduled visits.
- d. Duplicate all of Provider's records, forms, and other data, which Children's Services deems necessary.

F. Children's Services shall provide the Executive Director and Board of Directors of the Provider with written information concerning the results of the monitoring visit or evaluation.

G. As a result of all service inefficiencies uncovered by the monitoring visit or evaluation, the Provider is required to implement any corrective action plan required by Children's Services.

C. Children's Services' Annual Data Collection, Program Evaluation, and Fiscal Review

1. Scorecard Evaluation

The Scorecard is a comprehensive performance measurement and quality improvement system designed to:

- 1. Evaluate the quality of practice and services provided by foster care/residential programs, as well as their outcomes; and
- 2. Function as a tool for quality improvement.

The Scorecard organizes process measures into categories that are meaningful to provider practice. These categories include:

- 1. Safety
- 2. Permanency
- 3. Well-Being
- 4. Foster Parent Recruitment and Support

The Scorecard includes three (3) types of new measures, including:

- 1. Outcomes
- 2. Recruitment/Retention
- 3. Provider Agency Measurement System (PAMS; formerly PES)

The outcomes measures evaluate the work Providers do with the children/youth in their care – categorized to account for differences by age, need and time in care – in four (4) four areas:

1. Permanency Discharges (reunification, adoption);
2. Children Missing From Care;
3. Lateral Moves (e.g. moves from one foster care home to another);
4. Step-Ups, defined as any move between family-based care (family foster care, treatment foster care, special medical) and Children's Services-funded Residential Care [Group Homes, Group Residences, Agency Operated Boarding Homes (AOBH), or Institutions)]; and
5. Step-Downs, defined as any move between residential care, as defined above, and family-based care, as defined above.

D. Maintenance and Utilization of Electronic Systems of Record

1. Connections (CNNX)

The Provider shall document all processes and activities regarding children/youth and families in their care in CNNX, the New York State electronic system of record. This includes, but is not limited to:

- All case information as detailed in *Children's Services Procedure 108 and Children's Services Bulletin 05-1*;
- Health, Education and Permanency Hearing Report information as detailed in the *CNNX Build 18.9 Procedures No 108/Bulletin No 05.1 and 1008/03*; and
- All system changes and updates detailed in the CNNX Build 18.9 Procedure.

The Provider shall ensure that all relevant staff receives the necessary introductory and ongoing training to ensure knowledge of and proficiency with the CNNX system as well as all pertinent policies and procedures.

2. Legal Tracking System

Providers will have read-only access to the LTS, and shall make use of this capability in this regular course of business. Each Provider shall designate at least one (1) LTS liaison for all LTS-related issues and updates, including permanency hearing reports. The liaison will communicate regularly with designated individuals at Children's Services.

Uses of LTS shall include, but not be limited to, the reviewing of Court orders, hearing outcomes, and attorneys' Court Action Summaries. Additionally managers and supervisors at the Providers are expected to run and review LTS reports about Permanency Hearing (PH) report timeliness and submission rates, and they are expected to use the other management tools available in LTS, such as PH Due Dates Bulletin Boards and Court Calendars. The Provider shall follow all applicable procedures for submitting PH reports from CNNX to the Children's Services attorneys, including uploading of PH draft reports to LTS.

The Provider shall update designated individuals as soon as possible, but no later than each month, regarding changes in assigned Caseworker or other information as listed in LTS. The Provider shall not re-disclose the information contained in LTS to third parties, absent instruction from Children's Services.

3. Child Care Review System (CCRS)

CCRS is a statewide system used to track children in foster care as well as children placed as Persons In Need of Supervision (PINS). Children's Services shall open cases within three (3) business days of placement. Children's Services and the Provider shall mutually strive to keep CCRS accurate and timely at all times. After Children's Services has opened a CCRS case the Provider is required to enter data related to:

- Absence and return to care;
- Inter- and intra agency transfers; and
- Adoption codes.

4. Statewide Service Payment System (SSPS)

SSPS is a statewide payment system used to process payment for children in foster care, children of minor children in foster care, and child(ren)/youth placed as PINS. Providers are expected to:

- Submit an initial request for payment of services for each month by the fifth (5th) business day of the following month, i.e. on February 5th 2008 they would request payment for services provide in January 2008.
- Work with the Children's Services Reconciliation Center and Financial Services staff to reconcile any discrepancies.
- Submit the final request for payment of services for each month by the seventh (7th) business day before the end of the following month, i.e. on February 21, 2008 they would request payment for services provide in January 2008.
- Work with Children's Services Reconciliation Center, Financial Services and program area staff to rectify payments including any overpayments and underpayments, i.e., payments requested but not processed.

E. Reimbursements, Statistical and Fiscal Recording

1. Reimbursement of Special Payments, Other Expenses, Additional Funding Initiatives based on Children's Services' Policies, and the Payment Bulletin.

A. Reimbursement of Expenses

- a. The Provider shall submit all invoices/requests for reimbursement on a form acceptable to Children's Services for Special Payments, expenses related to incentive funding, PYA Funding, Reinvestment Funding and all other expenses outlined in the Payment Bulletin and this Section no later than the deadline for invoices/requests for reimbursement provided in the Payment Bulletin. Any invoice/request for reimbursement which does not comply with Children's Services Policies and is received after the time frame indicated in the Payment Bulletin will be disallowed.
- b. Children's Services' rate of reimbursement to the Provider for any Special Payment and/or expenses listed in the Payment Bulletin shall not exceed the

maximum amount allocable by Law and the Payment Bulletin and the Provider's Special Payment allocation as listed in the Budget.

- c. The Provider shall ensure that all purchases remain within the Provider's Budget.

B. Special Payments

Children's Services shall in accordance with the Law and the *Administration for Children's Services Payment Bulletin FC 07-12* or any amended or succeeding bulletin ("Payment Bulletin") reimburse the Provider for expenses listed specifically in the Payment Bulletin ("Special Payments") to the extent that such expenses comply with their Foster Care Contract Agreement, Children's Services Policies and the Payment Bulletin.

C. Preparing Youth for Adulthood (PYA) Funding

1. General: Children's Services may in Children's Services' sole discretion provide the Provider with funding for the following initiatives: PYA which supports Foster Children in and transitioning from foster care to strengthen the Provider's family foster care program. The Provider shall use this additional funding, if any, in accordance with their Foster Care Agreement, Children's Services Policies and the Law and such additional funding shall be subject to cost allocation.

2. PYA Funding: The Provider shall use PYA Funding to support special services and supports for Foster Children who are ages fourteen (14) years of age and older consistent with their Foster Care Contract Agreement and Children's Services Policies.

3. Children's Services payment/reimbursement to the Provider is subject to the following:

- a. The allocations for PYA funding as they appear in the Budget;
- b. The Provider's submission of the proposed expense to Children's Services and Children's Services advanced approval of the expense; and
- c. The Contractor's timely and appropriate submission of invoices/requests for reimbursement in compliance with Children's Services' Policies including the Payment Bulletin.

2. Cost Allocation

- A. The Provider shall fairly and accurately allocate costs which are attributable to the operation of two or more programs among such programs by a method which represents the benefit of such costs to each program, or a method as set forth in the *New York State Standards of Payment for Foster Care of Children Program Manual*. The Provider shall have a cost allocation plan setting forth such fair and accurate allocation of costs and shall submit its cost allocation plan to Children's Services within thirty (30) days of Children's Services' request. The Provider's cost allocation plan shall be updated annually. Children's Services may withhold any payments to the Provider for allocated costs if submitted later than the date of notice. Upon approval of the revised cost allocation plan, Children's Services shall reimburse the Provider for allowable costs.

B. The Provider shall not receive reimbursement from another funding source, including from the City or another Department of the City, when that particular expense/service is fully covered by Children's Services. Written permission of Children's Services shall not be required where the supplemental funding is intended to improve the efficiency of the foster care service to be provided. The Provider shall be permitted to seek private or public support to augment their services provision and fund the costs of delivering work. If clients are being served by a Provider in a distinctly different program, request for reimbursement for such clients who are simultaneously served in foster care shall not be construed as payment for duplication of contracted services.

C. The Provider shall not submit duplicate costs for reimbursement to separate City, State or Federal agencies. In the event of duplicative billing, Children's Services shall have the right to offset or recoup the duplicative billed amount from the Provider.

D. Where the Provider accepts funding for programs at location(s) under their Foster Care Contract Agreement from non-Children's Services funding sources, or from Children's Services for programs other than the services provided by the Provider pursuant to their Foster Care Contract Agreement the Provider shall:

1. Disclose to Children's Services each of the Provider's additional programs, including those that are privately funded;
2. Establish an allocation methodology that fairly, reasonably, and accurately apportions costs and include that allocation methodology in its cost allocation plan;
3. For each fiscal year, maintain books, records, documents and other evidence, in sufficient detail to support all claims against the Provider's family foster care program, including those that have been made on a cost allocation basis;
4. Make the records available for review by Children's Services or its representative(s) upon reasonable notice and request; and
5. Review allocation percentages on an annual basis and adjust them as necessary to reflect a reasonable cost distribution among programs.

E. Education Expenses

1. Children's Services shall reimburse the Provider their approved reimbursable rate for Tuition for each Foster Child in accordance with Children's Services Policies including the Payment Bulletin and the Law including *Title 18 NYCRR § 427.3* or any amended or successor regulation, and *Education Law § 4004* as amended.

2. Pursuant to *Education Law § 4002* and *Education Law § 4004*, Children's Services shall reimburse the Provider for the reasonable Tuition of a Foster Child attending a New York State Education Department approved private school operated by the Provider or a New York State Education Department approved private non-residential school.

3. In the event the Provider operates a school which provides education services to Foster Children, the Provider's school shall apply for all available State Education Department funds for the children who qualify and shall supply Children's Services with copies of all applications and awards. All funds received shall be deducted from any Tuition costs to the local district.

4. Children's Services payment/reimbursement to the Provider is subject to the following:

a. In compliance with *Title 18 NYCRR § 427.3* or any successor or amended regulation, the Provider's submission of the Foster Child's proposed school placement/service and expense to Children's Services, and Children's Services' approval of the proposed school placement/service and expense; and

b. The Provider's timely and appropriate submission of invoices/requests for reimbursement in compliance with Section 8.04(F) of their Foster Care Contract Agreement entitled "Reimbursement Requirements" and Children's Services Policies including the Payment Bulletin. Any invoice/request for reimbursement which does not comply with the Payment Bulletin and Children's Services Policies and is received after the time frame indicated in the Payment Bulletin will be disallowed.

5. All Children's Services approvals in connection with this Foster Care Quality Assurance Standards and *Title 8 NYCRR § 427.3* or any successor or amended regulation shall remain in effect only for the duration of the academic year in which approval was provided.

6. The Provider, shall, upon written request of Children's Services, report in writing any grants, commitments or funds received by the Provider from any source, governmental or non-governmental. The report shall include a copy of the proposal and budget, if any, upon which the grant, commitment or funding was given and shall be delivered to Children's Services within twenty (20) days from the date of request by Children's Services. The Provider shall also report how it is accounting for such grants and expenditures.

3. Statistical and Fiscal Recording

- The Provider shall maintain and produce reasonable program statistical records as required by Children's Services, and produce program narrative and statistical data at times prescribed by and on forms furnished by Children's Services.
- The Provider shall collect statistical data of a fiscal nature on a regular basis and make fiscal statistical reports at times prescribed by and on forms furnished by Children's Services.

4. Family Court Sanctions

In the event the Family Court imposes a fine or sanction against Children's Services which arises out of an act or failure to act by the Provider, Children's Services may, in its sole discretion, direct the Provider to pay the fine or sanction, in whole or in part, or Children's Services may, in its sole discretion, withhold further payments hereunder for the purpose of set-off in sufficient sums to cover the said fine or sanction.

5. Denial of Reimbursement

A.

1. Expenditures by the Provider for the care and maintenance of a Foster Child, and the administration thereof, shall not be reimbursed in whole or in part by Children's Services in such instances when, by an act or failure to act by the Provider Children's Services has been denied reimbursement by the Federal Department of Health and Human Services pursuant to the Law including Title IV-E of the Social Security Act. Moreover, the City may order the Provider to make repayment, and the Provider herewith agrees to make such repayment, of any monies previously paid as reimbursement under the terms of their Foster Care Contract Agreement for which Children's Services was denied reimbursement by the State and for which such denial of reimbursement was attributable to an act or a failure to act by the Provider.

2. In the event that another provider or providers have cared for the Foster Child during a period of time which is the subject of a denial of reimbursement, Children's Services shall, in its sole discretion, allocate the liability among the Provider and the other provider or providers in accordance with procedures promulgated by Children's Services.

B. Provider Liability: The Provider shall be liable for any denial of reimbursement imposed upon Children's Services by OCFS pursuant to the Law including Title IV-E of the Social Security Act when such denial results from an act or failure to act by the Provider.

F. Financial Audits, Audit Disputes and Resolution

1. Provider's Audit

The Provider shall conduct an annual financial audit performed by an independent CPA. The Provider shall submit the annual audit to Children's Services' Office of Audit, 150 William Street, 10th Floor, New York, New York 10038 along with a copy of all records relating to their Foster Care Contract Agreement within thirty (30) days after the Provider's receipt by the Provider from the CPA, but no later than nine (9) months after the audit period. The audit period shall be for a one (1) year period beginning July 1st. The audit must contain an opinion regarding the Provider's financial statements in conformity with GAAP and shall contain a separate opinion of the adequacy of the Provider's internal controls to safeguard its assets.

2. Audit by Children's Services

A. Children's Services may conduct an audit of the Provider at Children's Services' discretion and the Provider shall fully cooperate with all requests for documentation in accordance with their Foster Care Contract Agreement. If an audit is conducted by Children's

Services, a draft of such audit must be issued within six (6) years and ninety (90) days from the date the Provider submits applicable forms/documentation required by the *New York State Standards of Payment for Foster Care of Children Program Manual* to both OCFS and Children's Services and the final audit shall be issued within ninety (90) days of the Provider's submission to Children's Services of a written response to the draft audit. If the Provider fails to submit to Children's Services a written response to the draft within thirty (30) days of Provider's receipt of the draft audit, the Provider shall be deemed to have accepted the contents of the draft audit. The Provider may request from Children's Services an extension to the thirty (30) day comment period and such extension shall be granted at Children's Services sole discretion and must be in writing.

B. In the event the Provider submits a written response to the draft audit and the Provider's objections are supported by voluminous data or require that the auditors visit the Provider's offices to review its books and record or if the Provider's records are complex in nature, Children's Services may, in its sole discretion, extend the ninety (90) day period in which it shall issue the final audit, by an additional ninety (90) days. Children's Services in its sole discretion may provide for further extensions beyond the ninety (90) days. In any instance where Children's Services is materially prevented from completing a draft or final audit as a result of the conduct of the Provider, the time period during which the Provider's actions (or in-actions) prevented such completion of the draft or final audit, shall not be included, and shall specifically be excluded, for purposes of computing the time periods for issuing the draft or final audit.

C. The Provider shall be afforded an audit exit conference, prior to the issuance of a final audit. At the exit conference the preliminary findings of the auditors shall be made known to the Provider as well as a brief explanation of the basis upon which the auditors have made such preliminary findings. The Provider may be represented at the exit conference by anyone authorized by the Provider to act on its behalf.

D. The fiscal records of the Provider under their Foster Care Contract Agreement shall be examined by Children's Services at such times as Children's Services considers necessary.

E. The performances of Children's Services auditors shall be in accordance with GAAP and only those rules, regulations and procedures in effect at the time of actual expenditure will apply.

3. Children's Services Audit Dispute Resolution

The following subsections establish procedures for resolving disputes arising from a Children's Services audit of the Provider.

1. A copy of the final audit report shall be forwarded to the Provider by Children's Services.

2. Children's Services shall notify the Provider, in writing, within thirty (30) days of Children's Services' acceptance of the final audit of the action Children's Services intends

to take as a result of the final audit, if any, and of the Provider's right to have any of the Provider's audit objections be reviewed by the Children's Services Audit Review and Appeals Panel ("Final Audit Notification").

3. The audit shall be considered final and Children's Services shall take such action as noted in the Final Audit Notification, unless the Provider requests, in writing, within thirty (30) days of receipt of the Final Audit Notification, that the Provider's audit objections be reviewed by the Children's Services Audit Review and Appeals Panel ("Appeal Request"). The Appeal Request must contain all objections and disputes concerning the audit and briefly detail the specific items of the final audit with which the Provider disagrees. The Provider may request a conference ("Appeal Conference") with the Children's Services Audit Review and Appeals Panel in its Appeal Request. The purpose of the Appeal Conference is to give the Provider an opportunity to make an oral presentation and to document its objections to the audit findings, and to give the Audit Review and Appeals Panel an opportunity to clarify any issues.

4. If the Provider fails to request an Appeal Conference in its Appeal Request, the Children's Services Audit Review and Appeals Panel shall make its determination based on the final audit, the Final Audit Notification and the Appeal Request.

5. If the Appeal Request contains a request for an Appeal Conference, the Appeal Conference shall be scheduled within thirty (30) days or as soon thereafter as possible. The Provider will be notified, in writing, of the date and location of the Appeal Conference.

6. At the Appeal Conference the Provider may make an oral and/or written presentation and respond to questions of the Children's Services Audit Review and Appeals Panel. There shall be no post-conference submissions, unless specifically requested by the Children's Services Audit Review and Appeals Panel.

7. The Children's Services Audit Review and Appeals Panel shall make a determination regarding all items originally objected to by the Provider. The Provider shall be advised, in writing, of the Children's Services Audit Review and Appeals Panel's decision. The Children's Services Audit Review and Appeals Panel shall provide a detailed statement of the factual basis underlying its decision regarding any disallowance.

8. The decision of the Children's Services Audit Review and Appeals Panel shall be final and bindings on the parties. The Children's Services Audit Review and Appeals Panel may negotiate settlements regarding Children's Services audits or refer part or the entire audit back to the auditors.

9. The informed review procedure set forth above shall not be deemed to constitute a waiver, by either party, of any and all other rights or remedies at law or pursuant to their Foster Care Contract Agreement.

10. All notices to be provided pursuant to this Article shall be certified mail, return receipt requested.

4. Recoupment

A. When any audit of the Provider discloses overpayments and/or disallowed costs, which were previously made by the City to the Provider, pursuant to any agreement between the Provider and the City including their Foster Care Contract Agreement, Children's Services may, at its option, withhold for purposes of set-off monies due and owing to the Provider. The Provider may propose a re-payment schedule; however such repayment schedule must be submitted to Children's Services within thirty (30) days from the Provider's receipt of Children's Services' notification of such overpayment and/or disallowance. Children's Services in its sole discretion may accept or deny the Provider's proposed repayment schedule.

B. Before Children's Services commences recoupment through set-off, based upon an Children's Services audit pursuant to their Foster Care Contract Agreement, the Provider shall be afforded the opportunity to convene the audit dispute resolution procedure, as more fully described in this Part, and no set-off shall be made until such procedures are completed.

C. If an audit by Children's Services of the Provider conducted pursuant to sub-Section #11 of this part discloses an underpayment by Children's Services, Children's Services, in its discretion, may pay the amount of the underpayment to the Provider or offset the amount to the Provider against amounts owned by the Provider to Children's Services, if any.

PART XI: SPECIALIZED FAMILY FOSTER CARE

In addition to the standards and expectations set forth in these Foster Care Quality Assurance Standards, Specialized Family Foster Care providers must adhere to the following.

Children who have special needs and can best be supported within a Specialized Family Foster home shall be provided such care. The providers of this care shall meet the full range of physical, emotional and psychological needs of these children.

Typically, placements for children in Specialized Family Foster Care (FFC) shall be single placements; however, siblings can be placed together in one home when it is determined to be safe and appropriate to do so. Providers shall carefully assess the capacity of the foster parent, including the availability of supervision, to care for more than one child and the resources available to the foster parent given the potential risk to the second child. After the assessment is made and it is determined that a second child can safely remain or be placed in the home, the Provider shall ensure that adequate support is provided to foster parents. In this circumstance, no more than two (2) children shall be placed or reside in one home.

Recruitment, Training, Certification and Approval

In conjunction with appropriate medical staff, the Provider shall develop and implement child-specific training curricula for foster parents. For children with special needs, the Provider shall:

- provide foster parents and birth parents/caretakers with information on the child's condition and its effect on growth and development;
- provide information on how to access professional evaluations and other community resources through established provider protocol; and
- prepare foster parents for the demands of caring for a child with specialized needs (including need for intensive supervision, emotional stress, concerns expressed by family and neighbors, etc.); and provide foster parents and birth parents/caretakers with training on stress reduction.
- Foster parents must receive training relevant to the psychological and treatment goals of the children in their care.

This orientation and specific supplemental training on caring for children must occur prior to the placement of children in their homes.

Support of Birth Parent/Caretaker and Foster Parents

- prepare foster parents and birth parents/caretakers to address the complex social, medical, and emotional needs of children with these conditions or experiences;

Staff Training and Development

The provider must adhere to all sections under "Staff Training and Development," in addition to the following part listed below.

All staff directly involved in the care and/or management of special needs children must receive ongoing training and education. The training shall be designed to meet the changing and challenging needs of these specialized populations.

Staffing and Staff Qualifications

Whenever, possible Providers shall have casework staff that specializes in the case planning and case management for special needs children.

Staffing Ratios

The preferred caseload ratio for Specialized Family Foster Care programs is 1:12. Providers may offer lower caseload ratios at their discretion.

Family Foster Care and Social Work Services

The Provider shall develop a protocol to ensure close coordination with health and mental health providers caring for this population regarding necessary follow-up, specialty referrals, missed appointments, and other important information.

The Provider shall have access to a clinical expert in each child's special needs area to provide case consultation and advice on program issues.

The Provider shall ensure that its advisory groups have representation of special needs population groups.

The Provider shall identify health and welfare needs and plan to meet the needs of each child.

Monitoring, Evaluation and Quality Improvement

Due to the significant complexity of care of the special needs population, Providers shall ensure reduced caseloads for Caseworkers and other staff responsible for oversight and monitoring to ensure appropriate management including staff to client ratios.

A. Children with Special Medical Needs

Service Populations

Populations with special medical needs include, but are not limited to:

- oxygen-dependent and airway-compromised children;
- children who have undergone tracheotomies;
- children with neural tube defects (spina bifida) and neurodevelopmental disabilities;
- children with significant dysfunctions of major organ systems (e.g., heart, kidney, liver);
- children with diabetes and severe endocrine disorders;
- children with debilitating neurological disorders including progressive encephalopathies (mitochondrial disease) and non-progressive encephalopathies (cerebral palsy);

- children with significant hematological disorders, such as sickle cell disease;
- burn victims, and victims of physical trauma resulting in physical disabilities;
- children who are dependent on devices such as feeding tubes and wheelchairs;
- children who are undergoing chemotherapy and other complex modes of management of serious and/or chronic illnesses; and
- children with HIV and/or AIDS who are on a combination drug therapy, as well as HIV-exposed children whose HIV status is not yet determined. These children often require ongoing medical follow-up, close monitoring, more frequent health visits, and complex medical regimens. They may also have cognitive, behavioral and/or psychiatric issues.
- Children with ophthalmologic/optical conditions leading to loss of vision
- Children with orthopedic conditions resulting from congenital malformations
- Children with otologic/aural conditions leading to loss of hearing.

Family Foster Care and Social Work Services

Within fifteen (15) days of placement, the Provider shall assemble a clinical diagnostic team composed of, but not limited to, a pediatric/adolescent medicine specialist, a child developmental specialist, psychiatrist, psychologist, social workers, and educational, recreational, and vocational specialists to determine the most appropriate categorical/program placement and treatment plan for each child. This comprehensive assessment shall integrate the results of the CANS assessment, if one was done prior to the child's referral, and include an assessment for past trauma and presenting trauma symptoms. The screening shall include a nutritional assessment.

The Provider will ensure that children with special medical needs receive a highly-structured, closely-supervised therapeutic environment. To ensure each child's best interest, the provider shall design a model of integrated service delivery with a special emphasis on coordinating treatment plans with provider staff and linked service providers. Examples include, but are not limited to daily and weekly staff meetings and case conferencing.

Additionally, for all children with special medical needs, the Provider shall:

- ensure access to Homemaking Services for foster parents. The provider shall contract with a neighborhood-based Homemaking program, when possible. If a neighborhood-based Homemaking program is not available, the provider shall contact the NYC Children's Services', Family Support Services.
- refer children who qualify as "medically fragile" to the B2H program and/or other in-home medical programs.
- supply or arrange for home-based speech, occupational, and physical therapy as needed and when ordered and/or approved by the primary care provider.
- have formal referral linkages with at least one of the NY State Department of Health designated HIV specialized care centers in each borough when serving

children with HIV and/or AIDS. The Provider shall be prepared to work with all designated HIV specialized care centers since a child may already have been receiving care at one of the centers prior to placement with the Provider. Given the medical complexities and multiple conditions often diagnosed in children with HIV/AIDS, the Provider shall assume responsibility for developing and expanding its capacity through linkages with other providers and development of protocols for addressing the needs of such children.

- ensure that HIV-infected birth parents have HIV specialists as their primary care providers and are connected to support service networks.

Recruitment, Training, and Certification

Foster parents must receive training relevant to the health conditions of the children in their care, and they must demonstrate competencies in those areas. In conjunction with appropriate medical staff, the Provider shall develop and implement child-specific training curricula for foster parents. For children with special medical needs, the provider shall:

- prepare foster parents and birth parents/caretakers using counseling to address the complex social, medical, and emotional needs of children with these conditions or experiences;
- provide information on services that will be provided directly in the home, both by the Provider and through B2H and other in-home programs, and how to access other community resources through established relationships with health and service providers;
- prepare foster parents and birth parents/caretakers to understand the effects of medication, including risks and side effects, and how to properly and safely administer medication;
- prepare foster parents and birth parents/caretakers to understand and how to properly use medical equipment;
- train foster parents about the child's special medical needs and the skills required for parenting a chronically ill child as health conditions and care needs change, including how to identify signs and symptoms requiring urgent medical attention; and
- provide foster parents with all HIV training prior to placement of HIV-infected children in their home.

Support of Foster Parents and Birth Parent/Caretakers

- provide foster parents and birth parents/caretakers with information on the child's condition and its effect on growth and development; and
- provide information on services that will be provided directly in the home, both by the Provider and through B2H and other in-home programs, and how to access other community resources through established relationships with health and service providers.

Providers are encouraged to support special needs foster care parents with a daily telephone call using a Parent Daily Checklist and to provide weekly foster care parent support groups within the foster parent community.

Staffing and Staff Qualifications

Director of Social Work Services:

MSW or equivalent human services graduate degree and a minimum of three (3) years of documented administrative and supervisory experience in the field of child welfare.

Supervisor of Social Work Services:

MSW or equivalent human services graduate degree, with at least two (2) years documented satisfactory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) years casework experience and 1 year group work experience and/or one (1) year supervisory experience.

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. (May be shared across multiple programs).

Homefinder:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. (May be shared across multiple programs).

Adoption Specialist:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience. (May be shared across multiple programs).

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field. This staff is 'recommended' to help Providers enhance their recreational services.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant experience. This staff is 'recommended' to help Providers enhance their support services.

Foster Parent Advocate:

High school diploma or associate degree in human services with three (3) years foster parent experience. This staff is 'recommended' to help Providers enhance their support services.

Nurse:

New York State-Registered Nurse or Licensed Practical Nurse.

Consultants

Providers may utilize consultants that include, but are not limited to:

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Mental Health Clinician/Social Worker:

LCSW or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Dietician:

Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided. These staff may be shared across multiple programs.

Staffing and Staff Qualification shall be in accordance with *Title 18 NYCRR Part 442.18* or any successor or amended regulation.

B. Children who have Mental Retardation and/or Developmental Disabilities

In addition to the standards and expectations set forth in these Family Foster Care section, providers of this specialized service must adhere to the following standards:

Specialized Family Foster Care MR/DD Programs shall be used for children/youth are mentally retarded, are developmentally disabled, or have an Autism Spectrum Disorder and can best be supported within a specialized family foster care home. The Providers of this care shall meet the full range of physical, emotional, and psychological needs of these children.

The Provider shall assume direct service capacity and also expand its capacity through linkages with other organizations including those described in subsequent sections, in order to address the children's special and complex needs, including additional health and/or mental health conditions that may manifest themselves only after initial placement.

Service Population

Populations with developmental disability needs include, but are not limited to children/youth:

- who are severely neurologically impaired
- with severe behavioral disorders
- with severe learning disabilities
- who have an Autism Spectrum Disorder
- who have mental retardation with an IQ of 70 or below or the functional equivalent
- with cerebral palsy
- with Down Syndrome
- with severe neuromuscular disorders
- with a coexisting psychiatric diagnosis

The goals of this program are for children/youth are mentally retarded or severe developmental disabilities to make progress in seven (7) functional areas, to the extent possible:

- self care
- self direction
- adult living
- learning
- receptive and expressive language
- mobility
- economic self-sufficiency

Family Foster Care and Social Work Services

Providers shall adhere to all sections of these Foster Care Quality Assurance Standards in addition to the following:

Working with the children's health service providers, the Provider shall conduct periodic assessments of each child's treatment plan and make adjustments as necessary to ensure that the child is receiving proper and appropriate services based on the child's needs and changing conditions. The Provider shall ensure that social work staff conducts formal case conferences every three (3) months; the case conferences shall include the foster parent, birth parent/caretaker, and health providers, as appropriate, as well as any other service provider (physical therapist, educational staff, etc.). The Provider shall engage pertinent medical, developmental or mental health providers in case planning for the child.

Providers serving children who have mental retardation, are developmentally disabled, or have an Autism Spectrum Disorder shall have formal referral linkages with at least one of the NYS OPWDD specialized care centers (Article 16 clinics) in each borough. The Provider shall be prepared to work with all NYS-designated OPWDD specialized care centers since a child may have already been receiving care at one of the centers prior to placement with the Provider.

The following services and supports shall be made available for children in this program as well as for their foster and birth parents/caretakers:

- The Provider shall ensure access to Respite Care Services to foster parents. In the event that the foster parent is not receiving respite through the B2H, the Provider shall arrange appropriate Respite Care or a back-up foster parent who is trained and certified to provide adequate care in the event that a foster parent becomes unavailable to care for a child. To ensure continuity of care, the provider shall assure that the respite or temporary back-up foster parent (fully certified and trained to care for children with the same type of special need) is informed prior to assignment about the child's history and current medical status (including treatment, medication, healthcare provider, etc.). The provider shall contract with a neighborhood-based Respite Care program, when possible.
- The Provider shall ensure access to Homemaking Services for foster parents. The Provider shall contract with a neighborhood-based Homemaking program, when possible. If a neighborhood-based Homemaking program is not available, the Provider shall contact the Children's Services', Division of Family Support Services.
- The Provider shall ensure that each child receives a proper education, including referrals to Early Intervention programs, Preschool Special Education programs, or Specialized Day Treatment/Vocational services. The Provider shall actively participate in the child's education, so that all those involved in the child's life may review the child's work and school performance and make efforts to ensure that a child's special educational needs are planned for and met. Those participants in a child's life include, but are not limited to social workers, foster parents, Child Care Workers, and birth parents/caretakers.

- The Provider shall supply or arrange for home-based speech, occupational, and physical therapy as needed and when ordered by the primary care provider.
- The Provider shall ensure that foster and birth parents/caretakers of children who have mental retardation are developmentally disabled or have an Autism Spectrum Disorder have MR/DD specialists as their child(ren)/youth's primary care providers and are connected to parent advocacy and education programs, and other support service networks.
- Children/Youth, who are mentally retarded, developmentally disabled or have an Autism Spectrum Disorder, and their siblings as appropriate, shall be provided with on-going counseling to help them cope with living with their conditions. All children shall be assessed for past trauma and presenting trauma symptoms; children who have experienced trauma and/or loss shall receive individual counseling focusing on re-establishing physical and emotional safety, and group work sessions that promote a trauma-informed and safety-focused environment, in a manner that is developmentally appropriate.
- The Provider shall provide instruction to children who are mentally retarded, are developmentally disabled, or have an Autism Spectrum Disorder, and their foster parents with additional health care and personal hygiene information specific to their developmental disability status, including but not limited to:
 - education about their condition and its various effects;
 - the importance of keeping scheduled medical appointments and complying with their medical regimen; and
 - information relevant to their child's particular medicine and its effects and side effects or the use of medical equipment and other devices necessary for the treatment and maintenance of their condition.

Discharge Planning and Transitional Services

The Provider shall assure that the post-discharge caretaker is fully trained in the care of the child with special needs so that the child's health will not be compromised by discharge. The training curriculum for a post-discharge caretaker shall be the same as that provided for a foster parent. Discharge planning shall be done in conjunction with the child's health care and other service providers, such as B2H Health Care Integration Agencies. Whenever possible, the child shall keep the same health providers upon discharge.

Children shall be assessed for the need for Residential Care or any aftercare program as a goal after discharge from foster care. This assessment shall occur upon admission to the foster care program, and regularly thereafter to ensure a continuum of service that the family/child can rely on after discharge. Indicated referrals to MR/DD shall be made as soon as a need is identified. Such referrals shall be made based on the child's clinical needs, not simply the permanency plan (which may or may not be "Adult Residential Care").

Recruitment, Training, and Certification

Providers shall adhere to all sections of these Foster Care Quality Assurance Standards in addition to the following:

- where applicable provide the foster parents with training on how to prepare special diets and nutritional aspects of the management of the special MR/DD condition in children

For children who are mentally retarded, are developmentally disabled or have an Autism Spectrum Disorder, the Provider shall:

- educate foster parents and birth parents/caretakers to understand the effects of medication, including risks and side effects, and how to properly and safely administer medication;
- provide information to foster parents and biological parents on services that will be provided directly in the home, both by the Provider and through B2H and other in-home programs, and how to access other community resources through established relationships with MR/DD and other service providers;
- train foster parents and birth parents/caretakers about the child's special medical needs and the skills required for parenting a child with MR/DD, including how to identify signs and symptoms requiring medical attention, as health conditions and care needs change; and
- provide foster parents and birth parents/caretakers with all MR/DD training prior to placement/return of a developmentally disabled child(ren)/youth into their home. Foster parents must show competency in caring for children who are mentally retarded, developmentally disabled, or have an Autism Spectrum Disorder by demonstrating a full understanding of the contents of the training through completing post-training assessments.

Support of Foster Parents and Birth Parent/Caretaker

- prepare foster parents for the demands of caring for an MR/DD child;

The Provider shall establish a protocol for immediate re-placement of the child with another foster parent shall his/her foster parents not meet the recertification requirements. The Provider shall make every effort to assure that foster parents have adequate opportunities to receive training.

Monitoring, Evaluation and Quality Improvement

Providers shall adhere to all sections of these Foster Care Quality Assurance Standards in addition to the following:

- The Provider shall have a quality assurance plan in place describing how they shall provide quality assurance, planning and program evaluation for the care of OPWDD children placed in their care.

Involvement of Birth Parents/Caretaker in the Provision of Foster Care Services

Providers shall encourage involvement of birth parents and child care staff in service delivery to MR/DD population and document their efforts. Providers shall assure that the birth parent or other primary caretaker is trained in applicable special needs curriculum and is involved in the planning for the child.

Staffing and Staff Qualifications

Director of Social Work Services:

MSW or equivalent human services graduate degree and a minimum of three (3) years of documented administrative and supervisory experience in the field of child welfare.

Supervisor of Social Work Services:

MSW or equivalent human services graduate degree, with at least two (2) years documented satisfactory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) year casework experience and one (1) year group work experience and/or one (1) year supervisory experience.

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. This staff may be shared across multiple programs.

Homefinder:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. This staff may be shared across multiple programs.

Adoption Specialist:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience. This staff may be shared across multiple programs.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent

in the field. This staff is 'recommended' to help Providers enhance their recreational services.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant experience. This staff is 'recommended' to help Providers enhance their support services.

Foster Parent Advocate:

High school diploma or associate degree in human services with three (3) years foster parent experience. This staff is 'recommended' to help Providers enhance their support services.

Clinical Staff

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Nurse:

New York State-registered professional nurse or licensed practical nurse.

Staffing and staff qualification shall be in accordance with Title 18 NYCRR Part 442.18 or any successor or amended regulation.

C. Children who have been Sexually Exploited

In addition to standards and expectations set forth in these Foster Care Quality Assurance Standards, Family Foster Care Providers must adhere to the following.

Children who have been sexually exploited shall receive special treatment services in a highly structured home setting whenever it is safe to do so. The goals of this program are to reduce trauma and maximize the child's recovery.

Service Populations

Children/youth who have been sexually exploited include but are not limited to:

- Children/youth who have been victimized for the advancement of sexual gratification or profit: for example, prostituting a child, creating or trafficking in child pornography, presentation of unsolicited obscene material, online enticement to promote sexual acts, victims of sexual grooming, and children who have been sexually assaulted and/or molested, including by a family member.
- Children/youth whose mental health issues, mental retardation, and/or developmental delays made them at higher risk for the abuse they experienced and/or have been exacerbated because of their abuse.

Family Foster Care and Social Work Services

Within fifteen (15) days of placement, the Provider shall assemble a clinical diagnostic team composed of, but not limited to, a pediatric/adolescent medicine specialist, a developmental specialist, psychiatrist, psychologist, social workers, and educational, recreational, and vocational specialists to determine assessment shall integrate the results of the CANS assessment done prior to the child(ren)/youth's referral to Specialized FFC, and include an assessment for past trauma (including incest and other sexual abuse) and presenting trauma symptoms. To serve the specialized population of children who have been sexually exploited, the Provider must design and provide a highly structured, safe, therapeutic environment. Intensive psychological and psychiatric services must be available on a regular basis through provider staff. Individual, group, and family counseling must be provided to address the trauma and psychological needs of the child and other family members.

The service plan for each child(ren)/youth shall ensure the safety of all children/youth in the home/sibling group and address the possibility of the child(ren)/youth victimizing other child(ren)/youth who are in the home or known to him/her. The program shall also protect against risk posed by ongoing contact with the person/people who were exploiting the child(ren)/youth. Proper safety measures shall be in place to reduce risk to the greatest extent possible. The Provider must design structured therapeutic recreational events.

Discharge Planning and Transitional Services

Prior to discharge it must be assessed if the abuser/trafficker continues to pose a risk to the minor children/youth in the home or community the child is to be discharged to.

The Provider shall ensure that the post-discharge caretaker is fully trained in the care of sexually exploited children/youth. The training curriculum for a post-discharge caretaker shall be the same as that provided for a foster parent. Discharge planning shall be done in conjunction with the child(ren)/youth's mental health providers. Whenever possible, the child(ren)/youth shall maintain the same mental health and/or chemical dependency treatment providers upon discharge in as much as it is possible. Services to children/youth should be based in the community where they are being returned.

Children shall be assessed and linked with aftercare services prior to discharge from foster care. This assessment shall begin upon admission to the foster care program, and be revisited regularly thereafter to ensure a continuum of service that the family/child can rely on after discharge.

Indicated referrals to an aftercare rehabilitative program shall be made as soon as a need is identified. Such referrals shall be made based on the child(ren)/youth's clinical needs, not simply the permanency plan.

Training

Providers shall adhere to all sections of these Foster Care Quality Assurance Standards in addition to the following:

- foster parents must receive general training through the Provider to help them meet the needs of sexually exploited children and understand the expectations of the Provider. In addition to the required general foster parent training, the Provider shall provide supplementary training of specialized foster parents. Foster parents must receive all orientation and specific supplemental training on caring for children with special needs prior to placement of such children in their homes.

For children who have been sexually exploited the provider shall:

- Train foster parents about the child's special needs and the skills required for parenting a sexually exploited child including how to identify signs and address the child's behavioral triggers and signs that they may be contemplating or engaging sexual exploitation activity.
- Ensure that birth parents/caretakers are trained in applicable treatment curricula, similar to that used to train foster parents.
- Provide foster parents with all training prior to placement of a sexually exploited child in their home.

The training shall consist of the following:

1. Modality of treatment to be utilized;
2. Special training in treating child sexual abuse and exploitation and sexual trauma and recovery;
3. Exiting street life, barriers to leaving and detecting ongoing abuse;
4. Addressing cultural context of prostitution and trafficking culture;
5. Gang awareness and involvement;
6. Working with and preventing running away;
7. Crisis intervention, mediation, conflict resolution and relationship building;
8. Team approach to work towards reunification with birth family/caretaker, or foster family;
9. Behavior management system; and
10. Sensitivity training.

NB: All staff and foster parents shall be thoroughly knowledgeable about the behavior management system.

Recertification

Provider shall annually re-certify foster parents contingent upon the guidelines articulated in *Part II, Section D* of these *Foster Care Quality Assurance Standards*, and the following:

- Foster parents must show competency in caring youth who have sexually exploited demonstrating a full understanding of the contents of the training by completing post-training assessments.
- The demands of being a foster parent for sexually exploited youth.

Support of Foster Parents and Birth Parents/Caretakers:

The Provider shall assure that all non-offending birth parents and primary caretakers are also trained in an applicable special treatment curriculum for children who have been sexually exploited, similar to that used to train foster parents and is involved in the planning for the child.

Involvement of Birth Parents/Caretakers in Service Delivery

Providers shall encourage involvement of birth parents/caretakers in service delivery to sexually exploited youth. Training and support for birth parents/caretakers shall also address the impact of their child(ren)/youth's behavior on their family and ensure that the birth parent/caretaker fully understands how past abuse may impact to his/her current behavior.

Staffing and Staff Qualifications

Director of Social Work Services:

MSW or equivalent human services graduate degree and a minimum of three (3) years of documented administrative and supervisory experience in the field of child welfare.

Supervisor of Social Work Services:

MSW or equivalent human services graduate degree, with at least two (2) years documented satisfactory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/Licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) years casework experience and one (1) year group work experience and/or one (1) year supervisory experience.

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. This staff may be shared across multiple programs.

Homefinder:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. This staff may be shared across multiple programs.

Adoption Specialist:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience. This staff may be shared across multiple programs.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field. This staff is 'recommended' to help Providers enhance their recreational services.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

CASAC:

Bachelor-level CASAC.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience. This staff is 'recommended' to help Providers enhance their support services.

Foster Parent Advocate:

High school diploma or associate degree in human services with three (3) years foster parent experience. This staff is 'recommended' to help Providers enhance their support services.

Clinical Staff

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Nurse:

New York State-registered professional nurse or licensed practical nurse.

Staffing and staff qualification shall be in accordance with Title 18 NYCRR Part 442.18 or any successor or amended regulations.

D. Treatment Family Foster Care for Children with Moderate to Severe Emotional Disorders

In addition to the standards and expectations set forth in these Foster Care Quality Assurance Standards providers must adhere to the following standards:

Service Population

The Treatment Family Foster Care program will serve children/youth [up to twenty-one (21) years of age] who have moderate to severe emotional disorders and who can be supported within family settings. Children in the program shall receive special treatment services in a closely supervised, highly structured setting. The Provider of such care shall meet the full range of each child's physical, emotional, and psychological needs. Children will be referred to TFFC under the following circumstances:

- When a child(ren)/youth coming into foster care presents with serious behavioral or emotional disturbances that call for a placement with structured treatment and support, and birth parents require training to help them successfully manage the child(ren)/youth's behavior and enable the child to return home quickly with appropriate support services; or,
- When a provider has already tried a number of approaches to provide wrap-around services to a child(ren)/youth in family foster care without success.

The goals of this program are to support children/youth by providing the treatment and supports they need, and to help them to decrease problem behavior and increase developmentally appropriate and adaptive gains, while emphasizing the personal and social effects on behavior.

1. The Provider shall provide case planning and treatment services necessary to meet the emotional needs of this population in a manner that maximizes their chances for reunification or adoption. In instances where these options are not possible, children/youth shall be provided with skills necessary to develop close relationships with supportive friends and adults and live healthy, productive and self-sufficient adult lives in accordance with Children's Services mission.
2. The Provider shall have linkages with community service providers that can meet the full range of care needed by each child in a comprehensive, accessible, high quality, and child friendly way. This can be demonstrated through service provider contracts or formal service agreements, 'Letters of Agreement.'
3. The Provider can recommend or determine through a Family Team Conference (FTC) to place additional children with special needs in a TFFC home. Before placing a second child in the home (regardless of their level of need), programs must first assess

the capacity of the foster parent, family composition and support systems available. Given the complexity of children with severe emotional disorder, adequate assurance shall be provided by the provider for any placements of more than two children with special needs in one foster home.

Family Foster Care and Social Work Services

The Provider shall provide child welfare services that ensures each child(ren)/youth's safety, supports each child(ren)/youth's optimal health, development and well being. The Provider shall be strongly focused on addressing and promoting the best interests of each child with a moderate to severe emotional disorder.

The Provider shall conduct a comprehensive assessment upon intake which shall integrate the results of the CANS assessment done prior to the child(ren)/youth's referral to Specialized TFFC, and include an assessment of past trauma. The screening shall include a substance abuse assessment and nutritional assessment as indicated by the child(ren)/youth's health-related needs.

The treatment plan shall include an assessment of whether the child shall be referred to the B2H Waiver Program, or home-based programs within the mental health system. All children judged to be eligible for B2H shall be referred unless there is a documented reason not to do so. Since the goals of TFFC are similar to B2H, to avoid duplication of services, the provider must submit all Individualized Health Plan (IHP) requests to ACS for review and approval to ensure that all services requested by B2H are not already being provided through TFFC, as outlined in these TFFC Standards.

The Provider shall engage medical or mental health providers in case planning for the child(ren)/youth. The Provider shall design a structured individualized treatment plan for each child(ren)/youth with input from the treatment team that is implemented by the foster parents. The structured program builds on the child(ren)/youth's strengths and recognizes his/her trauma history and potential triggers. By setting rules, boundaries and safety plans that serve to manage behavior and maintain safety for the child and all household members. All staff shall be thoroughly knowledgeable about the individualized treatment and safety plans.

The team shall meet weekly to review progress on each child(ren)/youth, review regular behavioral information collected, and adjust the child(ren)/youth's individualized treatment plan.

Treatment Family Foster Care must maintain an appropriate level of contact to ensure the child's needs are being met, case planning is moving forward, and parents and youth are being adequately supported. The Treatment Family Foster Care intervention must include the following key program components:

- a. weekly individual, family or group therapy for the child as indicated by psychological assessment, and/or weekly sessions for the child and his/her biological parent(s) or permanency resource;
- b. skills training/behavior management and therapy for children and youth, including at least one weekly visit to the foster home by a skills trainer or behavior specialist to help reinforce the behavior program;

- c. parent training for birth parents/caretakers to help them in dealing effectively with youth with moderate to severe emotional disorders (or other aftercare resources);
- d. behavior management training and support for treatment foster parents, including: bi-weekly support groups that focus specifically on the needs of the child in their home; regular phone contact at least weekly to check on a child and his/her behavior plan, offer advice and flag potential serious issues that need attention; and on-call support available twenty-four (24) hours, seven (7) days a week;
- e. psychiatric consultation and medication management, if necessary; and
- f. service and discharge planning that include referral to New York State Office of Child and Family Services, Bridges to Health B2H services, special education, day treatment, and therapeutic extracurricular programs.

The Provider shall access health, mental health and substance abuse services that meet the full range of care (specialty, sub-specialty, ancillary, and hospital services) needed by each child(ren)/youth in a comprehensive, accessible, high quality, child-focused/friendly way.

Support for Foster Parents and Birth Parents/Caretakers

1. The Provider shall provide support groups for birth parents/caretakers, foster parents and children in Treatment Family Foster Care.
2. The Provider shall arrange appropriate respite care or a back-up foster parent is certified and trained to provide adequate care in the event that the foster parent becomes unavailable to care for a child(ren)/youth on either a planned or emergency basis. To ensure continuity of care, the Provider shall assure that the respite or back-up foster parent is informed about the child's history and current mental health status (including treatment, medication, etc.) prior to placement.
3. The Provider shall encourage involvement of birth parents or other primary resource in service delivery to this population. The Provider shall assure that birth parent or other primary resource is trained in applicable special needs curriculum and is involved in the planning for the child(ren)/youth.
4. Collaborative work with birth parent/foster parent and or primary resource will be encouraged. Efforts to engage the child(ren)/youth's birth parents/caretakers should be fully documented in the child(ren)/youth's record.

Discharge Planning and Transitional Services

The Provider shall conduct a pre-discharge conference with service providers including the discharge birth parents/primary resource and child(ren)/youth ten (10) years old and older. The Provider shall ensure that the post-discharge caretaker is fully trained in the care of the children with moderate to severe emotional disorders. Birth families/Caretakers shall learn to use the same behavior management system used in the Treatment Family Foster Care home to prepare for the child(ren)/youth's safe and expeditious return home.

Discharge planning shall be done in conjunction with the child(ren)/youth's mental health and health providers. Whenever possible, the child(ren)/youth shall keep the same mental health and health providers upon discharge.

To ensure continuity of in-home and community supports that address the child(ren)/youth's ongoing needs, services such as the B2H Waiver Program or in-home mental health services provided through the New York State OMH shall be arranged prior to discharge, as appropriate. Special emphasis shall be placed on ensuring a continuum of service.

Recruitment and Training

Treatment Foster Parents shall be recruited, receive specialized training, and show competency in caring for this population by demonstrating understanding on contents of the training through completing post-training assessments. In addition, the foster parent shall be supported to become part of the treatment team and to work intensively with a child(ren)/youth's birth parents or permanency resource. In the event that there is not an identified permanency resource for the child(ren)/youth, permanency should be emphasized in the Treatment Foster Parent training and retraining; and a permanent connection to the child(ren)/youth should be strongly encouraged.

The Provider shall provide a minimum of twelve (12) hours of additional training for foster parents caring for children/youth with moderate to severe emotional disorders, including training that addresses trauma and its manifestations; trauma-informed approaches to addressing challenging behaviors; psychotropic medication and the role of the foster parent in managing and administering it and recognizing side effects, chemical dependency/use and crisis stabilization.

The Provider shall establish a protocol for immediate re-placement of the child with another foster parent shall his/her foster parents not meet the recertification requirements.

Provider shall maintain records of individuals seeking services in addition to what is being offered by the provider.

The Provider shall document all referral information, including children who are and are not referred for B2H services.

Matching

The Provider shall make diligent efforts to identify the most appropriate Treatment Family Foster care home for each foster child/youth. Matching is the process used to identify the most appropriate foster home for the identified child(ren)/youth, and is to be conducted in a manner that will foster positive outcomes and avoid frequent placement disruptions and/or changes in placement. Children should be matched with a Treatment Foster Parent (TFP) who has the skills and family structure to best support the child(ren)/youth. OPA is to be used to facilitate the linkage between the referral Provider and the receiving Provider.

All Treatment Foster Care providers shall participate in the Referral and Matching process. Providers shall arrange a pre-placement visit between each child(ren)/youth and the prospective foster parent to determine whether the foster parent and the foster child are an appropriate match. Additional visits, including a face- to-face interview, day and overnight visits should occur if deemed necessary. Final placement decision is made based on the responses of the foster child /youth and the foster family.

Staffing and Staff Qualifications

Director of Social Work Services:

MSW or equivalent human services graduate degree and a minimum of three (3) years of documented administrative and supervisory experience in the field of child welfare.

Supervisor of Social Work Services:

MSW or equivalent human services graduate degree, with at least two (2) years documented satisfactory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/Licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two 2 years casework experience and 1 year group work experience and/or 1 year supervisory experience.

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. This staff may be shared across multiple programs.

Homefinder:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. This staff may be shared across multiple programs.

Adoption Specialist:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience. This staff may be shared across multiple programs.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field. This staff is recommended to help Providers enhance their recreational services.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Socio-Therapist/Behavior Specialist:

BA or AA degree with two years experience working with children and families, or a high school diploma with five (5) years experience working with children and families.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience. This staff is recommended to help Providers enhance their support services.

Foster Parent Advocate:

High school diploma or associate degree in human services with three 3 years foster parent experience. This staff is recommended to help Providers enhance their support services.

Clinical Staff

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Nurse:

New York State-registered professional nurse or licensed practical nurse.

Staffing and staff qualification shall be in accordance with Title 18 NYCRR Part 442.18 or any successor or amended regulations.

E. Rapid Intervention Teams

The purpose of the Rapid Intervention Teams (RIT) is to provide immediate crisis intervention services to Children's Services' approved/licensed foster homes (and/or residential care programs in limited circumstances) when emotional or behavioral crises involving a child(ren)/youth in care threaten to disrupt the current living situation.

The Provider develops service objectives and interventions that:

- a. reduce "step-ups" that remove the child from family foster care and/or residential care and place the child(ren)/youth in more restrictive systems of care, including residential foster care or programs run by other systems;

- b. reduce "lateral" moves between foster homes that cause repeated attachment and service disruptions for the child(ren)/youth, and can prolong length of time in foster care; and/or
- c. avoid referrals to an emergency room where progress in obtaining services may stall if children/youth do not meet the criteria for admission; and provide an enhanced family foster care service so that foster parents are better able to meet the needs of children/youth in their care and timelier permanency is achieved.

It is expected that RIT services/interventions would not exceed 60 days.

Service Population

The RIT shall provide services to family foster care including kinship foster care parents (and/or residential care programs in limited circumstances) on a borough-wide basis. It shall be available to respond to situations in which emotional or behavioral crisis involving a child(ren)/youth in family foster care and/or residential care threaten to disrupt the current living situation.

Family Foster Care, Residential and Social Work Services

An FTC shall be scheduled before RIT services can be initiated. The FTC team will determine the RIT need of the child/family if no other options are available. When planning for that FTC, the referring Provider shall adhere to guidance in the Foster Care Quality Assurance Standards, *Part III, Section: D-4(i) 'Permanency Placement Conferences' or, Section: D-5(c) for 'Follow-up CSC (20-day conference)'* if the initial CSC has already taken place in DCP.

The RIT shall establish a protocol for immediate response to a request from a Provider for their intervention and service. RIT services shall be accessed by each referring Provider foster care program when foster care or kinship parent(s) face an escalating situation that threatens stability of placement. The referring Provider staff making the referral shall have some knowledge of the case and its permanency plan; shall assess the situation and then call the RIT. The same process shall be done when a residential care program is the referring Provider.

RIT staff shall visit the home (or facility in limited circumstances) immediately and/or within twenty-four (24) hours of the receipt of referral to assess and stabilize the situation, unless the situation requires an immediate response as determined by the Provider in accordance with Children's Services Policies in which case the Contractor shall respond accordingly. The RIT staff shall make a telephone call to the referring Provider or Children's Services immediately to acknowledge the receipt of the request for services and to provide a timeframe of response.

1. (a) In a foster home setting the RIT will do the following:
Provide brief trauma-informed counseling to the foster parent and/or child(ren)/youth to stabilize the child(ren)'s and family's situation and to determine next steps to be taken.
- (b) In a residential care setting (in limited circumstances) the same pattern is followed as with the foster home. In this case, the interventions are done with the social services/child care staff and the child(ren)/youth.
2. An assessment of safety and risk shall be part of this initial visit and all subsequent visits and contacts. There are three possible outcomes of a RIT team visit:
 - the child(ren)/youth can safely remain in the home/facility, although the problems are serious enough to warrant short-term, intensive home-based services from the RIT working in partnership with the referring Provider;
 - the child(ren)/youth can safely remain in the home/facility, and the problems are at a level such that responsibility for managing their situation can be given to the referring Provider; and
 - as a last resort and when the child(ren)/youth cannot safely remain in the home/facility and the RIT shall work with the referring Provider if needed, to determine an alternate placement.

Role of Referring Provider

If the child(ren)/youth's behavior has escalated to the degree where involvement of the RIT becomes necessary before the initial FTC; the referring provider shall seek to schedule a follow-up FTC by the twentieth (20th) day of placement to inform the decision for needed services and

define the goals and services that the RIT will provide to the youth while in this setting. This conference shall be inclusive of all appropriate Children's Services staff, the referring Provider, the RIT team, foster parents and birth family/caretaker. The conference shall follow the guidelines articulated in *Part III, Section D* of these Foster Care Quality Assurance Standards.

Crisis Intervention Services

RIT criteria for identifying the problem:

- Physiological-How the child/caretaker/family functions
- Behavioral-How the child/caretaker/family acts
- Psychological-How the child/caretaker/family feels
- Relationship-The actions or reactions of a child or caretaker/family in specific situations in the environment.

The outcomes and criteria reflected above may also be used to establish an immediate functional emergency services plan for the child/family. This emergency services plan is designed to meet the needs of children/family experiencing acute emotional, behavioral, social, and/or family problems occurring within the home. This plan does not replace the FASP but may cause a modification of any future service plan.

The referring Provider shall be discouraged from arbitrarily disrupting foster home or residential care placements unless the child(ren)/youth's behavior or the relationship with the foster family is detrimental to the child(ren)/youth's health and safety and to achieving the permanency plan. If a caretaker and/or child are unable or unwilling to make the required changes, it is appropriate to consider an alternate placement.

The RIT is expected to set up protocols for communicating information to and/or obtaining information from both caretakers and referring Provider about children in a timely manner. The following are some areas that may be covered.

Whenever a child is a disturbance in the home or at risk, immediate action is needed. Problems shall be identified, addressed, and corrected within specific time frames as soon as possible.

Staffing and Staff Qualifications

Director of Social Work Services:

MSW or equivalent human services graduate degree and a minimum of three (3) years of documented administrative and supervisory experience in the field of child welfare.

Supervisor of Social Work Services:

MSW or equivalent human services graduate degree, with at least two (2) years documented satisfactory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/Licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience. This staff may be shared across multiple programs.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Clinical Staff

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Nurse:

New York State - Registered Nurse or Licensed Practical Nurse.

Staffing and staff qualification shall be in accordance with *Title 18 NYCRR Part 442.18* or any successor or amended regulations.

The Provider shall adhere to all relevant sections in the Foster Care Quality Assurance Standards. However, due to the intensive/therapeutic services that are to be provided, enhanced staffing (education, experience, number of staff) will be necessary.

Staffing Ratio

Due to the significant complexity of care of this special needs population, Providers must ensure that Caseworkers and other direct care staff shall carry reduced caseloads to ensure appropriate oversight. Providers shall provide specialized training to staff to help support foster parents in the care of special needs children.

Staff Training and Development:

The Provider shall adhere to all sections in these Foster Care Quality Assurance Standards.

PART XII: RESIDENTIAL CARE AND SPECIALIZED RESIDENTIAL CARE

It is expected that the residential and specialized residential programs shall offer high-level and intensive clinical services in a community or institution setting. Residential care facilities will only be utilized for child(ren)/youth whose current clinical, medical, or other needs cannot be safely and adequately met in a family setting. These may include but are not limited to children/youth who require around-the-clock services and supervision because they:

- i are in crisis;
- ii have severe emotional or behavioral problems and conditions that cannot be addressed in a family setting using community-based services;
- iii have serious substance abuse problems that cannot be addressed within a family or community setting;
- iv have medical needs or an inability to perform activities of daily living and or
- v are gang-involved, have histories of sexual acting out behavior, or have been sexually exploited and require placement outside of the community for these or other safety reasons.

All residential care programs shall be designed in a way that child(ren)/youth live with others in their age group, gender and/or developmental stage, such as child(ren)/youth who are twelve to fourteen (12-14), fifteen to seventeen (15-17), and eighteen to twenty-one (18-21) years of age. (Note that Children's Services is seeking to avoid the placement of children twelve (12) years old and under in residential settings unless absolutely necessary to meet their clinical and /or other needs.) All programs, unless designated for a specialized population with developmental delays, shall have the capability to serve child(ren)/youth with IQs of seventy-one (71) and above, and they shall be able to accept child(ren)/youth with lower IQs, on a case-by-case basis, where low scores are due to mental health conditions.

A. Residential Care Treatment and Social Work Services

Key Components and Approaches

1. The Provider shall ensure that placement and supportive services are in place and available to promote timely reunification between Foster Children and their families, while ensuring safe and stable foster care experiences for Foster Children in settings that are as familial and least restrictive as possible consistent with the needs of the child/youth. Children's Services shall share with the Provider as soon as possible any current assessment of the child/youth's needs and any identified safety issues.
2. Children's Services shall provide the Provider with all available relevant information regarding the needs of the child/youth and family for children/youth referred to the Provider.
3. The Provider shall operate according to the following principals and practices in efforts to maximize and improve safety, permanency and well-being for Foster Children:

- Minimized periods of time spent in foster care and timely permanency through family reunification or adoption according to the strengths and needs of each Foster Child/youth and his/her family.
- Placement stability that minimizes the occurrence of replacements and relocations and provides consistency in care throughout the time that Foster Children remain in care.
- In the event a Foster Child/youth is removed from family foster care to residential care, the Provider shall make efforts to minimize the length of time spent in residential care, returning the Foster Child/youth to a family setting as soon as possible consistent with the needs and behaviors of the child as determined at the FTC.
- Except where otherwise indicated for the safety and well-being of a Foster Child/youth, the Provider shall make efforts to place Foster Children in a Residential Care Facility that is in the same community in which their birth parents/caretaker resides.
- Ensure safety from abuse and neglect while in foster care.
- Implement discharge planning and services to avoid the need for re-entry of a Foster Child/youth into foster care after discharge.
- Implement services and support for Foster Children to develop to their fullest potential and become healthy, educated, and constructive members of the community with successful transitions to adulthood.
- Create and foster permanent adult connections for all Foster Children, including older Foster Children, when they leave foster care.

1. Treatment Planning

The Provider shall design a model of integrated practice with a special emphasis on coordinating treatment plans between Provider staff (including on-site clinical staff) and other community service providers. The Service Plan will include the full range of health and mental health services, extensive social services, and individually modified, structured, and appropriate recreational activities. All child(ren)/youth shall be assessed for past trauma and presenting trauma symptoms. Child(ren)/youth who have experienced trauma and/or loss shall receive individual counseling focusing on re-establishing physical and emotional safety, and group work sessions that promote a trauma-informed and safety-focused environment. The Provider shall design a comprehensive behavior management system to monitor the child(ren)/youth and record their level of progress. All Provider staff shall be thoroughly knowledgeable about the behavior management system. Child(ren)/youth who are in eligible settings (i.e., residences of twelve (12) or fewer beds) and meet the eligibility criteria for the "Bridges to Health" (B2H) Waiver Program shall be referred to that program. The Provider shall ensure that transportation services are readily available to transport each child(ren)/youth to the hospital, medical and mental health appointments and other sub-specialty providers as needed.

All staff shall contribute to the FTC within the timeframes set NYS for Service Plan Reviews; 90 days and six months following the child's initial removal into foster care and every six months thereafter. The treatment plan shall include goals to be achieved in the context of relevant recreational activities. Recreation goals shall address the child/youth's interests and strengths, and well as areas in the child's/youth's functioning which need to be modified, strengthened, or maintained. These goals shall be conveyed to recreation staff and reflected in the child's/youth's individual recreation plan where appropriate.

Based on the initial comprehensive assessment/evaluation described in foregoing sections of these *Family Foster Care Quality Assurance Standards* entitled "Initial Assessment/Evaluation," the Provider shall develop individualized written treatment plans and daily programs that address the mental health, behavioral, and/or other clinical issues that necessitate the Foster Child/youth's placement into residential care. The treatment plan shall include an assessment of the Foster Child/youth's needs and an explanation of the goals set for each Foster Child/youth while in residential care, services the Foster Child will receive, and the timeframes for delivery of services and achievement of treatment goals. The Provider shall ensure that the treatment plan employs the most appropriately indicated and most effective alternatives available to ensure the child's safety and well-being. Each Foster Child/youth's daily program shall specify their schedule of activities and behavioral expectations. The provider shall incorporate the treatment plan into the FASP as formal service goals for each Foster Child/youth's case.

The Provider shall ensure that its staff conducts regular Treatment Team Meetings in accordance with Children's Services policies to review treatment plans and goal. Treatment Team Meetings must include, if applicable, medical providers, birth parents/caretakers, and mental health providers, as well as any other relevant service providers. The Provider shall conduct periodic assessments of each Foster Child/youth, when appropriate, and adjust the treatment plan to ensure that the Foster Child/youth is receiving proper and appropriate services based on each his/her needs and changing conditions

Residential Care providers shall provide:

1. No less than the minimum number of residential care staff available to provide 24-hour supervision; and to meet the children/youth's needs, taking into account:
 - the children/youth's age,
 - their medical, physical, and mental condition; and
 - other factors that affect the amount of supervision required.
2. As appropriate, frequent and continuous interventions for child(ren)/youth with primary medical or habilitation needs. These interventions typically consist of hands-on physical intervention, assistance, and monitoring;
3. Written plans for the direct, continuous observation of a child(ren)/youth who presents a significant risk of harm to self or others;
4. Close daily supervision for a child(ren)/youth with developmental delays or mental retardation; and
5. Staff has specialized training to provide intense therapeutic and habilitation focus support and interventions in a highly structured service setting with little immediate outside access.

The Provider shall provide structured educational programs and structured therapeutic recreational events.

The Provider shall serve food of good quality and sufficient quantity, appropriate for the physical needs and medical conditions of the child(ren)/youth in care, providing suitable and sufficient nutrients and calories for each child in accordance with the provisions of *Title 18 NYCRR Part 442.22* or any successor or amended regulations.

2. Engagement of Birth Parents/Caretakers

Birth Parents/Caretakers are essential in the lives of their children/youth. The Provider is expected to make them a primary focus of their programming and effectively engage birth parents/caretakers throughout the planning process. The Provider is responsible for maintaining regular contact with birth parents/caretakers, including visits to the birth parent/caretaker's home or outreach or visits, when possible, to those in treatment or correctional facilities. Efforts must be made to identify birth fathers and attempts made to locate and engage these individuals and their extended family in case planning and permanency planning. Documentation of these efforts shall be kept in family case record.

Birth Parents/caretakers shall be actively involved in all conferences and encouraged to present their ideas, concerns and opinions. In addition, they will be offered the opportunity to identify outside support and to involve those individuals in the case planning and permanency process.

Providers shall schedule and facilitate the parent to parent meeting within three to five (3-5) days of placement of a child(ren)/youth into a residential program to ensure that they are aware of their child(ren)/youth's whereabouts and are familiar with the Provider. The Provider shall assign staff to prepare the birth parent/caretaker for this meeting to ensure that the purpose is clear and the meeting is effective. Refer to Part III: Permanency Planning for more information.

Provider staff shall be given skills training to develop their ability to effectively engage birth parents/caretakers, to understand the challenges that birth parents/caretakers face when child(ren)/youth are placed in care, and to appropriately address concerns when birth parents/caretakers are not responsive to planning efforts.

Providers shall maintain communication with birth parents/caretakers to inform and engage them in any decisions made about their child(ren)/youth. Birth parents/caretakers have a right and responsibility to participate in all planning and decision-making regarding their child's/youth's lives. Birth parents/caretakers shall be notified of any intention to change the placement of their child(ren)/youth. Birth parents/caretakers shall be notified about any medical concerns or injuries sustained by their child(ren)/youth.

Providers shall ensure that birth parents/caretakers shall be actively engaged in the child's/youth's education. Providers shall inform birth parents of the child's/youth's progress in school and all relevant meetings and conferences. Birth parents/caretakers shall participate in decision-making regarding school-related activities. When appropriate, birth parents/caretakers shall accompany or be involved with their child's/youth's medical appointments and attend open school night and other school activities.

The Provider shall be responsible for creating an engaging and supportive rapport between staff members and birth parents/caretakers as well as in the context of the Provider environment. Provider shall arrange for family visiting to support maintaining bonds and reunification. Refer to "*Visitation Plan.*" in *Part III: Permanency Planning*. Birth parents/caretakers that are not readily available due to incarceration or other institutional placement must still be engaged by the Provider. The Provider shall maintain communication with the birth parents/caretakers regarding the youth's well-being and development. Efforts must be made to facilitate visits and the birth parent/caretaker's involvement in conferences and other important events and activities. Refer to "*Visitation Plan*" in *Part III: Permanency Planning*. Assistance shall be provided to birth parents/caretakers that are being released from incarceration or institutional settings shall include, but not be limited to housing, employment and financial resources.

As part of service planning, the Provider shall assess the birth parent/caretaker family's need for services to support reunification. The Caseworker shall support achievement of the Family Assessment Service Plan goals by providing birth parents/caretakers and other significant family members with access to services to meet identified needs related to their medical and mental health, Chemical Dependency Disorder, domestic violence, and educational and/or vocational services. Providers shall support additional needs and presenting circumstances of birth parents/caretakers and extended family members to achieve successful reunification. These include, but are not limited to:

- Concrete needs, such as housing, public assistance, Medicaid and food stamps;
- Assess for chronic maltreatment in order to focus planning and engagement efforts appropriately;
- Access to job training and employment assistance;
- Chemical Dependency Disorder: prevention, treatment, aftercare and community support services;
- Domestic violence screening; when domestic violence is indicated or suspected, counseling and/or referral to support services for the survivor, child(ren)/youth and abusive partner;
- Services that address birth parent/caretaker's mental health needs, and the mental health needs of the child(ren)/youth (including siblings, who may be living with the parent or in another foster care placement);
- Health services, including those that address underlying medical conditions and physical disabilities that put child(ren)/youth at risk for maltreatment;
- Skills for effective parenting;
- Education about trauma and the impact of abuse/maltreatment on their child(ren)/youth, and training and supports to care for their child's/youth's needs upon reunification;
- Cultural and linguistic barriers to services;
- Connections to community supports and services;
- Immigration status;
- Impact of incarceration on permanency plans;
- Understanding of legal status regarding family court proceedings, including PINS petitions; and

- Support for responding to their own or their child(ren)/youth's sexual orientation and/or gender identity/gender expression.

Providers shall provide parenting skills training and psycho-education to birth parents/caretakers to address the issues that led to child(ren)/youth's placement in foster care and understand the impact of abuse/maltreatment on their child(ren)/youth. This will include developing an internal system to provide parent education, and/or identify external resources where they can refer birth parents/caretakers.

3. Parent Advocates and Supports

The Provider is required to employ Parent Advocates as staff members in their programs in order to enhance outreach to and engagement of birth parents/caretakers. Parent Advocates are extremely successful in engaging birth parents/caretakers and assisting them with the complicated process of navigating the child welfare system. In addition, they can provide advocacy on behalf of the birth parent/caretaker. The Caseworkers shall utilize the assistance of the Parent Advocates to engage birth parents/caretakers in case planning and permanency planning. This will include ensuring their attendance at and preparation for the FTCs, and general support of birth parents/caretakers in activities necessary to achieve service plan goals.

Parent Advocates shall be included in the development and review of the Provider policy and programs in order to ensure that the birth parent/caretaker perspective is adequately represented and considered. The Provider shall utilize best practice guidelines to develop the roles and responsibilities of the Parent Advocates.

Parent Advocates can be of assistance to the Provider in the following ways:

- Work with birth parents/caretakers and other Providers to create and sustain a network of birth parent/caretaker support groups;
- Establish a phone buddy system that links each new birth parent/caretaker to an experienced parent or a parent advocate. In addition, utilize outside organizations as supportive resources for birth parents/caretakers;
- Assist birth parents/caretakers to become meaningfully involved in the Provider's policy development and program planning activities;
- Create and sustain a vehicle for communicating birth parents'/caretakers' concerns to senior Provider staff and advise them as to how best to support their birth parents/caretakers;
- In planning for reunification, assist birth parents/caretakers in the transition of child(ren)/youth back into their home;
- Assist parents/caretakers in gaining a better understanding of trauma and the impact of abuse/maltreatment on their child(ren)/youth; as well as obtain specific training and supports to address the needs of their child(ren)/youth;
- Assist birth parents/caretakers in dealing with education-related issues via the Department of Education and/or other advocacy organizations; and
- Assist birth parents/caretakers in accessing after-school programs for their child(ren)/youth, and advocating for funds necessary to pay the cost of their child's/youth's participation in those programs as needed.

4. Court Participation and Involvement:

- Provide staff with adequate knowledge of the child(ren)/youth's history and current status and must be ready to testify in court when necessary;
- Complete timely and complete permanency reports, shall attend Family Court proceedings; and all Court orders shall be done in coordination/consultation with Children's Services;
- Provide Family Court Legal Services (FCLS) attorneys with updated information including child(ren)/youth status, location, assigned Caseworker and supervisor;
- Maintain contact with FCLS attorneys to review any important development, and communicate with lawyers for respondents and child(ren)/youth as necessary, pursuant to communications protocols;
- Provider staff must cooperate with FCLS attorneys in preparing court cases for trial;
- Retain counsel for termination of parental rights and adoption cases, as well as other situations where representation is needed;
- Explain why the child(ren)/youth would be in imminent danger if allowed to return home, supporting this position based on the child's medical and/or mental health needs, as appropriate;
- Explain the Provider's service plan and notify the court on the child's/youth's whereabouts, including where the child(ren)/youth is placed and what permanency resources are being explored and where the child(ren)/youth is placed;
- Inform the court of the birth parent's/caretaker's whereabouts (if the birth parents'/caretakers' whereabouts are unknown; and
- Responsible for informing the court about what avenues have been taken to locate and find the birth parents/caretaker).

5. Integration with Community Resources

All child(ren)/youth in residential care require a closely supervised living environment; need individually modified and appropriate recreational activities. The Provider shall integrate recreational programs into the residential care facility to serve the interests and special recreational needs of the child(ren)/youth. Where possible, the community shall be utilized for passive (e.g., movies, concerts) and active (e.g., YMCAs, pools) recreation. Child(ren)/youth shall be encouraged to participate in exploring community programs such as scouts, sporting leagues and school clubs, and the Provider will provide concrete assistance (e.g., transportation, paying membership fees) to child(ren)/youth interested in such activities as needed.

6. Discharge Planning and Transitional Services

The Provider shall adhere to the Foster Care Quality Assurance Standards, Part IV: Program Services. In addition, the Provider shall ensure that the post-discharge caretaker is fully trained in the care of the child(ren)/youth with special needs so that the child's/youth's health will not be compromised by discharge. The training curriculum for a post-discharge caretaker shall be the same as that provided for a foster parent. Discharge planning shall be done in conjunction with the child's health care and other service providers, such as Bridges to Health (B2H) Health Care Integration Agencies. Whenever possible, the child shall keep the same health providers upon discharge.

7. Staff Training and Development

The Provider shall continually assess the training needs of the staff based on the population in each facility and tailor the training to ensure that staff receives appropriate training.

In addition to the standards and expectation set forth in the *Foster Care Quality Assurance Standards*, Residential and Specialized Residential Care Providers shall adhere to the following:

All Provider staff, except support staff, shall receive at least 20 hours of training each year to help them understand the needs and characteristics of the population in care, provide emotional support and care needed by the child(ren)/youth, and appropriately manage their behavior.

The training shall consist of the following:

- (1) Trauma, the impact of abuse/maltreatment on child(ren)/youth, and the steps all residential care staff can take to mitigate past trauma and prevent additional trauma;
- (2) The complex social, medical, developmental, nutritional and emotional needs of children with serious special needs; the effect of those needs on their normal growth and development; and demands and skills required in caring for the specialized population;
- (3) The importance of initial and ongoing medical and mental health treatment;
- (4) Basic pharmacology (the actions, side effects, and possible adverse reactions regarding various medications);
- (5) (All Provider staff who administers psychotropic medications shall receive) training on the importance of properly administering medication including the dangers that can result from missed or improperly-administered doses of medications; training on psychotropic medication shall be conducted by a licensed physician, a registered nurse, or a pharmacist. After the psychotropic medication training, the trainer assesses each participant to ensure that the participant has learned the course content;
- (6) Behavior modification and management;
- (7) Training on youth development and permanency practice; Training on youth development and permanency practice; and
- (8) Training on the Family Court process.

The Provider shall ensure that staff that administers psychotropic medications receives training on the importance of properly administering medication including the dangers that can result from missed or improperly-administered doses of medications. The Provider shall ensure that training on psychotropic medication is conducted by a licensed physician, a registered nurse, or a pharmacist. Upon completion of psychotropic medication training, the Provider shall ensure that the training physician, nurse, or pharmacist assesses each staff participant to ensure that the participant has learned and understands the course content.

8. Staffing and Staff Qualifications

Director of Child Care:

MSW or graduate degree with appropriate training and three (3) to four (4) years documented experience in residential care setting/program.

Director of Social Work Services:

LMSW or equivalent human services graduate degree, and a minimum of three (3) years of documented administrative and supervisory experience with relevant experience in a residential care setting/program.

Supervisor:

LMSW/equivalent human services graduate degree with at least two (2) years of documented satisfactory supervisory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) years casework and one (1) year group work experience and/or one (1) year supervisory experience

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience.

Supervisor of Childcare:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented relevant supervisory experience working with youth in a group residency.

Childcare Worker:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented satisfactory experience working with youth.

Consultants

Providers may utilize consultants that include, but are not limited to:

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Mental Health Clinician/Social Worker:

LCSW or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Nurse:

New York State-Registered Nurse or Licensed Practical Nurse.

Dietician:

Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided.

To the degree possible, the Provider shall supply on-site speech, occupational and physical therapy when ordered by the primary care provider.

Staffing and staff qualification shall be in accordance with *Title 18 NYCRR Part 442.18* or any successor or amended regulations.

9. Monitoring, Evaluation and Quality Improvement

The Provider must adhere to all sections under *Part IX in the "Monitoring, Evaluation and Quality and Improvement"* section of these *Foster Care Quality Assurance Standards*.

10. Food Procurement Standards

Providers must adhere to New York City guidelines for food procurement, preparation, and service as outlined by the Mayor's Executive order number 122. Providers are expected to follow the standards described in each of three sections:

- Standards for Purchased Food
Addresses food items purchased by providers and gives specific standards by food category.
- Standards for Meals and Snacks Served
Addresses the overall nutrient requirements that should be achieved based on the number of meals and snacks served and describes standards for snacks and special occasions.
- Provider and Population-Specific Standards and Exceptions
Describes standards for specific populations (e.g. children)

B. Specialized Residential Programs and Services

Specialized residential care programs are offered by Providers with the expertise and the physical setting that is needed for children/youth who have particular needs and conditions. Specialized residential programs are provided to children/youth with very serious and severe medical and/or developmental conditions that may call for longer-term residential care and who may ultimately need to transition to adult residential care.

Specialized residential programs include services for children/youth:

- with special and severe medical needs;
- with mental retardation, developmental delays, and/or developmental disabilities;
- with sexual behavior problems and who have sexually abusive behaviors;
- who have been sexually exploited; and
- who need short-term crisis intervention and stabilization services.

Specialized Residential Care, Treatment and Social Work Services

Within fifteen (15) days of placement, the Provider shall assemble a clinical diagnostic team composed of, but not limited to, pediatric/adolescent medicine specialists, developmental specialists, psychiatrists, psychologists, social workers, and educational, recreational, and vocational specialists to determine the most appropriate program placement and treatment plan for each child(ren)/youth. This comprehensive assessment shall integrate the results of the CANS assessment, if one was done prior to the child's/youth's referral, and include an assessment for past trauma and presenting trauma symptoms. The screening shall include a nutritional assessment.

As noted above all children/youth shall be assessed for past trauma and presenting trauma symptoms at intake, as well as regularly thereafter. Children/youth who have experienced trauma and/or loss shall receive individual weekly counseling focusing on re-establishing physical and emotional safety, and group work sessions that promote a trauma-informed and safety-focused environment within the residential program. Group sessions shall be made available to help children/youth on at least a monthly basis; sessions shall be available more frequently as needed.

The Provider shall assess, on a regular basis, whether each child(ren)/youth is receiving appropriate services in the least-restrictive level of care possible, given his/her presenting issues. Whenever possible, the Provider shall utilize the results of this assessment to develop a "step-down" plan to identify and obtain those services and resources necessary to secure a safe and stable placement in a less-restrictive environment. In these instances, the Provider shall make a referral to the Bridges to Health (B2H) Waiver Program, or other home-based services, to ensure that appropriate supports are available to the caretaker (either the birth parent or a foster parent). If a child(ren)/youth is assessed to be in need of higher level of care and, for example, deemed eligible for services through the Office of Mental Health, the Provider shall make a referral.

The Provider shall ensure that social work staff conducts regular case reviews. Such case reviews shall include the medical provider, birth parent/caretaker, and mental health provider, as well as any other relevant service providers (physical therapist, educational staff, etc.). Provider staff shall conduct periodic assessments of each child's/youth's program placement and adjust their treatment plan to ensure that the child(ren)/youth is receiving proper and appropriate services based on the child's/youth's needs, strengths and changing conditions.

On-site nursing and medical care shall be available to monitor and address child's/youth's health needs and ensure that child(ren)/youth care staff and child(ren)/youth have an understanding of, and are compliant with, long-term complex medical and mental health care. To the degree possible, the Provider shall provide or make arrangements for on-site speech, occupational and physical therapy, when ordered by the primary care or specialty care provider.

The Provider shall:

- Provide supportive supervision that maintains/enhances the child's/youth's functioning, and provides for the child's/youth's safety and security, by
 - 1) establishing clear rules appropriate to the developmental and functional levels of the child;
 - 2) providing structured daily routines with clearly defined expectations;
 - and
 - 3) including intermittent interventions such as verbal guidance, assistance, and monitoring;
- Establish a clear system of rewards and consequences;
- Have a written policy statement that is provided to both child(ren)/youth and parents describes how supervision is provided to child(ren)/youth and explains how the program is structured to stabilize or improve the child's/youth's functioning;
- Develop specialized training to provide therapeutic and habilitation support and interventions in a treatment setting;
- Have the minimum number of residential care staff available to provide 24- hour supervision to meet a child's/youth's needs including frequent one-to-one monitoring, taking into account: the child's/youth's age, his or her medical, physical, and mental condition, and other factors that affect the amount of supervision required;
- Have written plans for the direct, continuous observation of those child(ren)/youth who present a significant risk of harm to self or others;

- Provide close daily supervision for child(ren)/youth with developmental delays or mental retardation; and
- Have staffing patterns and assignments documented in writing. The documentation includes the child(ren)/youth-to-Provider staff ratios, hours of coverage, and plans for providing backup staff in emergencies.

Youth shall receive Preparing Youth for Adulthood (PYA) services that meet the long-term interests and needs of the specialized population should be integrated into the programming at the Residential Care facility. Youth shall receive PYA services specifically adapted to their psycho/educational functioning and which serves the long-term interests and needs of each youth. In addition the Provider shall:

- Have access to a clinical expert in each child's special needs area to provide case consultation and advice on program issues;
- Ensure that their advisory groups have representation of special needs population groups;
- Keep records of individual service requests and the response to each request;
- Identify employment support for youth receiving services apart from what is offered by the provider;
- Regularly assess and address the health and welfare needs of each youth; and
- Document all referral information, including youth who are and are not referred for B2H services.

The service plan for each youth shall also ensure the safety of all youth and address the possibility of a youth victimizing other residents or staff. Proper safety measures shall be in place to avoid any threat of risk. Examples of risk management techniques include, but are not limited to, multiple placement facilities, separate floors in a single facility, and linkages with other providers.

Educational

The Provider shall provide structured educational programs.

Enrichment/Recreational Activities

The Provider shall design structured therapeutic recreational events.

The Provider shall offer Residential Care placement and specialized services for youth in accordance with existing federal, State, and City laws, rules, and regulations, and consistent with policies, procedures, and standards promulgated by Children's Services.

1. Youth Who Have Special Medical Needs

This section contains those standards that are specific to Residential Care for children/youth who have Special Medical Needs. These standards are in addition to those in previous sections of the Foster Care Quality Assurance Standards. In some areas, standards in this section are somewhat different from, and may be more stringent than those in the main text of the Foster Care Quality Assurance Standard. Where this is the case, the Residential Care for child(ren)/youth who have Special Medical Needs standards take precedence.

Children/youth who are served in Specialized Medical Needs Residential Care settings shall receive all the support, treatment, and understanding necessary to meet their broad range of physical, emotional, and developmental needs, in a manner that maximizes their chances for reunification with family or adoption. When these options are not possible, programs must provide children/youth with the skills necessary to live healthy, productive, and self-sufficient adult lives.

The goals of this program are for child(ren)/youth with special medical needs progress in following functional areas, to the extent possible:

- self care
- self direction
- adult living
- learning/functional academics
- social/leisure
- community use
- home living
- receptive and expressive language
- mobility
- work/economic self-sufficiency

Service Population

Providers of Residential Care to Children with Special Medical Needs shall provide services to populations which include, but are not limited to:

- a. oxygen-dependent and airway-compromised children;
- b. children who have undergone tracheotomies;
- c. children with neural tube defects (spina bifida) and neurodevelopmental disabilities;
- d. children with significant dysfunctions of major organ systems (e.g., heart, kidney, liver);
- e. children with diabetes and severe endocrine and metabolic disorders;
- f. children with debilitating neurological disorders including progressive encephalopathies (mitochondrial disease) and non-progressive encephalopathies (cerebral palsy);
- g. children with significant hematological disorders, such as sickle cell disease;
- h. burn victims, and victims of physical trauma resulting in physical disabilities;
- i. children who are dependent on devices such as feeding tubes and wheelchairs;
- j. children who are undergoing chemotherapy and other complex modes of management of serious and/or chronic illnesses ; and
- k. children or adolescents with HIV and/or AIDS who are on a combination drug therapy, as well as HIV-exposed children whose HIV status is not yet determined.
- l. Children with ophthalmologic/optical conditions leading to loss of vision
- m. Children with orthopedic conditions resulting from congenital malformations
- n. Children with otologic/aural conditions leading to loss of hearing.

Specialized Residential Care, Treatment and Social Work Services

Providers shall adhere to all sections of these Foster Care Quality Assurance Standards in addition to the following:

Working with the children's health service providers, the Provider shall conduct periodic assessments of each child's treatment plan and make adjustments as necessary to ensure that the child is receiving proper and appropriate services based on the child's needs and changing conditions. The Provider shall ensure that social work staff conducts formal case conferences every three (3) months; the case conferences shall include the foster parent, birth parent/caretaker, and health providers, as appropriate, as well as any other service provider (physical therapist, educational staff, etc.). The Provider shall engage pertinent medical, developmental or mental health providers in case planning for the child.

Providers serving children who have special medical needs shall have formal referral linkages with at least one of the NYS Mental Health specialized care centers (Article 16 clinics) in each borough. The Provider shall be prepared to work with all NYS-designated mental Health specialized care centers since a child may have already been receiving care at one of the centers prior to placement with the Provider.

The following services and supports shall be made available for children in this program as well as for their foster and birth parents/caretakers:

- The Provider shall ensure that each child receives a proper education, including referrals to Early Intervention programs, Preschool Special Education programs, or Specialized Day Treatment/Vocational services. The Provider shall actively participate in the child's education, so that all those involved in the child's life may review the child's work and school performance and make efforts to ensure that a child's special educational needs are planned for and met. Those participants in a child's life include, but are not limited to social workers, foster parents/caretakers, Child Care Workers, and birth parents/caretakers.
- The Provider shall supply or arrange for home-based speech, occupational, and physical therapy as needed and when ordered by the primary care provider.
- The Provider shall ensure that foster and birth parents/caretakers of children who have special medical needs have trained NYS medical specialists as their child(ren)/youth's primary care providers and are connected to parent advocacy and education programs, and other support service networks.
- Children/Youth, who have special medical needs and their siblings as appropriate, shall be provided with on-going counseling to help them cope with living with their conditions. All children shall be assessed for past trauma and presenting trauma symptoms; children who have experienced trauma and/or loss shall receive individual counseling focusing on re-establishing physical and emotional

safety, and group work sessions that promote a trauma-informed and safety-focused environment, in a manner that is developmentally appropriate.

- The Provider shall provide instruction to children with special medical needs their foster parents/caretakers with additional health care and personal hygiene information specific to their developmental disability status, including but not limited to:
 - education about their condition and its various effects;
 - the importance of keeping scheduled medical appointments and complying with their medical regimen; and
 - information relevant to their child's particular medicine and its effects and side effects or the use of medical equipment and other devices necessary for the treatment and maintenance of their condition.

Staffing and Staff Qualifications

Director of Child Care:

MSW or graduate degree with appropriate training and three (3) to four (4) years documented experience in residential care setting/program.

Director of Social Work Services:

LMSW or equivalent human services graduate degree, and a minimum of three (3) years of documented administrative and supervisory experience with relevant experience in a residential care setting/program.

Supervisor of Social Work Services:

LMSW/equivalent human services graduate degree with at least two (2) years of documented satisfactory supervisory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) years casework and one (1) year group work experience and/or 1 year supervisory experience

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience.

Supervisor of Childcare:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented relevant supervisory experience working with youth in a group residency.

Childcare Worker:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented satisfactory experience working with youth.

Consultants

Providers may utilize consultants that include, but are not limited to:

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Mental Health Clinician/Social Worker:

LCSW or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Nurse:

New York State-Registered Nurse or Licensed Practical Nurse.

Dietician:

Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided.

Staffing and staff qualification shall be in accordance with *Title 18 NYCRR Part 442.18* or any successor or amended regulations.

Staff Training and Development

The Provider shall continually assess the training needs of the staff based on the population in each facility and tailor the training to ensure that staff receives appropriate training.

In addition to the standards and expectation set forth in the Foster Care Quality Assurance Standards, Residential and Specialized Residential Care Providers shall adhere to the following:

All Provider staff providing both direct/indirect care shall receive at least 20 hours of training each year to help them understand the needs and characteristics of the population in care, provide emotional support and care needed by the child (ren)/youth, and appropriately manage their behavior. The training shall consist of the following:

- (1) Trauma, the impact of abuse/neglect on child(ren)/youth, and the steps all residential care staff can take to mitigate past trauma and prevent additional trauma;
- (2) The complex social, medical, developmental, nutritional and emotional needs of children with serious special needs; the effect of those needs on their normal growth and development; and demands and skills required in caring for the specialized population;
- (3) The importance of initial and ongoing medical and mental health treatment;
- (4) Basic pharmacology (the actions, side effects, and possible adverse reactions regarding various medications);
- (5) All Provider staff who administers psychotropic medications shall receive training on the importance of properly administering medication including the dangers that can result from missed or improperly-administered doses of medications; Training on psychotropic medication shall be conducted by a licensed physician, a registered nurse, or a pharmacist. After the psychotropic medication training, the trainer assesses each participant to ensure that the participant has learned the course content;
- (6) Stress reduction techniques;
- (7) The importance of keeping scheduled medical and mental health appointments as well as compliance with treatment;
- (8) Use of medical equipment;
- (9) Behavior modification and management; and
- (10) Initial first-aid and cardiopulmonary resuscitation training.

Discharge Planning and Transitional Services

The Provider shall adhere to the *Foster Care Quality Assurance Standards, Part IV: Program Services*. In addition, the Provider shall ensure that the post-discharge caretaker is fully trained in the care of the child(ren)/youth with special needs so that the child's/youth's health will not be compromised by discharge. The training curriculum for a post-discharge caretaker shall be the same as that provided for a foster parent. Discharge planning shall be done in conjunction with

the child's health care and other service providers, such as Bridges to Health (B2H) Health Care Integration Agencies. Whenever possible, the child shall keep the same health providers upon discharge.

2. Youth Who Have Mental Retardation and/or Developmental Disabilities

This section contains those standards that are specific to Residential Care for children/youth who have Mental Retardation and/or Developmental Disabilities. These standards apply in addition to those in previous sections of the Foster Care Quality Assurance Standards. In some areas, standards in this section are somewhat different from, and may be more stringent than those in the main text of the Foster Care Quality Assurance Standard. Where this is the case, the Residential Care for children/youth who have Mental Retardation and/or Developmental Disabilities standards take precedence.

Mentally Retarded and Developmentally Disabled (MR/DD) children/youth should be placed in the most appropriate, least restrictive and safest foster care setting available. Children/youth who are served in Specialized MR/DD Residential Care settings shall receive all the support, treatment, and understanding necessary to meet their broad range of physical, emotional, and developmental needs, in a manner that maximizes their chances for reunification or adoption. When these options are not possible, programs must provide them with the skills necessary to live healthy, productive, and self-sufficient adult lives if possible. MR/DD children/youth shall be placed in the most appropriate, least restrictive and safest foster care setting available which would provide them with the skills necessary to live healthy, productive, and self-sufficient adult lives if possible; those children/youth with more complex needs who will need life-long support must be referred to such programs once those needs have been identified.

Service Populations

Children/youth who have MR/DD include but are not limited to the following:

- who are severely neurologically impaired;
- with severe learning disabilities;
- with Autism Spectrum Disorder;
- who have mental retardation with an IQ below 70 or its functional equivalent;
- with Cerebral Palsy;
- with Down Syndrome; and
- with severe neuromuscular disorders.

Residential Care, Treatment, and Social Work Services

Children/youth with MR/DD diagnoses shall receive special treatment services in a highly structured setting. The goals of this program are for child(ren)/youth who are have mentally retarded or severe developmental disabilities to make progress in following functional areas, to the extent possible:

- self care
- self direction

- adult living
- learning/functional academics
- social/leisure
- community use
- home living
- receptive and expressive language
- mobility
- work/economic self-sufficiency

Staffing and Staff Qualifications

Director of Child Care:

MSW or graduate degree with appropriate training and three (3) to four (4) years documented experience in residential care setting/program.

Director of Social Work Services:

LMSW or equivalent human services graduate degree, and a minimum of three (3) years of documented administrative and supervisory experience with relevant experience in a residential care setting/program.

Supervisor Work Services:

LMSW/equivalent human services graduate degree with at least two (2) years of documented satisfactory supervisory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or 2 years casework and one (1) year group work experience and/or one (1) year supervisory experience.

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience.

Supervisor of Childcare:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented relevant supervisory experience working with youth in a group residency.

Childcare Worker:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented satisfactory experience working with youth.

Consultants

Providers may utilize consultants that include, but are not limited to:

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologists:

Certified as a psychologist in New York State.

Mental Health Clinician/Social Worker:

LCSW or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Nurse:

New York State-Registered Nurse or Licensed Practical Nurse.

Dietician:

Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided.

Staffing and staff qualification shall be in accordance with *Title 18 NYCRR Part 442.18* or any successor or amended regulations.

Staff Training and Development

In addition to required Residential Care training described in the Foster Care Quality Assurance Standards, the Provider shall provide supplementary training to staff who care for or interact with MR/DD child(ren)/youth to help them meet their specialized needs. The training shall take into account the individual needs of the children served and shall be provided by either the Provider or an outside educational institution. The Provider shall provide all staff continuous and ongoing training to meet the need the changing needs of the MR/DD population.

Discharge Planning and Transitional Services

The Provider shall adhere to the *Foster Care Quality Assurance Standards, Part IV: Program Services*. In addition, the Provider shall ensure that the post-discharge caretaker is fully trained in the care of the child(ren)/youth with special needs so that the child's/youth's health will not be compromised by discharge. The training curriculum for a post-discharge caretaker shall be the same as that provided for a foster parent. Discharge planning shall be done in conjunction with the child's health care and other service providers, such as Bridges to Health (B2H) Health Care Integration Agencies. Whenever possible, the child shall keep the same health providers upon discharge.

3. Youth with Sexual Behavior Problems and Youth Who Have Sexually Abusive Behaviors

This section contains those standards that are specific to Residential Care for children/youth with Sexual Behavior Problems and Children/Youth Who Have Sexually Abusive Behaviors. These standards apply in addition to those in previous sections of the Foster Care Quality Assurance Standards. In some areas, standards in this section are somewhat different from, and may be more stringent than those in the main text of the Foster Care Quality Assurance Standards. Where this is the case, the Residential Care for Youth with Sexual Behavior Problems and Youth Who Have Sexually Abusive Behaviors standards take precedence.

Children/youth with sexual behavior problems and child(ren)/youth who have sexually abusive behaviors who cannot be safely placed in a family setting shall receive specialized treatment services in a highly structured setting. The goals of this program are to work with child(ren)/youth to address the issues underlying their harmful behaviors, hold them accountable for their behaviors, and help them to develop empathy for their victim, address their own history of abuse, and fundamentally change their harmful behaviors. These children/youth shall receive extensive treatment to address the issues which have led or contributed to their offending behaviors.

Service Population

This population includes, but is not limited to:

- Child(ren)/youth with sexual behavior problems or have sexually abusive behaviors, adjudicated, or non-adjudicated who present a risk to the community based on their sexual acting-out behaviors.
- Child(ren)/youth who require intensive treatment due to their sex offending habits.

- Child(ren)/youth with a history of sexual abusive behaviors.

Residential Care, Treatment, and Social Work Services

Specialized assessment services, followed by individual, group, and family counseling; shall be provided to address the underlying causes of the child(ren)/youth's harmful acts and move toward changing their behaviors. The Provider shall integrate structured educational programs and structured, closely supervised therapeutic recreational events into their residential programs.

The Provider shall integrate structured educational programs and structured, closely supervised therapeutic recreational events into their residential programs. Emphasis will be placed on promoting healthy, age-appropriate activities and interaction, while still providing a therapeutic milieu, including counseling, support and psychiatric consultation.

The Provider must provide positive care and support for the child(ren)/youth while advising against and informing him/her of the dangers of their sexually behavior. Child(ren)/youth will be empowered to thrive on their own, armed with the knowledge and technical skills to live independently.

Staffing and Staff Qualifications

Director of Child Care:

MSW or graduate degree with appropriate training and three (3) to four (4) years documented experience in residential care setting/program.

Director of Social Work Services:

LMSW or equivalent human services graduate degree, and a minimum of three (3) years of documented administrative and supervisory experience with relevant experience in a residential care setting/program.

Supervisor of Social Work Services:

LMSW/equivalent human services graduate degree with at least two (2) years of documented satisfactory supervisory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or 2 years casework and one (1) year group work experience and/or one (1) year supervisory experience

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience.

Supervisor of Childcare:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented relevant supervisory experience working with youth in a group residency.

Childcare Worker:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented satisfactory experience working with youth.

Consultants

Providers may utilize consultants that include, but are not limited to:

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Mental Health Clinician/Social Worker:

LCSW or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Nurse:

New York State-Registered Nurse or Licensed Practical Nurse.

Dietician:

Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided.

Staffing and staff qualification shall be in accordance with Title 18 NYCRR Part 442.18 or any successor or amended regulations.

Staff Training and Development

Provider staff will be trained in the areas of sexual abuse, sexual exploitation, family systems counseling, play therapy and trauma resolution. Staff should also be trained in non-violent crisis intervention techniques, the use of de-escalation, mediation and CPR/First Aid.

4. Youth Who Have Been Sexually Exploited

This section contains those standards that are specific to Residential Care for children/youth who have been Sexually Exploited. These standards apply in addition to those in previous sections of the Foster Care Quality Assurance Standards. In some areas, standards in this section are somewhat different from, and may be more stringent than those in the main text of the Foster Care Quality Assurance Standards. Where this is the case, the Residential Care for children/youth who have been Sexually Exploited standards takes precedence.

Children/youth who have been sexually exploited and have treatment or safety-related needs that require the specialized treatment opportunities provided by Residential Care facilities shall be provided such care. Children's Services' definition of sexually exploited child(ren)/youth includes but is not limited to:

- Children/youth who have been victimized for the advancement of sexual gratification or profit: prostituting a child(ren)/youth, and creating or trafficking in child(ren)/youth pornography, presentation of unsolicited obscene material, online enticement to promote sexual acts, victims of sexual grooming, and children/youth who have been sexually assaulted and/or molested; and
- Children/youth whose mental issues/ psychiatric disorders increased their risk of being abused, or children/youth whose mental issues/psychiatric disorders were exacerbated by this abuse.

Children/youth who have been sexually exploited and are served in Specialized Residential Care settings must receive all the support, treatment, and understanding necessary to meet physical, emotional, chemical dependency/use and developmental needs, in a manner that maximizes their chances for reunification or adoption, or when these options are not possible, which provides them with the skills necessary to live healthy, productive, and self-sufficient adult lives. The Provider shall meet the full range of physical, emotional, chemical dependency/use and psychological needs of the child(ren)/youth and describe the resources available to serve them.

Residential Care, Treatment, and Social Work Services

Providers must provide a comprehensive, culturally sensitive program that includes assessment of risk factors and safety issues related to sexual exploitation. Providers will work with child(ren)/youth and their families (when appropriate) to provide therapy, life-skills coaching and assess to community resources that will help them through this difficult time.

Specialized assessment services, followed by individual, group, and family counseling; shall be provided to address the underlying causes of the child(ren)/youth's harmful acts and move toward changing their behaviors. Providers will address specific issues encountered by the child(ren)/youth using creative and effective ways to assess risk factors and problems areas, encourage dialogue, and promote healing and positive progress.

The Provider shall integrate structured educational programs and structured, closely supervised therapeutic recreational events into their residential programs. Emphasis will be placed on promoting healthy, age-appropriate activities and interaction, while still providing a therapeutic milieu, including counseling, support and psychiatric consultation.

The Provider must provide positive care and support for the child(ren)/youth while advising against and informing him/her of the dangers of their sexually behavior. Child(ren)/youth will be empowered to thrive on their own, armed with the knowledge and technical skills to live independently.

Discharge Planning and Transitional Services

Prior to discharge it must be assessed if the abuser/trafficker continues to pose a risk to the minor children/youth in the home or community the child is to be discharged to.

The Provider shall ensure that the post-discharge caretaker is fully trained in the care of sexually exploited children/youth. The training curriculum for a post-discharge caretaker shall be the same as that provided for a foster parent. Discharge planning shall be done in conjunction with the child(ren)/youth's mental health providers. Whenever possible, the child(ren)/youth shall maintain the same mental health and/or chemical dependency treatment providers upon discharge in as much as it is possible, where appropriate. Services to children/youth should be based in the community where they are being returned.

Children shall be assessed and linked with aftercare services prior to discharge from foster care. This assessment shall begin upon admission to the foster care program, and be revisited regularly thereafter to ensure a continuum of service that the family/child can rely on after discharge. Indicated referrals to an aftercare rehabilitative program shall be made as soon as a need is identified. Such referrals shall be made based on the child(ren)/youth's clinical needs, not simply the permanency plan.

Involvement of Birth Parents/Caretakers

The provider shall involve birth parents/caretakers in all decisions affecting their youth from intake to termination of services. Foster parent of those youth who were previously in a foster home must also be involved in all decision-making, particularly regarding services to be provided to the youth upon return to the foster home. The Provider shall develop protocols for

working with the birth/caretaker/foster family and involving them in service planning, treatment and the goal of the youth's reunification with his/her family. The focus shall be on reunification whenever possible and community reintegration that provides supervision and resources tailored to the youth's needs and the birth parent/caretaker's needs in a short-term setting; where the process of introducing new behaviors can be practiced and reinforced during visitation and home visits. Outreach shall include home visits to family and discharge resources.

The provider shall promote and support contact between the youth and birth parent/caretaker and/or discharge resource by providing for flexibility in the visitation schedule. The provider must adhere to all sections under "*Visitation and establishment of Visitation Plan*" Section III. Part B.3 of these *Foster Care Quality Assurance Standards*.

Staffing and Staff Qualifications

Director of Child Care:

MSW or graduate degree with appropriate training and three (3) to four (4) years documented experience in residential care setting/program.

Director of Social Work Services:

LMSW or equivalent human services graduate degree, and a minimum of three (3) years of documented administrative and supervisory experience with relevant experience in a residential care setting/program.

Supervisor of Social Work Services:

LMSW/equivalent human services graduate degree with at least two (2) years of documented satisfactory supervisory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) years casework and one (1) year group work experience and/or one (1) year supervisory experience

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience.

Supervisor of Childcare:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented relevant supervisory experience working with youth in a group residency.

Childcare Worker:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented satisfactory experience working with youth.

Consultants

Providers may utilize consultants that include, but are not limited to:

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Mental Health Clinician/Social Worker:

LCSW or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Nurse:

New York State-Registered Nurse or Licensed Practical Nurse.

Dietician:

Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided.

Staffing and staff qualification shall be in accordance with Title 18 NYCRR Part 442.18 or any successor or amended regulations.

Staff Training and Development

The Provider shall continually assess and train staff appropriately. In addition to the standards and expectation set forth in the Foster Care Quality Assurance Standards, Residential and Specialized Residential Care Providers shall adhere to the following:

All Provider staff both direct/indirect care shall to help them understand the needs and characteristics of the population in care, provide emotional support and care needed by the child(ren)/youth, and appropriately manage and stabilize crisis. The training shall consist of the following:

- Modality of treatment to be utilized;
- Special training in treating child sexual abuse and exploitation and sexual trauma and recovery;
- Exiting street life, barriers to leaving and detecting ongoing abuse;
- Addressing cultural context of prostitution and trafficking culture;
- Gang awareness and involvement;
- Working with and preventing running away;
- Crisis intervention, mediation, conflict resolution and relationship building;
- Team approach to work towards reunification with birth family/caretaker, or foster family;
- Behavior management system; and
- Sensitivity training.

5. Rapid Intervention Centers

This section contains those standards that are specific to Residential Care for Rapid Intervention Centers. These standards apply in addition to those in previous sections of the Foster Care Quality Assurance Standards. In some areas, standards in this section are somewhat different from, and may be more stringent than those in the main text of the Foster Care Quality Assurance Standards. Where this is the case, the Rapid Intervention Centers standards take precedence.

The Rapid Intervention Center (RIC) shall serve youth who are in a family setting or residential care in NYC and out-of-city, and are temporarily unable to maintain safe placement within their family setting or residential care facilities. The RIC must provide intensive and therapeutic services to stabilize such youth and provide a short-term treatment intervention in a residential setting so that the youth may be returned to their birth parents/caretakers, foster care families, or other facilities as promptly as possible. Use of such programs does not relieve the planning Provider from its responsibility to attend to crisis intervention and treatment needs, but rather,

shall supplement the planning Provider's clinical resources and expertise where necessary for exceptional problems, to avoid re-placement and further crisis.

Youth who are served in the RIC, and their birth parent/caretaker/foster parent/residential care provider of origin, shall receive all the support, treatment, and concrete services necessary to meet their wide range of emotional, developmental, and physical needs. The services provided shall maximize their chance of re-unification with their family. When this option is not possible, the RIC shall provide them with skills and training that will help them to resume healthy living conditions in their previous family setting/residential care placement.

The RIC must provide intensive assessment and treatment services beginning at intake or immediately afterwards. The goals for youth served by Rapid Intervention Center are:

- Crisis stabilization,
- Reunification to a permanent family-based living situations, and
- Development and continuity of positive family relationships.

To achieve these outcomes, the RIC's activities shall include, but not be limited to following:

- Working to avert placement in a new and/or higher level family foster care or residential care program by providing effective short-term intervention for youth and families in crisis situations.
- Promoting and supporting involvement of the birth parent and/or caregiver in the care of the youth's intake and continuing to support this involvement throughout the duration of the youth's placement in the Rapid Intervention Center.
- Supporting the goals of timely permanency placement for youth in family foster care and residential care, and implementing service plans consistent with timely achievement of the permanency outcome of reunification.
- Collaborating with the Caseworker from the referring provider, and with the birth parent and/or caregiver, so that rapid intervention program services are consistent with the youth and family's overall service plan goals.
- For youth who can return to their permanent homes, make services available to the family to support family reunification.
- For youth returning to foster home or residential care programs, make services available to foster families/residential care staff to help ensure a smooth transition and stable placement.
- Developing individualized assessments and strength-based treatment plans tailored to the youth's particular needs, requirements for safety, and best interests. Services shall be appropriate for the youth's clinical needs and shall promote and sustain educational achievement.
- Assessing the youth's needs in the context of the family's strengths, socio-economic environment, cultural and religious heritage.

The Provider shall have formal referral linkages with community-based substance abuse programs to address the full range of youth and family substance abuse treatment needs.

Service Population

Children/youth who would benefit from the RIC may include but is not limited to:

- Youth in severe mental health (or emotional) or behavioral crisis where the appropriate permanency and/or treatment plan is not immediately clear. This may include youth that have MR/DD diagnoses and youth who are chronically missing from care.
- Youth in crisis where intervention/respite is needed to divert them from hospital stays or for post-hospitalization stays to stabilize the youth and to assess all possible reunification or family-based placement options if these were not considered before. Persons-In-Need of Supervision/Juvenile Delinquent youth who enter care with a history of violence or gang involvement and/or criminal behavior and/or who need short-term stabilization to remain with or return to families.
- Youth with substance abuse issues, including youth who are dual diagnosed with substance abuse and mental health issues that are interfering with the youth's functioning in the home and require immediate crisis intervention and temporary placement in a different setting. (Such youth may be referred to substance abuse treatment directly from the RIC.)
- Youth who have been victims of commercial sexual exploitation and who are not safe in a home setting or even in their communities. While not all youth who have been exploited need to be in a residential program, this short-term intervention might allow some of them to avoid longer-term residential placement.

Youth in need of emergency placement in a Rapid Intervention Center shall receive intake, assessment, and intensive treatment services for the length of time needed to stabilize the youth and/or family situation. This shall range from one day to sixty. If the youth and birth/caretaker family need more than sixty 60 days to achieve a positive treatment outcome that will allow for return to a family setting, family reunification or successful placement in a foster family, then the youth and family shall receive that service in the RIC rather than experience another move in care. These decisions shall be made on an individual basis and shall be reviewed monthly.

Family Foster Care, Residential and Social Work Services

Prior to making the referral to the RIC, the referring provider must they have been unable to address the needs of the youth and family even with the use of existing community-based resources.

Primary case planning responsibility must remain with the referring provider, unless a referral was made by ACS without the involvement of another Foster Care program. Where there is no preexisting case planning program, the Rapid Intervention Center would be responsible for case planning and monitoring of youth until they exit foster care via final discharge or move to another foster care program or preventive service program. Note that expectations for aftercare supports do not apply for cases that exit foster care. For children in foster care who move to another program, case planning will shift to the new program.

Intake Screening and Assessment:

Case Planning, Treatment, and Social Work Services staff shall ensure:

- Completion of an appropriate diagnostic screening/ assessment on each child by the fifteenth (15th) day of admission. The assessment shall address the child's strengths and needs in the following areas.
- Psychological
- Behavioral
- Social
- Educational

NOTE: It is expected that some youth may have had a complete diagnostic workup during the past year, and thus; the diagnostic reports will be included in the referral packages. However, for those youth that who were recently placed and the diagnostic evaluations have not yet been completed, the RIC clinical staff shall develop appropriate screening evaluations to use as a baseline for treatment/services.

RIC Service Planning:

The RIC shall develop a Service Plan by the fifteenth (15th) day of the youth's admission, which should be based on the youth's plan for permanency. This plan shall include but not be limited to:

- an estimate of the length of time the child will remain in the RIC;
- a description of the service goals and the treatment plan, including crisis de-escalation, mental health services (individual and group), psychiatric services, educational programming (which would ideally consist of the youth remaining in their prior school placement);
- specific instructions for childcare staff regarding the youth's social, emotional and educational needs, and triggers that could put the youth back into crisis;
- identifying any additional need that has arisen since the previous service plan was developed; and
- family, social and emotional needs.

Involvement of Birth Parents/Caretakers:

The RIC shall involve birth parents/caretakers in all decisions affecting their youth from intake to termination of services. Foster parent of those youth who were previously in a foster home must also be involved in all decision-making, particularly regarding services to be provided to the youth upon return to the foster home. The Provider shall develop protocols for working with the birth/caretaker/foster family and involving them in service planning, treatment and the goal of the youth's reunification with his/her family. The focus shall be on reunification whenever possible and community reintegration that provides supervision and resources tailored to the youth's needs and the birth parent/caretaker's needs in a short-term setting; where the process of introducing new behaviors can be practiced and reinforced during visitation and home visits. RIC outreach shall include home visits to family and discharge resources.

The RIC shall promote and support contact between the youth and birth parent/caretaker and/or discharge resource by providing for flexibility in the visitation schedule. The RIC must adhere to all sections under "*Visitation and establishment of Visitation Plan*" Section III. Part B.3 of these Foster Care Quality Assurance Standards.

Education

The Provider must adhere to all sections under "Education" Section V Part A of these Foster Care Quality Assurance Standards.

RIC is a program where educational services shall be provided quickly and intensely within a 60 day educational service period. Whenever possible the RIC shall ensure youth continue their education at the school of origin to minimize educational disruption.

Staffing and Staff Qualifications

Director of Child Care:

MSW or graduate degree with appropriate training and three (3) to four (4) years documented experience in residential care setting/program.

Director of Social Work Services:

LMSW or equivalent human services graduate degree, and a minimum of three (3) years of documented administrative and supervisory experience with relevant experience in a residential care setting/program.

Supervisor of Social Work Services:

LMSW/equivalent human services graduate degree with at least two (2) years of documented satisfactory supervisory experience working with a similar population.

Mental Health Clinician:

LCSW (preferred) or LMSW/licensed mental health professional with equivalent human services graduate degree with at least two (2) years documented relevant experience.

Family Team Conference Facilitator:

MSW or equivalent human services graduate degree or two (2) years casework and one (1) year group work experience and/or one (1) year supervisory experience

Caseworker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years of documented relevant experience.

Intake Worker:

MSW or equivalent human services graduate degree (preferred) or BA/BS/BSW with at least two (2) years documented relevant experience.

Recreation Therapist:

BA in recreational therapy and is currently a Certified Recreation Specialist or has the documented equivalent in education, training and experience and is currently competent in the field.

Educational/Vocational Specialist:

MSW or equivalent human services graduate degree (preferred) in education, guidance and counseling or related field with at least two (2) years documented relevant experience.

Birth Parent Advocate:

High school diploma or General Equivalency Diploma, and one (1) year relevant work experience.

Supervisor of Childcare:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented relevant supervisory experience working with youth in a group residency.

Childcare Worker:

High School diploma/General Equivalency Diploma or one (1) year of college (preferred) with at least one (1) year of documented satisfactory experience working with youth.

Consultants

Providers may utilize consultants that include, but are not limited to:

Physician:

Licensed and currently registered to practice medicine in New York State.

Psychiatrist:

New York State-licensed physician with a specialized rating in psychiatry.

Psychologist:

Certified as a psychologist in New York State.

Mental Health Clinician/Social Worker:

LCSW or LMSW/licensed mental health professional with equivalent human service graduate degree with at least two (2) years documented relevant experience.

Nurse:

New York State-Registered Nurse or Licensed Practical Nurse.

Dietician:

Bachelor's degree with major studies in food and nutrition and be registered or eligible for registration with the American Dietetic Association.

Providers that utilize consultants shall have a signed contract for each consultant and keep a record of the consultative services provided.

Staffing and staff qualification shall be in accordance with Title 18 NYCRR Part 442.18 or any successor or amended regulations.

Staff Training and Development

The Provider shall continually assess and train staff appropriately. In addition to the standards and expectation set forth in the Foster Care Quality Assurance Standards, Residential and Specialized Residential Care Providers shall adhere to the following:

All Provider staff both direct/indirect care shall receive at least 20 hours of training each year to help them understand the needs and characteristics of the population in care, provide emotional support and care needed by the child(ren)/youth, and appropriately manage and stabilize crisis. The training shall consist of the following:

1. Trauma, the impact of abuse/maltreatment on child(ren)/youth, and the steps all residential care staff can take to mitigate past trauma and prevent additional trauma;
2. Crisis Intervention and family mediation;
3. Team Approach to work towards reunification with birth family/caretaker, foster family or residential program;
4. Wrap-around services and community linkages;
5. The importance of initial and ongoing medical and mental health treatment;
6. Training on psychotropic medications to be conducted by appropriate medical staff;
7. Stress reduction techniques;
8. The importance of keeping schedule medical and mental health appointments as well as compliance with treatment;
9. Behavior medication and management.

PART XIII: CONTRACT AGENCY ADMINISTRATION AND ORGANIZATION

A. Provider Mission and Purpose

The Provider's clearly stated mission and purpose reflects a commitment to serve children and their families, and is consistent with the mission and objectives of NYC Children's Services.

The Provider's mission statement shall reflect a commitment to respect and respond to the diversity of the ethnic, cultural, religious and sexual groups it serves, while fostering a community-based, family-focused approach through its linkages and community involvement and integration of the family:

- a. Every effort shall be made to ensure adequate representation among the board and staff of the ethnic groups in the client population, and staff shall be educated in cultural and religious factors and practices of the populations served, with particular reference to ways in which culture or religion may impact on the treatment service process.
- b. There shall be programs and activities designed to foster the cultural (ethnic/religious/sexual) awareness and identity of the children in care, and to continue a seamless connection with their community of origin.

The Provider shall make an effort to utilize contributions from the community and family in their policy-making process, and involve them in service planning. They shall actively seek present and former family members' and foster-family members' involvement to ensure continuity of these principles.

B. Provider Program Goals, Policies and Procedures

- The Provider has clearly identified programs and services that include written goals and objectives. The Provider has a written plan that includes resources and programs for the provision of services, which is supported by a financial plan. These are reviewed periodically and updated as necessary.
- The Provider's philosophy is reflected in its goals, objectives, policies, procedures, and in the implementation of programs and services.
- The Provider has a written plan, which allocates resources to programs for the provision of services, which is supported by a financial plan. These are reviewed periodically and updated as necessary.
- The Provider has a long-range program plan, which covers a minimum of three (3) years. This is reviewed periodically and updated as necessary.
- The Provider's program mission, policies, and procedures are disseminated to, and reviewed and implemented by appropriate staff and foster parents.
- The Provider has program procedures and goals that promote provision of services and allow for stable foster care experiences by children in the most family-like and least restrictive settings as possible; for populations served – by age, siblings, and need.
- The Provider shall provide services to its target population within its service communities that will ensure the safety of children and address the needs of the target group as a

whole. Intervention must occur as early as possible to provide the greatest benefit and most timely resolution of presenting needs.

- The Provider shall develop a practice model that follows a team focused, decision-making approach, in service delivery and planning, and in accountability/self-evaluation.
- The Provider shall design a plan to ensure regular meeting of a team inclusive of administrative and direct care staff, foster parents, birth families, and community service providers. The team shall seek to ensure and provide feedback that the stated goals of the program and Children's Services are being met effectively.
- The Provider has a quality assurance plan in place describing how they shall provide quality assurance, planning and program evaluation of their specific service population. The Provider shall assign designated staff to oversee a formal participatory evaluation of the service delivery in consultation with direct services staff, foster parents and the birth families served. The evaluation format includes a review of goal achievement (family and program) and a review to ensure compliance with OCFS, NYC Children's Services and other promulgated administrative standards.
- The Provider shall seek to maintain an appropriate cultural, ethnic, and appropriate sexually-oriented environment that is both aesthetically pleasing and appropriate for the populations served. The Provider must formulate written policies for the interaction of staff with the service populations in the various planning environments (birth families, foster home, other organizations or community service providers, and family court).

C. Linkages to Community and Participation in Community Partnership Initiative

The Children's Services' Community Partnership Initiative (CPI) is designed to strengthen the connections between the child welfare system and NYC's local communities. Children's Services envisions that Community Coalitions will work to develop and support holistic, seamless local networks of service providers, community members and families, and other stakeholders with the goal of assisting families and offering safety and support where they reside. Community Coalitions will identify community needs and draw upon community resources to address those needs and will work to identify and overcome obstacles to child welfare system success. Relationships and partnerships formed within the Community Coalitions shall significantly impact core child welfare outcomes of safety, permanency, and well-being. The Coalition shall seek to close the divisions between Children's Services, contract providers, other neighborhood organizations, and residents of our city's neighborhoods.

All Foster Care Providers as well as representatives from Children's Services' Division of Child Protection and other divisions of Children's Services as needed, are required to participate in local Community Coalitions. Family Foster Care programs operating on a borough-wide basis are required to participate in at least one Community Coalition in their borough. These programs shall participate in a Community Coalition for a Zone where a substantial proportion of their clients reside. All Residential Care and Family Foster Care programs operating on a city-wide basis are required to participate in at least one Community Coalition.

Each Community Coalition will be diverse and inclusive in recruiting members. Besides foster care providers, Community Coalitions shall include representatives from health, mental health, chemical dependency/use, and domestic violence service providers. They may also include

residents, families (including foster families), community leaders, school personnel, police precinct staff, employment readiness programs, child and youth development programs, housing organizations, faith and civic groups, and businesses. In addition, coalitions are strongly encouraged to link to the Family Support Programs funded through the New York City Department of Health and Mental Hygiene.

Coalitions will work with foster care providers to find foster care homes that enable children to remain in their neighborhoods and schools after placement which is essential to mitigate the trauma of family separation and promote earlier discharge from foster care

1. Neighborhood-Based Service Provision

When neighborhood placement is not possible, due to the specialized nature of the program model, site location issues, or any other reasons deemed appropriate and/or in the best interest of the child, then the provider shall establish relationships and linkages with the child's home community and/or with the community the child will be residing in upon discharge, if known. The Provider shall facilitate and promote the child's relationship with her/his home community and facilitate visiting in that community, including locating appropriate space for visits.

For Residential Care Providers, the community shall be considered both the neighborhood the site is located within, whether in New York City or beyond, as well as the home neighborhood(s) of the children who will be receiving service.

Due to the special needs of many of the children residing in residential care, and the specialized nature of many of these programs, concern about living in close proximity to residential care facilities has been raised at times by neighborhood residents. Therefore, the provider shall develop a community outreach strategy to educate the community, respond to community concerns, and build community acceptance of and support for residential care sites, programs, and treatment models. This strategy can include but shall not be limited to regular attendance at significant community events.

Family foster care providers shall establish a sufficient number of foster care beds and homes to serve children needing substitute care either within their own communities or as close to their own communities as possible, when appropriate, and consistent with a determination that neighborhood placement is in the best interest of the child.

2. Community Board of Directors Participation

Providers shall ensure that appropriate members of the socio-economic communities served by the provider's Children's Services-funded programs have the opportunity to contribute to and be informed about policy-making processes. In doing so, they shall actively solicit family members' involvement in services provided to their children. Providers shall have community members serve on their Board of Directors, on advisory panels, or on committees of the Board of Directors. Providers will encourage consumer involvement in the foster care provider.

3. Interagency and Community Relations

Interagency and Community Relations: The Provider shall provide “wraparound” services which offer children the full range of services that they need to achieve placement stability and permanency goals in the least restrictive setting as possible. If the Provider does not have the expertise or capacity to directly provide all services necessary to assist and support clients, the Provider shall meet the full range of service through the establishment of formal linkages with other social services and community-based organizations. In that instance, the Provider shall establish linkages including but not limited to service provider contracts, formal service agreements, “letters of linkage,” and “memoranda of understanding.” It is expected that the Provider will also support and develop linkages in the child and family’s community of origin and/or residence, since all services are to be community-based.

D. Non-Discrimination Policy

All discrimination – including, but not limited to, discrimination based on an individual’s actual or perceived sex, and discrimination based on an individual’s gender identity, self-image, appearance, behavior or expression, or an individual’s sexual orientation – constitutes a violation of the City’s Human Rights law, as well as New York State Human Rights Law. Moreover, New York State Social Services regulations prohibit any act by Children’s Services or Provider staff that would be detrimental to any child in care.

E. Confidentiality/Clients’ Rights

While a child is in care, it is important for the Provider to ensure the protection of the individual rights of both the birth parent or caretaker and child. The Parents’ and Children’s Rights Unit within the Children’s Services Office of Advocacy provides a forum to which birth parent(s) or caretaker(s) and relatives, youth and foster parents may bring their concerns and complaints. The Office of Advocacy provides a similar forum to which children who are in care and their foster parent(s) may bring their concerns and complaints. Information regarding the availability of the Parents’ and Children’s Rights Unit must be posted in all facilities and made available to all youth, parents and foster parents.

The Provider shall adhere to the Children’s Rights of Privacy Standards which are based on the *Title 18 NYCRR Part 441.18* and Parents Rights *Title 18 NYCRR Part 421.4*.

While Children’s Services believes that the increased focus on both the development of partnerships between birth parents or caretakers and foster parents, and neighborhood-based foster care placement will significantly improve the lives of children and families, it is also recognized that issues of confidentiality and security may become an even greater concern due to the closer proximity envisioned between birth parent(s) or caretaker(s), foster parents, and children. Therefore, the Provider shall establish protocols that are in line with applicable state laws and set clear rules of conduct and delineate appropriate boundaries guiding visiting, contact,

and the sharing of information, which all parties involved in the child's/youth's care need to follow and respect.

When domestic violence is present and a birth parent/caretaker is residing in a domestic violence shelter, references in the case record shall be made to the business address (often designated as a Post Office (P.O.) box number or a P.O. station) of the shelter and not to the street address of the shelter. The actual street address of the shelter shall never be documented in CONNECTIONS, a FASP, an Article 10 petition, permanency hearing report or other court report or given to anyone directly or indirectly, particularly the abusive partner (see *Title 18 NYCRR Part 452.10*).

All information pertaining to domestic violence safety planning (e.g. a shelter's business address or an actual address of a survivor of domestic violence) shall be clearly and boldly identified in the case record by Provider staff as "Confidential Information Due To Domestic Violence, Do Not Share".

Similarly, when domestic violence is present and the birth parent/caretaker is living in the community, Article 10 petitions shall not include the survivor's address. The address shall be listed on the face of the petition as "Confidential." The survivor's address and the address of any service providers shall be retracted from any records provided to parties in court proceedings.

F. Program Site

1. Physical Facilities and Equipment

The physical plant and equipment shall meet the specifications as established by OCFS and all applicable local ordinances. The Provider's physical facilities shall be clean, the appearance of the interior and exterior of the building shall be maintained, and the physical facilities shall reflect the mission of the Provider and program.

2. Furnishings and Environment

The furnishings contained in a family foster home shall accommodate the characteristics of the population and where appropriate provide a "homelike" living environment. Furniture and furnishings shall be clean and in good condition, and shall be arranged for the safety and greatest mobility of the population. Each child(ren)/youth shall have a separate bed, chair, dresser or other storage space and a closet or locker for jackets, coats and other outerwear. This standard also applies to residential care.

Private offices as well as common areas are clean, well lit, and appropriately furnished.

The site is decorated with posters/works of art that reflect the culture of the client population to be served.

3. Accessibility

The building housing the program site is clearly named and/or numbered. Prominent signs direct family members to the program site. Within the program site, there is an obvious reception area where family members are greeted.

4. Accessibility – American Disability Act

The Provider sites must comply with the Americans with Disabilities Act and applicable state and local laws make services and service locations accessible to family members with physical disabilities including, but not limited to, developing plans for: making facilities wheelchair accessible, utilizing sign language interpreters and large print informational reading materials.

To further facilitate family access to appropriate services, the Provider has established referral protocols to programs serving distinct disabled communities.

5. Hours of Operation

Providers must have flexible hours in the early morning, evening and/or on weekends to accommodate family members who work, attend treatment or school, or are otherwise engaged in essential activities.

6. Space

Space and Privacy

The Provider has sufficient space to support the range of services being offered. If the Provider site is used at all for counseling, there is space for its conduct in privacy to ensure confidentiality is maintained. The Provider site complies with all applicable health, fire and safety regulations.

Space Changes

If planned usage of the Provider site changes during the contract year, the provider must notify Children's Services, Office of Agency Program Assistance and the Office of Program Analysis and Development in writing at least 90 days prior to the proposed change

7. Health and Safety

Facilities are free of hazards, including but not limited to the following conditions:

- peeling paint, cracked plaster, water stains, and holes in walls, doors or ceilings;
- unlighted stairways, halls or entrance areas;

- cracked or broken windows;
- frayed or exposed electrical wiring;
- improperly stored combustible materials or poisonous substances;
- excessive litter or soil;
- signs of rodent infestation or vermin;
- unsanitary or unusable bathroom facilities;
- lack of operative charged and inspected fire extinguishers;
- inoperative smoke and/or fire alarms;
- uncapped electrical outlets;
- extension cords; and
- torn carpeting or unsecured rugs/runners, holes in flooring, missing/ broke.

ALL sites have:

- two exits clearly signed, well lighted and NOT blocked, chained or otherwise difficult to open; **OR**
- if there is only one visible means of egress, the site has been inspected and approved by the fire department;
- a plan for building evacuation; printed procedures to follow in case of fire conspicuously posted in all halls and reception areas; regularly held fire drills;
- annual FDNY inspection report;
- appropriate current Certificate of Occupancy; and
- adult supervision for all children's/youth's activities with age-appropriate ratios of adults to children.

8. Physical Protection

- The physical environment of the Provider provides for the safety of all the persons on the premises from physical harm, drugs, and other criminal activity.
- The Provider shall have a security plan which includes: precautions to be used when dealing with individuals who may be dangerous; actions to be taken when dangerous or potentially dangerous incidents occur; the circumstances under which the police are to be called; and maintaining good relationships with the local police and the precinct community relations officer.
- All staff has the local precinct's phone number readily available for emergency use.
- Only Fire Department approved gates are used on windows that are potentially accessible from outside.

9. Disaster Plan

The Provider disaster plans shall incorporate general disaster planning information; detail the procedures to be followed in caring for children/youth, youth and families in the event of a disaster or emergency; and focus on planning and procedures for the

continued care and supervision of all children/youth in the provider's care, both during and after the disaster or emergency.

Families receiving in-home services, including families of children/youth in out-of-home placement, shall also be encouraged to develop and update family disaster plans. Providers shall provide such families with emergency preparedness information and emergency contact numbers to call and check on the safety and status of their children/youth following a disaster or evacuation.

OCFS recommends that disaster plans of foster families and other child care providers include, but not be limited to, the following information:

- where the foster family, provider children and youth would go in an evacuation (if possible, identify two alternate locations);
- personal telephone numbers and contact information (for example, cell phone numbers, fax numbers, e-mail address);
- emergency contact information for individuals who may know where they are currently (for example, out-of-area relatives or friends);
- a list of critical items to take when evacuating with children/youth, including identification for the child(ren)/youth (birth certificate, SSN, citizenship documentation), the child(ren)'s/youth's medical information (including health insurance card), medication and/or medical equipment, educational records, and existing court orders dealing with who has legal authority over the child(ren)/youth; and
- normal contact, emergency contact or toll free telephone numbers for Provider personnel, including foster parents and voluntary child(ren)/youth care providers.

OCFS recommends that Provider disaster plans include, but not be limited to, the following information and planned activities:

- encouraging staff to develop personal disaster plans and keep them updated;
- requiring staff to check in after disasters and provide information on how to do so;
- keeping emergency supplies in the office (including satellite offices);
- training all staff on the Provider disaster plan and having them participate in drills;
- establishing personal and professional support services for staff;
- the protection of vital records; establishing off-site backup for information systems with case and client records;
- protecting data and equipment from environmental factors (for example, covering/bagging computers and office equipment, installing surge protectors);
- assessing the critical nature of paper records, prior to a disaster, and then determining what steps may be necessary to protect such records from potential damage in a disaster (for example, use of fire-safe metal filing cabinets); and

- the prior establishment of disaster planning agreements with organizations in neighboring counties and states that would likely be involved in running emergency shelters to help locate displaced children/youth and families following a disaster.

For more information, please access *Coping with Disasters and Strengthening Systems: A Framework for Child Welfare Agencies* (February 2007), which provides child welfare agencies a framework for dealing with disasters. This publication is available free of charge and may be accessed via the Internet:

<http://muskie.usm.maine.edu/helpkids/rcpdfs/copingwithdisasters.pdf>

G. Contract Termination Process

1. Termination

A. Children's Services and the Contractor shall have the right to unilaterally terminate their Foster Care Contract Agreement in whole or in part, upon thirty (30) days' written notice to the other subject to the terms of their Foster Care Contract Agreement including Section 12.02(A) of this Part II entitled "Responsibilities after Notice of Termination." In addition to any other rights to terminate their Foster Care Contract Agreement, which are contained in their Foster Care Contract Agreement, Children's Services may terminate this Agreement in whole or in part to conduct a new solicitation for the same services. This may include solicitation for any pilot program

B. The City shall not incur or pay any further obligation pursuant to their Foster Care Contract Agreement beyond the termination date. The City shall pay for services provided in accordance with their Foster Care Contract Agreement prior to the termination date. Any obligation necessarily incurred by the Provider on account of their Foster Care Contract Agreement prior to receipt of notice of termination and falling due after the termination date shall be paid by the City in accordance with the terms of this Agreement. In no event shall such obligation be construed as including any lease agreement, oral or written, entered into between the Provider and its landlord.

2. Responsibilities after Notice of Termination

A. Upon Children's Services' receipt of the Provider's notice to terminate their Foster Care Contract Agreement or the Provider's receipt of Children's Services' notice of termination or expiration of their Foster Care Contract Agreement, Children's Services shall make its best efforts to arrange for the transfer or discharge of all Foster Children to another foster care provider, as soon as possible. The Provider shall continue to provide all care and services required by the Foster Care Contract Agreement and the Law for all Foster Children in the Provider's care and not to discharge or refuse to continue to provide care and services to such charges until all Foster Children are transferred or discharged at the Commissioner's direction. Children's Services shall pay the Provider the rate established in their Foster Care Contract Agreement or any modified rate established by OCFS, until all Foster Children are transferred or

discharged. Children's Services will bring to the attention of OCFS the Provider's costs and expenses in closeout.

B. Upon notice of termination or expiration, the Provider shall comply with all Children's Services close-out procedures, including but not limited to:

1. Accounting for and refunding to Children's Services, within thirty (30) days after notice of termination or expiration, any unexpended funds which have been provided to the Provider pursuant to their Foster Care Contract Agreement;
2. Furnishing within thirty (30) days after notice of termination or expiration an inventory to Children's Services of all equipment, appurtenances and property purchased through or provided under their Foster Care Contract Agreement and carrying out any Children's Services or City directive concerning the disposition of such equipment, appurtenances and property;
3. Turning over to Children's Services or its designees all books, records, documents and material specifically relating to their Foster Care Contract Agreement that the Department has requested be turned over;
4. Submitting to Children's Services, within ninety (90) days after termination or expiration, a final report of receipt and expenditures of funds relating to their Family Foster Care Contract Agreement. The report shall be made by a CPA or a licensed public accountant;
5. Transmitting forthwith to Children's Services copies of all case records; and
6. Providing reasonable assistance to Children's Services in the transition, if any, to a new contractor.

APPENDIX 3

PROMOTING A SAFE AND RESPECTFUL ENVIRONMENT FOR LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUESTIONING (LGBTQ) YOUTH AND THEIR FAMILIES INVOLVED IN THE CHILD WELFARE, DETENTION AND JUVENILE JUSTICE SYSTEM

The City of New York Administration for Children's Services

Policy # 2012/01

**Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender
and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention
and Juvenile Justice System**

Approved By:  Ronald E. Richter, Commissioner	Date Issued: <u>11/21/12</u>	Number of Pages: 29	Number of Appendices: 5
Related Laws: N/A	Children's Services Divisions/Provider Agency: Children's Services Divisions of Child Protection; Family Support Services; Family Permanency Services; Youth and Family Justice; and Provider Agency Staff	Contact Office/Unit: For additional information on this policy please contact LGBTQ@dfa.state.ny.us	
Supporting Statutes and Regulations: • Foster Care - SSL 372, 373-a, 409-e, 409-f; 18 NYCRR 357.3, 430.12; • Preventive Services - SSL 409-a, 409-e, 409-f, 18 NYCRR 423.7 • CPS - SSL 422(4), (5), (6), (7); 422-a, and 424(4), (5); 18 NYCRR; • Adoption - DRL 114; SSL 373-a; 18 NYCRR 357.3, 421.2 (d), 421.18 • HIV- Public Health Law Article 27; • Domestic Violence - SSL 459-g; 18 NYCRR 452.10	Supporting Standards: ACS Foster Care Quality Assurance Standards 2011		
Bulletins & Directives: • OCFS PPM 3442.00 entitled <i>Lesbian Gay Bisexual and Transgender Youth</i> dated 3/17/08; • 09-OCFS-INF-06 entitled <i>Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender, and Questioning Children and Youth in Out-of-Home Placement</i>, dated 12/30/09.	Related Policies: • <i>Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care</i> – Policy 2010/04 dated 6/7/10 ; • Policy # 2011/02 entitled <i>Flexibility in Sleeping Arrangement Requirements for Sibling Foster Care Placements</i>; • <i>ACS Non-Discrimination – Youth and Families Policy # 2008/05</i>; • DJJ Operations Order # 06/03 entitled <i>Resident Personal Property and Grooming Paraphernalia</i>; DYFJ Directive # 17.1 entitled <i>Continuity of Care Policy and Procedures</i> • Children's Services Case Record Management Information Sharing Guidelines Guidance	Supersedes: This policy incorporates language from the following documents and hereby renders them obsolete: • Division of Child Protection Policy entitled <i>Assessing Safety of LGBTQ Children and Youth</i> dated 5/22/2009; • <i>Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare System Policy #2011/05</i> dated 7/27/2011; and • <i>Guidelines for Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved with DYFJ Directive #01-</i>	

APPENDIX 3 -PROMOTING A SAFE AND RESPECTFUL ENVIRONMENT FOR LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUESTIONING (LGBTQ) YOUTH AND THEIR FAMILIES INVOLVED IN THE CHILD WELFARE, DETENTION AND JUVENILE JUSTICE SYSTEM

	2009/04; • <i>Sharing Child Case Record Information between Children's Services, Foster Care and Preventive Provider Agencies – Guidance 2008/01</i>	2011 dated 7/27/2011.
Related Forms/Links/Sources: • FSS-009- ACS LGBTQ Senior Advisor Form • DYFJ- Resident Request for Ombudsman Services Form • http://10.239.3.195:8080/docushare/dsweb/Get/Document-137906/ACS LGBTQ Youth Community Resource Guide - August 2010.pdf • Caitlin Ryan's Family Acceptance Project • http://www.wpath.org/publications_standards.cfm • http://www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf • Teen SENSE Model Policies and Standards • GLAAD Media Reference Guide: http://www.glaad.org/reference/lgb; and http://www.glaad.org/reference/transgender		
SUMMARY: Children's Services is committed to providing all youth ¹ and families served by Children's Services and our contracted provider agencies a safe, healthy, inclusive, affirming and discrimination-free environment. This includes any child, youth or family member receiving services from Children's Services Protective, Preventive, Foster Care, Juvenile Justice Placement, Detention, or Alternative to Detention (ATD) and Alternative to Placement (ATP) settings, who self-identifies as or is perceived to be lesbian, gay, bisexual, transgender and questioning (LGBTQ). This LGBTQ policy provides best practice guidelines to both Children's Services and provider agency staff on sensitive, respectful and culturally competent practice as well as strategies to address bias and meet the unique needs of youth and their families.		
SCOPE: This Policy applies to all Children's Services staff, as well as provider agency staff responsible for providing services to youth and families within the purview of Children's Services. ² The provision of services within Children's Services' facilities and programs shall be based on professional standards as found in the New York State Office of Children and Family Services (OCFS) Guidelines for Good Childcare Practices with Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth, ³ and the OCFS policy entitled <i>Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender, and Questioning Children and Youth in Out-of-Home Placement</i> (09-OCFS-INF-06, 12/30/09). Additionally, this policy incorporates language from the Division of Child Protection Policy entitled <i>Assessing Safety of LGBTQ Children and Youth</i> , 5/22/2009; <i>Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare System</i> , 7/27/2011; and <i>Guidelines for Promoting a Safe and Respectable Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved with DYFJ Directive 01-2011</i> , 7/27/11. All three policies are hereby rendered obsolete.		

¹For the purpose of this policy all references to "youth" and/or "children" will apply to youth/children receiving custodial and/or community-based services from Children's Services, including children and youth receiving any and all child protective and preventive services, youth in alternative-to-detention/placement programs, youth in foster care placements, youth in juvenile justice placement, and youth in detention facilities.

² All references to staff in this policy include volunteer staff where applicable.

³ These guidelines are listed in the OCFS PPM 3442.00 entitled *Lesbian Gay Bisexual and Transgender and Questioning Youth*, dated 3/17/08.

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I. **General Information About The Term “LGBTQ”**

A. Definitions⁴

LGBTQ⁵ is an acronym commonly used to refer to lesbian, gay, bisexual, transgender, and questioning individuals. In order to ensure the broadest levels of protection under this policy, LGBTQ youth shall include youth who have self-identified or are perceived by others as LGBTQ. The following is an explanation of each of the terms used to define LGBTQ:

1. Lesbian - refers to a woman who is emotionally, romantically, and/or physically attracted to other women. Some lesbians may prefer to identify as gay to describe themselves or as gay women.
2. Gay - refers to a person who is emotionally, romantically, and/or physically attracted to people of the same gender. Sometimes, it may be used to refer to gay men and boys only. It is preferred over the term “homosexual,” which is an outdated term considered derogatory and offensive to many LGBTQ people.
3. Bisexual - refers to a person who is emotionally, romantically, and/or physically attracted to men and women. Bisexual people do not need to have had sexual experiences with both men and women; in fact, they do not need to have had any sexual experience at all to identify as bisexual.
4. Transgender - may be used as an umbrella term to include all persons whose gender identity or gender expression does not correspond with their sex assigned at birth. For purposes of protection from discrimination and harassment, transgender refers to both self-identified transgender individuals and individuals perceived as transgender without regard to whether they qualify for a diagnosis of Gender Identity Disorder.
5. Questioning - refers to a person, often an adolescent, who is exploring or questioning issues of sexual orientation or gender identity or expression in his or her life. Some questioning people will ultimately identify as lesbian, gay, bisexual and/or transgender; others will ultimately self-identify as straight and/or non-transgender.

B. Sexual Orientation vs. Gender Identity

Sexual orientation and gender identity are two different constructs because sexual orientation is separate from gender identity. If someone identifies as

⁴ A more comprehensive definition section is included in Attachment A: Glossary of Terms.

⁵ For some youth the Q can represent “queer” and at times is used interchangeably with “Questioning.”

transgender he/she may also identify his/her sexual orientation as straight, gay, lesbian, or bisexual. Youth may also identify differently on different days, as they continue to develop their identities. It is important for staff to understand that children and adults whose identity is fluid may be exploring their identity and/or may simply be expressing their sexual orientation or gender identity. Please refer to Attachment A for a glossary of other LGBTQ related terms.

II. General Policy

A. Applicability of General Requirements and Guidelines

It is ACS policy that all LGBTQ youth shall be in LGBTQ-affirming homes and LGBTQ-affirming congregate facilities. The following requirements and guidelines apply to all Children's Services and contracted provider agency staff involved in any way with custodial and/or community-based services provided directly by Children's Services staff or under contract with Children's Services, including child protective and preventive services, alternative-to-detention/placement programs, foster care, congregate care, juvenile justice placements, and detention facilities.

B. Non-Discrimination

Children's Services is committed to being respectful of the dignity of all youth and families, and to keeping children and youth (hereinafter referred to as "youth") safe while meeting their unique needs, regardless of their sexual orientation, gender identity and/or gender expression. No Children's Services or provider agency staff shall unlawfully discriminate against other persons in the course of their work. The Children's Services policy entitled *Non-Discrimination -Youth and Families Guidance 2008/05 (6/20/08)* prohibits discrimination on the basis of race, ethnicity, creed, color, age, sex, national origin, religion, marital status or partnership, mental or physical disability, gender identity, gender expression, sexual orientation, veteran status, alienage and citizenship status.

C. Coercion and Imposition of Beliefs

1. Under no circumstance is any staff member of Children's Services or its provider agencies to attempt to convince an LGBTQ youth to reject or modify his/her sexual orientation or gender identity. Medical and mental health professional organizations, including the National Association of Social Workers, the American Psychiatric Association, the American Academy of Pediatrics, the American Medical Association, and the American School Counselor Association strongly condemn any attempt to "correct" or change youths' sexual orientation or gender identity through corrective or reparative therapy. Additionally, staff are prohibited from attempting to convince or coerce an LGBTQ youth to disclose or reveal his/her sexual orientation or gender identity only out of

curiosity, or for any other reason not listed as permissible in the section below entitled, *"Disclosure by youth and/or family members"* [see Section II (H)].

2. Children's Services and provider agency staff are prohibited from imposing their personal, organizational and/or religious beliefs on all families, including LGBTQ youth or families. Personal beliefs of Children's Services and provider agency staff shall not under any circumstances impact the way individual needs of youth or families are met.
3. Children's Services and provider agency staff are prohibited from employing, contracting with, or making referrals to, mental health providers and/or other service providers who attempt to change a youth's sexual orientation or gender identity. (Attachment C provides a list of recommended LGBTQ affirming providers).

D. Staff Conduct

1. Children's Services and provider agency staff must model appropriate and affirming behavior at all times. This means that bias, discrimination, bullying or harassment by staff or by youth towards youth and/or families is not tolerated, and immediate action to intervene in any such situations must be taken by staff. Children's Services and provider agency staff are obligated to report staff conduct that violates the Non-Discrimination Policy and/or this policy. If an issue arises, the staff member must confer with his/her supervisor and, if unresolved, contact the Children's Services LGBTQ Senior Advisor. (See section on *Expectations for the ACS LGBTQ Senior Advisor* for additional information).

E. Addressing Incidents

1. Supervisory and management staff must treat all incidents of discrimination and harassment as serious and follow up promptly. In accordance with Children's Services' policy and procedures, alleged violations of this policy by staff or youth will be investigated promptly and, if determined to have occurred, will result in the enforcement of corrective and/or disciplinary action.

F. Guidelines for Staff Interaction with Youth

1. Safety and security, as well as good childcare practices, remain paramount for all youth in care. Children's Services and provider agency staff shall establish and maintain a culture where the dignity of every youth is respected and all youth feel safe. All youth, regardless of gender identity, gender expression, and/or sexual orientation, need to feel safe in their surroundings in order for positive programming and outcomes to occur.

- a. Policies must be established and enforced to promote dignity and respect for all youth and families regardless of their gender identity, gender expression, sexual orientation, or family association.
- b. All Children's Services and provider agency staff must promote the positive adolescent development of all youth by demonstrating respect for all youth, reinforcing respect for differences among youth, encouraging the development of healthy self-esteem in youth, and helping youth manage the stigma often associated with difference.
- c. Staff must not over-emphasize or focus specifically on gender identity, gender expression, and sexual orientation issues with youth.
- d. Staff must set a good example and make youth and families aware that any anti-LGBTQ threats of violence, and/or disrespectful, suggestive comments or gestures towards any youth will not be tolerated. Staff also shall not engage in these behaviors.
- e. Staff shall be aware that the psychosocial stress associated with explicit and implicit homophobia, heterosexism, and transphobia, and the stigma associated with being LGBTQ youth, may contribute to depression and anxiety, increased suicide risk, substance use, and truancy or dropping out of school.
- f. Staff must be familiar with the unique family dynamics that emerge for LGBTQ youth in general, and LGBTQ youth involved with the child welfare and/or juvenile justice systems in particular, and recognize that many LGBTQ youth involved in the juvenile justice system have child welfare histories that precede or have resulted from recognition of sexual orientation and/or gender identity by self and others. All staff must recognize that family responses to youth sexual orientation and/or gender identity may vary widely and interact with other aspects of youth and families' identities including race, class, gender, citizenship, etc.
- g. All staff must be aware that many LGBTQ youth, particularly those involved with the child welfare and/or juvenile justice systems, have had experiences of trauma (e.g. violence, sexual abuse, verbal harassment, etc.) related to their sexual orientation and/or gender identity and should receive ongoing clinical training specific to these unique forms of trauma. Staff must also be aware that LGBTQ youth are particularly susceptible to trauma, discrimination and abuse, especially within congregate care facilities. Staff must be able to recognize signs of distress, support disclosure when appropriate, and follow appropriate protocols for reporting.

G. LGBTQ Identities, Language and Terminology

1. All individuals have their own preferences for how they describe themselves, which often evolve over time. All Children's Services and provider agency staff are required to use respectful, inclusive, and gender-neutral language. Examples of such language include, but are not limited to: lesbian, gay, bisexual, transgender, gender non-conforming, sexual orientation, gender identity, "involved with someone," and "partner."
2. Staff are prohibited from using value-laden and outdated terms, including but not limited to: "homo," "homosexual," "sexual preference," "alternative lifestyle," "trannie," "transvestite," and "sex change."
3. Since some terms may be acceptable and/or preferable to one person and offensive to another, staff must reflect/mirror the language and terminology employed by that youth or family member (when appropriate) during one-on-one interaction. Staff must help all youth and family members use language that is respectful to all parties. (For an explanation of LGBTQ-related terms, see the *Glossary of Terms* - Attachment A).

H. Confidentiality

1. LGBTQ youth face great risk of abuse when their sexual orientation and/or gender identity are disclosed to a parent or primary caretaker, particularly when the disclosure occurs without the youth's consent and/or in an inappropriate manner.⁶ As such, the following proscriptions concerning confidentiality and disclosure -- which govern all information obtained by staff in the course of their work with all youth and families -- must be followed carefully when staff are working with LGBTQ youth.
2. CONNECTIONS has safeguards incorporated into its design to support the confidentiality of the individual and family case record. Federal statutes and numerous sections of the Social Services Law (SSL), the Public Health Law (PHL) and the New York Codes, Rules and Regulations (NYCRR) address the issue of confidentiality.⁷

⁶ This often includes, but is not limited to, serious physical harm, homelessness, substance abuse and mental health conditions such as depression.

⁷ E.g. Foster Care - SSL 372, 373-a, 409-e, 409-f; 18 NYCRR 357.3, 430.12; Preventive Services - SSL 409-a, 409-e, 409-f, 18 NYCRR 423.7; CPS - SSL 422(4), (5), (6), (7); 422-a, and 424(4), (5); 18 NYCRR ; Adoption - DRL 114; SSL 373-a; 18 NYCRR 357.3, 421.2 (d), 421.18; HIV- Public Health Law Article 27-F; 18 NYCRR 421.2 (d), 431.7; Domestic Violence - SSL 459-g; 18 NYCRR 452.10.

3. All staff are required to protect and/or maintain the confidentiality of the families they serve.
4. ACS and provider agency staff shall inform youth during engagement of services and when age-appropriate of the need for their case record information to be shared with other legally authorized individuals, including but not limited to, the courts, school, medical services, agency staff, and all other legally authorized persons. These people/entities may be provided with specific information, pursuant to state and federal laws governing confidentiality, so they may fulfill their responsibilities; adequately provide services; and plan for the health, safety, permanency and well-being of youth and their families.
5. Staff are prohibited from disclosing a youth's sexual orientation or gender identity to other individuals or agencies, without the youth's permission, unless such disclosure is consistent with state or federal law or regulation.⁸ Some examples of permissible disclosure include: if the information is necessary to determine safety or if a judge orders the disclosure.

I. Disclosure by Youth and/or Family Members

1. A person may disclose his/her sexual orientation and/or gender identity to staff when, and if, he/she feels ready. Usually, youth and/or family members will disclose in a safe, trusting environment. If a youth or family member discloses that he or she is LGBTQ, staff must speak with him or her about it utilizing appropriate, inclusive and gender-neutral language. Staff must also speak to the youth about circumstances in which the staff member may be required to disclose the LGBTQ status of the youth and whether there may be circumstances where the staff member will ask the youth for permission to disclose his/her sexual orientation and/or gender identity.
2. There are some circumstances when it is appropriate for staff to try affirmatively to provide an opportunity for youth to disclose that they are LGBTQ. Often, this will be raised when discussing the need for residential and/or foster care placement options and medical and/or community supports. This information may also prove relevant to decisions regarding educational services, the PINS and delinquency diversion processes, disposition, reunification and placement. If the staff member is unsure about how best to raise these issues with a youth and/or family member, the staff member must contact for guidance the ACS LGBTQ Senior Advisor. Provider agency staff may also reach out to their supervisors and/or their agency's LGBTQ Point Person (see Section III[L] beginning on page 26 for guidance).

⁸ See 05-OCFS-ADM-02 relating to confidentiality of records.

J. Use of Preferred Name

1. All youth may request that Children's Services and provider agency staff use a preferred first name, and the gender with which they identify if applicable, rather than their legal name. All staff are required to comply with such requests; and youth can report noncompliance to the LGBTQ Point Person at the provider agency or directly to the ACS LGBTQ Senior Advisor. Youth must also be referred to by the pronoun that they state reflects their preferred gender identity or expression.
2. When a young person requests the use of a preferred first name and/or preferred gender pronoun, Children's Services and provider agency staff must ask the youth which name (legal name or preferred name) and gender pronouns Children's Services and provider agency staff should use to refer to the youth in conversations with the youth's family, and which name (legal or preferred) and gender pronouns staff should use to refer to the youth in conversations with other service providers (e.g. community-based service providers, Department of Education, or other related agencies, etc.) and the Family Court. Please see the section below entitled, "Documentation," regarding the requirements for documenting these preferences in Connections ("CNNX") or other systems of record.
3. Staff must comply with the youth's requests regarding name and pronoun at all times. Use of the incorrect name or pronoun may pose safety risks to youth who have not disclosed their gender identity to family members, friends, other services providers, and/or the Family Court. If necessary, staff must reiterate the proscriptions regarding confidentiality above when discussing the use of preferred names and/or pronouns with youth.
4. When discussing name and pronoun preference with young people the following questions can be used to assist the dialogue:
 - a. Which name would you prefer for me to use when I call your family?
 - b. Which gender pronoun should I use for you when I call your family?
 - c. When I call your family, would you feel safer if I used your legal name or your preferred name?
5. Staff must periodically check in with young people to see if it is still safe for staff to refer to them by their name and/or pronoun of choice when calling parents/guardians.

K. Documentation

1. When documenting progress notes in Connections (CNNX) or other systems of record, the worker must use the youth's legal name followed by the preferred name (e.g. John a/k/a Jennifer). Staff must also clearly indicate which name is preferred and in which situations, and which name is the legal name. Children's Services and provider agency staff must inform the youth about who will have access to these documents before they are disseminated.
2. Children's Services and provider agency staff must reach out to the assigned Children's Services Family Court Legal Services attorney if records are being produced or subpoenaed by the court and the youth's different names are noted in the records. If the youth is requesting that certain names be kept confidential from the Court, this issue must be raised with the FCLS attorney as soon as the issue arises and before each court date, so that the attorney can determine whether to request that the Court redact the records before they are provided to the other parties (e.g. the parent[s]) involved in the court case.
3. All pertinent documentation under the control of Children's Services and provider agency staff must have both the legal and preferred name of the youth, and clearly indicate which name is preferred and which name is the legal name.

L. LGBTQ-Affirming Literature and Written Materials

1. Children's Services and provider agency staff must make available LGBTQ affirming literature and resources to all youth and families served by the agencies. LGBTQ-affirming literature includes but is not limited to:
 - a. written and verbal information regarding respect for, and supports available to, LGBTQ youth,
 - b. website list of community resources supports,
 - c. other appropriate books and materials,
 - d. the youth's rights and responsibilities and the procedures for reporting complaints, and
 - e. a copy of this policy where age appropriate shall be given to all youth. Regardless of age-appropriateness or literacy level, the policy must be explained to each youth upon admission to detention, juvenile justice placement, foster care, and congregate care settings. Only staff familiar with the policy and terminology within shall explain the policy to youth.
2. Programs must affirm the identity of each youth by creating supportive environments (e.g. incorporating LGBTQ culturally specific art or social events, such as "LGBTQ Pride" into the general schedule or curriculum). This will indicate that staff and foster parents are knowledgeable of and open to communication on this topic. Educational books and other reading materials for youth interested in learning more about LGBTQ issues must be made available to

youth in foster care and facilities. Materials must be made available in languages other than English, as needed, and as funding is available.⁹

3. Children's Services and provider agencies must display LGBTQ literature and visible signage providing information about the contact information for the ACS LGBTQ Senior Advisor and the provider agency's designated LGBTQ Point Person (see section on *Provider Agency LGBTQ Point Person Expectations*) in common areas that are visible to all staff, youth, and families.

M. Advocacy

1. The Children's Services Office of Advocacy can be used as a resource for LGBTQ youth receiving any services – community-based or custodial – that have questions. Information about the Office of Advocacy may be accessed at http://www.nyc.gov/html/acs/html/advocacy/office_advocacy.shtml or at the Parents and Children's Rights Helpline at (212) 676-9421.
2. The attached *LGBTQ Rights* flyer (Attachment B) can also be used as a supplemental resource for the youth. Additionally, Children's Services has a comprehensive *Community Resource Guide for LGBTQ Youth* which is available electronically (via DocuShare at the following link [http://10.239.3.195:8080/docushare/dsweb/Get/Document-137906/ACS LGBTQ Youth Community Resource Guide - August 2010.pdf](http://10.239.3.195:8080/docushare/dsweb/Get/Document-137906/ACS_LGBTQ_Youth_Community_Resource_Guide_-_August_2010.pdf)) and in hard copy (both in document and pocket size). LGBTQ youth and families can also call 311 for further information.

N. Service Referrals

1. All Children's Services and provider agency staff are responsible for referring youth and families for counseling, health, mental health, or other services as needed and appropriate, regardless of a youth's sexual orientation, gender identity, or gender expression. If a youth discloses that he or she is LGBTQ, the youth must be offered the opportunity for counseling and information regarding LGBTQ-appropriate health, and mental health or other services. Referrals to community-based providers who can supplement Children's Services and/or provider agency services, must be made when appropriate.
2. When discharge and transition planning, staff /supervisory staff must refer youth who identify as LGBTQ to community-based providers who have demonstrated that they are culturally competent in working with LGBTQ youth. If a youth who identifies as LGBTQ is referred to a community-based provider which staff

⁹ See Executive Order 120 entitled Citywide Policy on Language Access to Ensure the Effective Delivery of City Services dated July 22, 2008.

become aware is not culturally competent in working with LGBTQ youth, staff must inform the youth and provide the youth with other LGBTQ community-based resources to which the youth can turn for assistance. If the youth's gender identity and/or sexual orientation is known to the family or other caretakers to whom the youth is returning/residing, the family must be given this information as well.

3. When making these referrals, staff must recognize that many youth are exploring their sexual orientation, gender identity, and/or gender expression, and that youth may not know all relevant terminology, or may be questioning their own sexual orientation and/or gender identity.

O. Medical and Mental Health Assessments and Services

1. The following requirements and guidelines shall be followed by all clinicians when conducting medical and/or mental health assessments of, providing medical and/or mental health services to, or arranging the provision of medical and/or mental health services to, youth.¹⁰
 - a. Clinicians working with youth must facilitate exploration of any LGBTQ issues by being open, non-judgmental, and empathetic. If the mental health clinicians are not Children's Services or provider agency staff, the Children's Services and/or provider agency staff working with mental health clinicians who are providing services to youth must explore the clinicians' attitudes and opinions towards LGBTQ people to confirm that they can provide services that are open, non-judgmental, and empathetic.
 - b. Clinicians must not assume any mental illness/pathology because a youth identifies as LGBTQ or is gender non-conforming. Clinicians must also recognize that all adolescents experience developmental and social challenges during those years; however, LGBTQ youth face additional pressures based on their gender identity or sexual orientation.
 - c. Clinicians must be aware that the psychosocial stress associated with explicit and implicit homophobia, heterosexism, and transphobia, and the stigma associated with being LGBTQ youth, may contribute to depression and anxiety, increased suicide risk, substance use, and truancy or dropping out of school.

¹⁰ Per applicable regulations, all youth in foster care, detention, and juvenile justice placement must receive a comprehensive medical and mental health screening upon entry into custodial care, and as needed while in Children's Services' custody, so that individual needs are identified and a treatment response provided. Proscriptions regarding hormone therapy are included below in Section III of this policy.

- d. Clinicians must be familiar with the unique family dynamics that emerge for LGBTQ youth in general, and systems involved with LGBTQ youth in particular, and recognize that many LGBTQ youth are in the child welfare and/or juvenile justice systems due to stigma related to their sexual orientation, gender expression, or gender identity.
- e. Clinicians must also recognize that many LGBTQ youth are in the child welfare, and/or juvenile justice systems for reasons other than their sexual orientation, gender expression, or gender identity. Clinicians must recognize that family responses to youth's sexual orientation and/or gender identity may vary widely and interact with other aspects of youth and families' identities including race, class, gender, citizenship, etc. Clinicians must therefore employ a comprehensive approach to counseling and facilitate family reconciliation where indicated and possible.
- f. Clinicians must be aware that many system-involved LGBTQ youth have had experiences of trauma (e.g. violence, sexual abuse, verbal harassment, etc.) related to their sexual orientation and/or gender identity. Therefore, clinicians must receive ongoing clinical training specific to these unique forms of trauma. Clinicians must also be aware that LGBTQ youth are particularly susceptible to trauma, discrimination and abuse within residential care facilities and must be able to recognize signs of distress, and support disclosure where appropriate, as well as to follow appropriate protocols for reporting.
- g. Clinicians must be prepared to help LGBTQ youth explore their feelings about their gender identity and/or sexual orientation along with related issues and questions in a safe and affirming manner. Clinicians shall be familiar with community resources available to LGBTQ youth for the purposes of both collaboration and referral.
- h. Clinicians shall be trained and become versed in World Professional Association for Transgender Health's Standards of Care for Gender Identity Disorders (WPATH Standards of Care for the Health of Transsexual Transgender, and Gender Non-conforming People),¹¹ and the Endocrine Society's Clinical Guidelines on the Endocrine Treatment of Transsexual Persons (2009)¹² and be able to meaningfully integrate counseling and mental health services with medical care that transgender and gender non-conforming youth may be receiving. (Please refer to Attachment C for a list of suggested clinicians within New York that meet these criteria).

¹¹ See http://www.wpath.org/publications_standards.cfm for complete WPATH Standards.

¹² For complete guidelines See <http://www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf>

- i. All clinicians must be made aware that nearly every professional organization within the mental health and medical fields, including the National Association of Social Workers and the American Psychiatric Association, strongly condemn any attempt to “correct” or change youth’s sexual orientation or gender identity through corrective or reparative therapy. Attempts to do so are strictly prohibited by this policy (See Section II [B]).
- j. Where medically indicated as for all youth, the program clinical staff working with LGBTQ youth must refer the youth to an appropriate specialist.
- k. All clinicians must be told by the provider agency either by phone prior to the appointment or when accompanying the youth to the medical or mental health appointment that Children’s Services’ policy is that youth may only be asked about behaviors, not identities, to appropriately screen and treat for medical conditions. For example, when youth are screened for sexual activity, they shall be asked the sex of sexual partners, rather than whether the young person identifies as LGBTQ. Contracted medical service providers must also provide to their patients appropriate medical information and education for all youth, inclusive of any related to LGBTQ medical and mental health issues.
- l. With the exception of emergency medical treatment where following these proscriptions is not possible, all clinicians to which youth are referred shall receive a copy of this policy (one copy, at the first appointment, is sufficient). The provider agency must also confirm with the clinician, prior to the youth receiving clinical services, that the clinician has received professional LGBTQ cultural competency training tailored to the medical profession.¹³

P. Training

- 1. All Children’s Services and provider agency staff and foster parents having direct contact with children and families are required to be trained on the goals and expectations of this policy.¹⁴ Training shall be provided to staff during the staff’s initial orientation, and at least once every two (2) years thereafter.
- 2. The Children’s Services’ and provider agencies’ curriculum shall include but not be limited to:
 - a. assessing, identifying, and addressing the specific needs of LGBTQ youth and their families;

¹³ As such providers are expected to use contractors that meet the same requirement.

¹⁴ It is expected that all provider agency staff will be trained on the goals and expectations of this policy within one year of the policy issue date.

- b. recognizing the difference between their personal values and their professional responsibilities;
 - c. implementing this ACS LGBTQ Policy and related policies;¹⁵
 - d. developing the skills needed to assist families in negotiating the difficulties that may emerge when an adolescent self-identifies as LGBTQ;
 - e. demonstrating sensitivity when addressing this issue with parents, and helping parents to sustain a positive and healthy relationship with their child; and
 - f. for supervisory staff, monitoring the implementation of this policy and related services.
3. Training may be provided in a classroom setting, or using various technology resources (e.g. e-learning, webinars, or teleconference).
4. LGBTQ training curriculums must be vetted by ACS. Curriculums shall be sent to LGBTQ@dfa.state.ny.us for approval. In collaboration with the James Satterwhite Academy, provider agencies, and the LGBTQ advocacy and provider community, Children's Services may be available to assist in the provision of training concerning LGBTQ cultural competency, and working with LGBTQ youth and families.

III. Requirements and Guidelines for Specific Divisions and/or Program Areas

A. Applicability of Special Requirements and Guidelines

While the general requirements and guidelines above apply to all Children's Services and provider programs, there are additional requirements and guidelines that are unique to specific Children's Services and provider program areas. The following provides expectations of all Children's Services and provider agency staff within the stated program areas.

B. Children's Services Division of Child Protection ("DCP") Staff Conducting Child Protective Investigations

1. Safety and Risk Assessments

- a. When assessing the safety and risk of an LGBTQ youth, Children's Services staff within DCP¹⁶ must, in addition to looking for other safety factors, assess whether a parent's attitude about the child's actual or perceived sexual

¹⁵ This ACS Policy on Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families involved in the Child Welfare, Detention, and Juvenile Justice System; ACS Non-Discrimination Policy, and ACS Non-Medicaid Reimbursable Policy.

¹⁶ Although this refers only to Child Protective Services staff within the Division of Child Protection, safety assessments of this nature, and the proscriptions and requirements contained within this policy with respect to such assessments,

orientation and/or gender identity is contributing to the parent's behavior, and in turn, whether the parent's behavior impacts the child's safety or places the child at risk.

- b. Children may experience maltreatment on the basis of a caretaker's *perception* of the child as being LGBTQ, regardless how the child identifies. Occasionally, youth who are not LGBTQ are perceived by others to be LGBTQ and abused and/or neglected as a result. This may even be true for very young children and toddlers who behave in gender atypical ways (e.g. boys who play with dolls or girls who play with trucks) but are too young to identify as LGBTQ.

2. Interviewing an LGBTQ Youth

- a. Often, LGBTQ youth experience hostility and rejection in their home (or other places where their families might not be able to protect them) based upon their actual or perceived sexual orientation and/or gender identity. This hostile atmosphere might not be apparent to the Child Protective Specialist (CPS), so appropriate measures must be taken to speak privately with the youth during child protective investigations. The CPS should use sensitive and inclusive language that signals to the young person that he/she will be treated with respect and dignity, regardless of how he/she identifies.

3. Interviewing the Parent/Caretaker of an LGBTQ Youth

- a. As noted above, LGBTQ youth face great risk of abuse when their sexual orientation and/or gender identity are disclosed to a parent or primary caretaker, particularly when the disclosure occurs without the youth's consent and/or in an inappropriate manner. CPS interviews with parents may include a discussion of the child's actual or perceived sexual orientation/gender identity only when the youth has already identified openly as LGBTQ to the parents (or other primary caretaker) and the alleged abuse/and or maltreatment are directly related to the child's perceived or actual sexual orientation, gender expression, or gender identity. In this instance:
 - i. The CPS must focus the investigation on eliciting from the parents their attitudes and beliefs about LGBTQ people.
 - ii. The CPS may not divulge to the parents any personal details the youth may have told the CPS about his or her sexual orientation or gender identity, without the express consent of the youth.
 - iii. If the parent displays negative attitudes about LGBTQ people, even when deeply rooted in religious beliefs and cultural values, and the alleged abuse

also apply to mandated reporter staff throughout Children's Services when they are conducting safety and risk assessments.

and/or maltreatment are related to the youth's perceived or actual sexual orientation, gender expression, or gender identity, the CPS must determine whether those attitudes are impacting the youth's immediate safety, as well as whether those attitudes may put the youth at risk for future physical or emotional harm.

4. Completing the Safety Assessment of an LGBTQ Youth in CONNECTIONS (CNNX)

- a. The parent/caretaker's attitude about the child's actual or perceived sexual orientation and/or gender identity, as well as the behaviors that stem from that attitude, must be carefully considered when identifying safety factors in cases involving LGBTQ youth. When documenting the youth's safety assessment in CNNX, the CPS must select the applicable safety factors. For example:
 - i. If a parent will only allow the child to remain in the home if the child is "straight": Safety Factor 7 (Parent/Caretaker is unable and/or unwilling to meet the children's needs for food, clothing, shelter, medical or mental health care and/or control child's behavior) must be chosen;
 - ii. If a parent is verbally abusive to the child, ostracizes the child, ridicules, or belittles the child: Safety Factor 10 (Parent(s)/Caretaker(s) view, describe or act toward the child(ren) in predominantly negative terms and/or have extremely unrealistic expectations of the child(ren)) must be chosen;
 - iii. If a parent will not allow the child to dress in a manner in accordance with his/her gender identity: Safety Factor 10 (Parent(s)/Caretaker(s) view, describe or act toward the child(ren) in predominantly negative terms and/or have extremely unrealistic expectations of the child(ren)) must be chosen; and
 - iv. If the child is afraid to remain in the household out of fear that the parent may harm the child, or allow the child to be harmed: Safety Factor 14 (Child(ren) expresses or exhibits fear of being in the home due to current behaviors of Parent(s)/Caretaker(s) or other persons living in or frequenting the household) must be chosen.
- b. As with any other safety assessment, the assessment must focus on the behaviors the caretaker is displaying that impact the safety of the child and/or place the child at risk of physical and/or emotional harm. Neither a child or youth's actual or perceived sexual orientation and/or gender identity, nor the parent's cultural and/or religious beliefs, excuses a parent's or caretaker's abusive or neglectful behavior.

- c. Safety planning for LGBTQ youth must include interventions that will cause the youth to be both physically and emotionally safe.

C. Preventive Services¹⁷

1. When Children's Services and provider agency preventive services staff come in contact with youth and families that identify as LGBTQ, the following guidelines shall be followed:
 - a. Staff involved with preventive services shall help stabilize and create safety for LGBTQ youth in their homes to prevent out-of-home placement for LGBTQ youth whenever possible. This work shall include providing LGBTQ specific community resources to youth and families for support (e.g. a copy of the ACS LGBTQ Community Resource Guide.)¹⁸
 - b. Staff shall carefully consider the parent/caretaker's attitude towards the child's actual or perceived sexual orientation, gender identity, and other related behaviors throughout the life of the case when identifying possible safety factors in a family receiving, or being recommended for, preventive services. This shall be done on an ongoing basis by engaging parents/caretakers and informing them that family rejection is a strong predictor of negative health outcomes (e.g. mental health, substance abuse and sexual risk). It is also essential to emphasize that a continued relationship with some level of acceptance and understanding is critical to the health of the child.¹⁹
2. If a case is referred to preventive services because of an LGBTQ-specific issue and the determination of the preventive provider agency, at intake or at any time throughout the life of the case, is that this is not a case that can be appropriately serviced by the agency because the agency lacks sufficient expertise in LGBTQ issues, the preventive provider shall communicate this to the ACS LGBTQ Senior Advisor via the LGBTQ Senior Advisor Request Form (Form FSS-009) (see section on Advocacy and Incident Reporting Procedures for Youth for additional information).²⁰ These requests must be sent to LGBTQ@dfa.state.ny.us.

¹⁷ This applies to all Preventive ACS and provider agency staff that provide services to youth and families who self-identify as or are perceived to be lesbian, gay, bisexual, transgender and questioning (LGBTQ). This includes all preventive services procured by Children's Services, including but not limited to, the Juvenile Justice Initiative and Family Assessment Program within the Division of Youth and Family Justice.

¹⁸ Provider agency staff can access this document via DocuShare at [http://10.239.3.195:8080/docushare/dsweb/Get/Document-137906/ACS LGBTQ Youth Community Resource Guide - August 2010.pdf](http://10.239.3.195:8080/docushare/dsweb/Get/Document-137906/ACS%20LGBTQ%20Youth%20Community%20Resource%20Guide%20-%20August%202010.pdf)

¹⁹ See Caitlin Ryan's Family Acceptance Project.

²⁰ For additional information on LGBTQ Senior Advisor, see section on *ACS LGBTQ Senior Advisor*.

3. As in all preventive cases, when eliciting information from a child's parent or other caretaker, a worker must take the necessary steps and actions to verify that a child is not left in neglectful circumstances. Once the conversation has occurred, the preventive staff shall make strong efforts to interview the youth, apart from the parents/caretakers, because youth are in the best position to determine whether they feel comfortable in their home. If a preventive worker has reasonable cause to suspect that a child is an abused or maltreated child, the worker must make a report to the Statewide Central Register of Child Abuse and Maltreatment, consistent with his/her mandated reporting responsibility.
4. The preventive provider agency will report each and every incident of LGBTQ-related bias, harassment and/or abuse to the ACS LGBTQ Senior Advisor via form FSS 009 and the ACS LGBTQ Senior Advisor will keep track of incidents and how they are handled.

D. General Responsibilities for LGBTQ Youth in Foster Care, Congregate Care, Detention and Juvenile Justice Placement Settings

1. When a youth who identifies as LGBTQ enters foster care, congregate care, detention and/or juvenile justice placement settings (hereinafter referred to as "Children's Services custodial care"), staff must make diligent efforts to place the youth in an LGBTQ affirming home or facility, and shall ensure that other needs of the youth are recognized and met.²¹
2. Staff shall also ensure that the families and facilities that are providing an LGBTQ affirming home/environment for youth are given the support needed to provide optimal care for LGBTQ youth.
3. All youth shall be held to the same standards of age-appropriate behavior. Standards regarding romantic and sexual behavior shall be applied evenhandedly, regardless of sexual orientation or gender identity. Staff must maintain boundaries for safe and appropriate behavior with all residents. Staff must not respond in a more punitive or more lenient manner to any inappropriate behavior related to dating or sex that is not permitted in Children's Services custodial care. The same consequences apply to all youth, including LGBTQ youth, who violate these rules.
4. All youth must be included in all activities for which they are eligible and show a positive interest. Encouraging or discouraging participation in activities on the basis of the sexual orientation and/or gender identity of the youth is prohibited.

²¹ An LGBTQ- affirming home or congregate care setting is one with foster parents and/or staff who welcome LGBTQ youth, treat them with respect and dignity, and diligently work to meet their unique needs.

E. Mental Health Services in Congregate Care Settings, including Congregate Care Foster Care Settings, Juvenile Justice Placement, and Detention

1. In addition to the general guidelines for mental health assessments and services outlined in Section II(N) Children's Services and provider agency staff in congregate care settings must provide psycho-educational awareness-raising sessions for the entire youth population in the residential settings. These sessions shall engage youth in a meaningful dialogue about the concepts of homophobia and transphobia, and the importance of increasing tolerance and respect. These sessions must be facilitated by a qualified professional with expertise in working with LGBTQ youth.
2. Psycho-educational sessions for the youth in congregate care settings must include group and individual opportunities, as appropriate to the behavior model used by the program, to discuss any sexual orientation or gender identity questions or feelings that may arise as a result of having youth in the Children's Services custodial care setting who may be perceived as "different."

F. Hormone Therapy

1. All youth in Children's Services custodial care receive an initial health screening, which includes identification of existing medications being taken by the youth. During the course of that initial screening, if the youth reports that he/she was prescribed hormones by a licensed medical provider in the community, this medication shall be continued upon medical assessment and approval while the youth is in care. If hormone therapy is discontinued for a youth, the youth shall continue to be monitored by medical and behavioral health staff in order to treat any symptoms that may occur as a result.
2. If it is learned that hormone therapy is being obtained by a youth on the street or without a prescription, the youth must be immediately referred to LGBTQ clinically and culturally competent medical and mental health providers for an evaluation. Staff must ensure that all necessary treatment continues if determined necessary by the medical and mental health clinicians.
3. If a **youth in foster care or juvenile justice placement** makes a request to begin hormone therapy while in Children's Services' custodial care, he/she must be promptly referred to a LGBTQ culturally competent medical and mental health provider for an evaluation. The medical provider, in consultation with the youth's case planner, must initiate a request for financial support and treatment

through the Children's Services Non-Medicaid Reimbursable (NMR) Policy.²² A determination will be made through the process described in the NMR policy regarding the initiation of hormone therapy based on the determination of the Deputy Commissioner, with recommendations from the Children's Services Health Review Committee, and the accepted standards of care in the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People.²³

4. If any **youth in detention** makes a request to begin hormone treatment, the contracted medical provider(s), in consultation with Children's Services, will make a determination regarding the initiation of hormone therapy or other medical treatments related to gender identity based on accepted standards of care (see WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People).²⁴
5. For all youth under the age of 18 in Children's Services custodial care, appropriate consent from the youth's parent/legal guardian must be first sought and obtained as required by law and/or ACS policy.²⁵
6. When youth in foster care and/or juvenile justice placement are also in detention, the rules regarding youth in detention, above, stand. All youth in detention are treated the same with regard to hormone therapy, regardless of any other custodial status.

G. Medical Care Specific to LGBTQ Youth Other Than Continuity of Care Hormone Therapy for Youth In Detention

Where the initiation of other medical care specific to LGBTQ youth is at issue (e.g. medically necessary transition-related surgeries), DYFJ's Deputy Commissioner or his/her designee may review the request and decide whether initiating the recommended treatment while the youth is still in DYFJ custody is appropriate and feasible. If DYFJ's Deputy Commissioner determines that the medical treatment cannot be initiated while the youth is in DYFJ's custody, the youth's medical provider in his/her community or medical department at OCFS, or other discharge agency must be informed, upon the youth's request.

²² Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care – Policy 20101/04 dated 6/7/10 (page6).

²³ See http://www.wpath.org/publications_standards.cfm for complete WPATH Standards. See also the Endocrine Society's Clinical Guidelines on the Endocrine Treatment of Transsexual Persons (2009) at <http://www.endo-society.org/guidelines/final/upload/endocrine-treatment-of-transsexualpersons.Pdf>

²⁴ In accordance with DYFJ Directive # 17.1 entitled *Continuity of Care Policy and Procedures*.

²⁵ See ACS Procedure 102/Bulletin No. 99-1 (amended), Guidelines for Providing Medical Consents for Children in Foster Care. Note: As of November 2012, this Procedure/Bulletin is being revised and will be released as a policy under the same title.

H. Medical Care Other Than Hormone Therapy for Youth in Foster Care or Juvenile Justice Placement

If a youth in foster care or juvenile justice placement makes a request for gender affirming medical care while in Children's Services' care and custody, he/she must be promptly referred to an LGBTQ culturally competent medical and mental health provider for an evaluation. If the medical care is non-Medicaid reimbursable, the youth's case planner, after consultation with the youth's medical provider, must initiate a request for treatment and financial support through the Children's Services Non-Medicaid Reimbursable (NMR) Policy.²⁶ A determination will be made through the process described in the NMR policy regarding the initiation of gender affirming medical care based on the determination of the Deputy Commissioner, with recommendations from the Children's Services Health Review Committee and the accepted standards of care in the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Non-conforming People.²⁷

I. Bedrooms

1. Generally, it is most appropriate to house transgender youth in Children's Services custodial care based on their gender identity (i.e. their internal, personal sense of being a young man or a young woman or a boy or a girl)²⁸. In considering the appropriate placement for a known transgender youth, individual sleeping quarters must be considered if available.
2. Foster boarding homes
 - a. In foster boarding homes, separate bedrooms are required for children of the opposite sex over seven years of age. Children of the opposite sex in residential facilities must be placed in separate bedrooms at the age of five or older. In cases where it is necessary to keep siblings or half siblings placed together in the same foster home, children are permitted to share the same bedroom providing this sleeping arrangement is consistent with the health, safety, and welfare of each of the siblings or half-siblings.²⁹
 - b. For cases where a transgender youth is residing in a foster boarding home, the agency is expected to make sleeping arrangement decisions on an individualized basis. Decisions on bedrooms for transgender youth in foster boarding homes must be based on the youth's individualized needs and must prioritize the youth's emotional and physical safety. The agency staff must

²⁶ Provision of Non-Medicaid Reimbursable Treatment or Services for Youth in Foster Care Policy #2010/04, dated 6/7/10 (page 6).

²⁷ See also the Endocrine Society's Clinical Guidelines on the Endocrine Treatment of Transsexual Persons (2009).

²⁸ Horizon (718) 401-2499; Crossroads (718) 240-3862; and NSD (718) 597-3431.

²⁹ See Children's Services Policy # 2011/02 entitled *Flexibility in Sleeping Arrangement Requirements for Sibling Foster Care Placements*.

take into account the youth's perception of where he or she will be most secure, as well as any recommendations by the youth's health care provider. It is critical to include the transgender youth in the decision making process.

3. Congregate Care Settings - Foster Care, Juvenile Detention, and Juvenile Justice Placement

- a. For cases where a transgender youth is residing in a residential facility, Children's Services shall make every effort so that LGBTQ youth are housed in a facility that can provide individual sleeping quarters (one-person bedroom) to allow for privacy. Transgender youth must not automatically be housed according to their gender assigned at birth. As in foster care settings, the agency shall make housing decisions for transgender youth based on the youth's individualized needs and that prioritize the youth's emotional and physical safety. The agency staff shall take into account the youth's perception of where he/she will be most secure, as well as any recommendations by the youth's medical and/or mental health care provider, if any.
- b. When a youth in detention or a juvenile justice placement is not housed according to his/her identified gender, authorization must be provided by the appropriate Associate Commissioner or his/her designee and documented in the youth's record.

J. Bathroom Facilities

Bathroom facilities shall take into account the safety and privacy needs of transgender and gender non-conforming youth. All youth shall be allowed to use individual stalls, within commonly accepted time limits, and be allowed to shower privately. Transgender youth shall not be required to shower or undress in front of other youth.

I. Hair and Other Personal Grooming

Grooming rules and restrictions, including rules regarding hair, make-up, and shaving, shall be the same for all youth in Children's Services custodial care regardless of LGBTQ status. A youth shall not be prevented from using, or disciplined for using, a form of personal grooming because it does not match gender norms. Transgender and gender non-conforming youth shall be permitted to use approved forms of personal grooming consistent with their gender identity.

J. Clothing

Youth in Children's Services custodial care shall be permitted to wear clothing consistent with their gender identity. Youth will be made aware that they are always able to wear undergarments and/or other clothing of their identified gender. When Children's Services and provider agencies are providing clothing for youth, staff shall make reasonable efforts to ensure that gender appropriate undergarments are available. As with all youth, outer attire should be congruent with the occasion. In keeping with safety and security concerns, youth in detention and juvenile justice placement facilities may, but are not required to, shave their faces and bodies as permitted by Children's Services Procedure.³⁰

K. Discharge and Permanency Planning

1. It is critical to work with youths' families throughout their stay in Children's Services custodial care to enhance reunification or other discharge efforts. During discharge and permanency planning, staff shall be mindful that a youth may not want to disclose LGBTQ status to his/her family/discharge resource. If this was not a precipitant of the youth's removal from the home, and he or she wishes to keep his/her LGBTQ status private, during discharge planning, staff shall not disclose the youth's LGBTQ status to the family and/or discharge resource.³¹
2. Children's Services and provider agency staff working with LGBTQ youth in Children's Services custodial care must identify and become familiar with community resources to support LGBTQ youth. When appropriate, staff must assist families of LGBTQ youth in identifying supportive resources in their area that are culturally competent in LGBTQ issues in order to help create a seamless transition to permanency with adequate support systems in place.

L. Provider Agency LGBTQ Point Person Expectations

1. Foster care and juvenile justice placement provider agencies are required to designate an LGBTQ Point Person. Each designated Point Person is required to receive LGBTQ cultural competency training, attend all ACS LGBTQ Action Group meetings, maintain a record of all LGBTQ-related issues that arise within his or her agency (including, but not limited to reports of harassment or bias and any unmet need for an LGBTQ-affirming foster home or juvenile justice placement), and coordinate trainings within the provider agency to ensure that all staff working directly with youth receive cultural competency training related to LGBTQ youth and families. A Point Person Network will be created by Children's Services, and maintained by the ACS LGBTQ Senior Advisor. In order to increase the effectiveness of the Point Person Network, all youth in foster care,

³⁰ DJJ Operations Order # 06/03 entitled *Resident Personal Property and Grooming Paraphernalia*

³¹ Please refer to *Confidentiality* section for further information.

congregate care, and/or juvenile justice placement with a provider agency must be notified of the existence and role of the LGBTQ Point Person and must be provided with the means by which to access the Point Person in order to report issues, complaints or concerns.

2. The agency Point Person will report all incidents reported to him/her to the ACS LGBTQ Senior Advisor. To report LGBTQ youth and family-related concerns, Point Persons shall complete (for foster care) the attached *ACS LGBTQ Senior Advisor Request* (Form FSS 009) (See Attachment D) and forward it to the ACS LGBTQ Senior Advisor at LGBTQ@dfa.state.ny.us. The ACS LGBTQ Senior Advisor will keep track of incidents and how they are handled.³²

M. Advocacy and Incident Reporting Procedures for Youth in Children's Services Custodial Care

1. Foster Care and Juvenile Justice Placements

- a. The Foster Care Point Person Network is available for youth in foster care and juvenile justice placements to express and resolve concerns regarding the care and treatment of LGBTQ youth in those settings, and their families. The Foster Care Point Person Network is convened by Children's Services LGBTQ Senior Advisor and the Division of Family Permanency Services periodically to discuss issues related to the implementation of the LGBTQ policy, best practices in working with LGBTQ youth and families, and other issues related to LGBTQ policy and programs. Each agency is required have a designated LGBTQ Point Person who can be accessed as a resource to assist when an issue requiring case consultation arises and/or be utilized as a reporter to the Children's Services LGBTQ Senior Advisor. The LGBTQ Point Person must keep track of all reportable bias, harassment, and bullying issues of LGBTQ youth and families, and model appropriate and affirming behavior at all times. If the Point Person receives a grievance related to harassment or discrimination on the basis of actual or perceived gender identity, gender expression or sexual orientation, the LGBTQ Point Person must notify his/her supervisor for help in resolving the issue.
- b. All legal-related inquiries must first be brought to the attention of the assigned FCLS attorney. The FCLS attorney will then notify the ACS LGBTQ Senior Advisor and the attorney for the child.
- c. The provider shall report each and every incident of LGBTQ-related bias, harassment, and/or abuse to the ACS LGBTQ Senior Advisor via form FSS 009,

³² A user-friendly version of this form is accessible on DocuShare.

and the ACS LGBTQ Senior Advisor will keep track of incidents and how they are handled.

2. Detention Facilities

- a. The Resident Advocacy Program and Ombudsperson shall be available for youth in detention to express and resolve concerns regarding their care and treatment. If Ombudspersons receive a grievance related to harassment or discrimination on the basis of actual or perceived gender identity, gender expression, or sexual orientation, the Ombudsperson shall notify an Associate Commissioner of Detention immediately. The Associate Commissioner notified must ensure the grievance is addressed appropriately. The Resident Advocacy Program and Ombudspersons shall protect the confidentiality of youth who make grievances related to harassment or discrimination on the basis of actual or perceived gender identity, gender expression, or sexual orientation and should take appropriate measures to prevent retaliation.
- b. Youth in detention must be advised upon admission that they may contact the appropriate Ombudsperson to report issues, complaints, or concerns about any issue, including those related to LGBTQ youth and families.³³

IV. ACS LGBTQ Senior Advisor

A. Overarching Responsibilities

The ACS LGBTQ Senior Advisor is responsible for assessing LGBTQ needs within the child welfare system. The Senior Advisor develops and maintains relationships with community-based LGBTQ programs to improve access to services for youth involved with protective, preventive and foster care services. He/she also develops training curricula for child welfare staff and works with other areas of Children's Services so that policies and programs address the LGBTQ-specific needs of children and families.

B. Monitoring Responsibilities

1. The ACS LGBTQ Senior Advisor shall track and monitor the following:
 - a. all incident reports received (FSS 009, *LGBTQ Senior Advisor Request Form*);
 - b. provider agencies to determine compliance with the LGBTQ expectations, and provide technical assistance where needed;³⁴

³³ Horizon - (718) 401-2499; Crossroads - (818) 240-3862; and NSD - (718) 597-3431

³⁴ Provider agencies are responsible for gathering tracking information and submitting it to the ACS LGBTQ Senior Advisor

- c. the redesigned Point Person Network; and
 - d. the integration of LGBTQ policies into practice.
2. The ACS LGBTQ Senior Advisor will collaborate with other program areas that provide oversight of Children's Services' staff and contracted providers to hold all pertinent staff accountable for their performance with respect to this policy.

For additional information on training resources as well as on this policy please contact the ACS LGBTQ Senior Advisor at LGBTQ@dfa.state.ny.us.

Attachment A: GLOSSARY OF TERMS

Anatomical sex: An individual's sex, male or female, based on the appearance of his/her sexual organs.

Biological sex: An individual's sex, male or female, based on his/her sex chromosomes.

Birth sex: The sex, male or female, that is noted on an individual's birth certificate issued at birth.

Bisexual: refers to a person who is emotionally, romantically, and/or physically attracted to both men and women. Bisexual people do not need to have had sexual experiences with both men and women; in fact, they do not need to have had any sexual experience at all to identify as bisexual.

Gay: refers to a person who is emotionally, romantically, and/or physically attracted to people of the same gender. Sometimes, it may be used to refer to gay men and boys only. It is preferred over the term "homosexual," which is an outdated term and is considered derogatory and offensive to many LGBTQ people.

Gender: The set of meanings assigned by a culture or society to someone's perceived biological sex. Gender is not static and can shift over time. Gender has at least three parts:

- a) **Gender Identity:** An individual's internal view of his/her gender; one's own innermost sense of being male or female. This will often influence name and pronoun preference for an individual.
- b) **Physical Markers:** Aspects of the human body that are considered to determine sex and/or gender for a given culture or society, including genitalia, chromosomes, hormones, secondary sex characteristics, and internal reproductive organs.
- c) **Role/Expression:** Aspects of behavior and outward presentation that may (intentionally or unintentionally) communicate gender to others in a given culture of society, including clothing, body language, hairstyles, socialization, relationships, career choices, interests, and presence in gendered spaces (e.g. restrooms, places of worship, etc.). Refers to the manner in which a person expresses his or her gender through clothing, appearance, behavior, speech, etc. A person's gender expression may vary from the norms traditionally associated with his or her biological sex. Gender expression is a separate concept from sexual orientation and gender identity.

Gender Identity Disorder or GID: A diagnosable medical condition where an individual has a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the opposite sex, as well as a persistent discomfort about one's assigned birth sex or sense of inappropriateness in the gender role of that sex. In addition, the individual must

be evidencing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender non-conforming: Having or being perceived to have gender characteristics and/or behaviors that do not conform to traditional or societal expectations. Gender non-conforming people may or may not identify as LGBT.

Gender roles: Social and cultural beliefs about appropriate male or female behavior, which children usually internalize between ages 3 and 7.

Genderqueer: A term of self-identification for people who do not identify with the binary terms that have traditionally described gender identity (for instance, male or female only). Also see *gender non-conforming*, *queer*, and *transgender*.

Heterosexism: The assumption that all people are or should be heterosexual. Heterosexism excludes the needs, concerns, and life experiences of lesbian, gay, bisexual, and transgender people, while it gives advantages to heterosexual people. It is often a subtle form of oppression which reinforces realities of silence and invisibility.

Heterosexuality: A sexual orientation in which a person feels physically and emotionally attracted to people of the “opposite” sex; “straight” is a synonym.

Homophobia: The irrational hatred and fear of homosexuals or homosexuality. Homophobia includes prejudice, discrimination, harassment, and acts of violence brought on by fear and hatred. It occurs on personal, institutional, and societal levels.

Internalized homophobia: The fear and self-hate of one’s own homosexuality that occurs for many individuals who have learned negative ideas about homosexuality throughout childhood. One form of internalized oppression is the acceptance of the myths and stereotypes applied to the oppressed group.

Lesbian: refers to a woman who is emotionally, romantically, and/or physically attracted to other women. Some lesbians may prefer to identify as gay when describing themselves, or as gay women.

LGBTQ: an acronym commonly used to refer to lesbian, gay, bisexual, transgender, and questioning individuals.

Preferred Gender Pronouns (PGP): are the ways people refer to themselves and how they prefer to be referred to in terms of gender. The most commonly used PGPs include:

- She – her – hers
 - Example: “She forgot her wallet. She thinks that she left it in her car.”
- He – him – his

- Example: “He had a lot more energy, once his fever went away.”
Some people do not identify as either male or female and accordingly prefer gender neutral pronouns:
- Zie or Ze – hir – hers
 - Example: “Zie opened hir door to find a package waiting.”

Some people who do not identify as either male or female may also use their name or “they” as a PGP.

Queer: A historically derogatory term for LGBTQ people. The term has been widely reclaimed, especially by younger LGBTQ people, as a positive social and political identity. It is sometimes used as an inclusive, or umbrella, term for all LGBTQ people; more recently, queer has become common as a term of self-identification for people who do not identify with the restrictive and binary terms that have traditionally described sexual orientation (for instance lesbian, gay, or bisexual only). Some LGBTQ community members still find queer an offensive or problematic term. Also see *Genderqueer*.

Questioning: refers to a person, often an adolescent, who is exploring or questioning issues of sexual orientation or gender identity or expression in his or her life. Some questioning people will ultimately identify as lesbian, gay, bisexual, and/or transgender; others will self-identify as straight and/or non-transgender.

Sexual orientation: refers to a person’s emotional, romantic, and physical attraction to persons of the same and/or different gender.

Straight: A person (or adjective to describe a person) whose primary emotional, romantic, and physical orientation is toward people of the opposite gender.

Transgender: may be used as an umbrella term to include all persons whose gender identity or gender expression do not match society’s expectations of how an individual should behave in relation to his or her gender. This term can include transsexual, genderqueer, cross-dresser, and other people whose gender expression varies from traditional gender norms. For purposes of protection from discrimination and harassment, transgender refers to both self-identified transgender individuals and individuals perceived as transgender without regard to whether they qualify for a diagnosis of *Gender Identity Disorder* (see above).

Transgender men and boys: are young people who were assigned the sex of female at birth and who now identify as male. Similarly, the term FTM, or female-to-male, refers to those who now identify as boys or men. Also see *transsexual*.

Transgender women and girls: are young people who were assigned the sex of male at birth and who now identify as female. Similarly, the term MTF, or male-to-female, refers to those who now identify as girls or women. Also see *transsexual*.

Transition: An individualized process by which a transgender person starts living as the gender she or he identifies as. There are three general aspects to transitioning: social (i.e. selection of a new name, a request that people use the correct pronoun), medical (i.e. possibly hormones, surgery, etc.), and legal (i.e. gender marker and legal name change, etc.). A transgender individual may transition in any combination, or none, of these aspects.

Transphobia: A reaction of fear, loathing, and discriminatory treatment of people whose identity or gender presentation (or perceived gender or gender identity) does not “match,” in the societally accepted way, the sex they were assigned at birth.

Transsexual: A term for someone who transitions from one physical sex to another in order to bring his/her body more in line with their innate sense of their gender identity. It includes those who were born male but whose gender identity is female, and those who were born female but whose gender identity is male, as well as people who may not clearly identify as either male or female. Transsexual people have the same range of gender identities and gender expression as non-transsexual people. Many transsexual people refer to themselves as transgender.

Definitions for this glossary have been adapted from the following resources:

Breaking the Silence, National Center for Lesbian Rights

Hidden Injustice: Lesbian, Gay, Bisexual, and Transgender Youth in Juvenile Courts, The Equity Project

LGBTQIA Glossary, University of California, Davis, Lesbian Gay Bisexual Transgender Resource Center *Trans Action Guide*, Gay Lesbian Straight Educational Network

Attachment B: LGBTQ RIGHTS FLYER

(Taken from the NYC Anti-Violence Project, - LGBTQ Youth Violence Initiative “A Guide for NYC LGBTQ Public School Students” and “Staying Safe – LGBTQ Youth and the NYPD”.)

LGBTQ youth in foster care and the juvenile justice system have rights:

- To feel safe
- To be free from discrimination because they are LGBTQ
- To have people accept them for who they are
- To have adults stick up for them

LGBTQ youth and school

All NYC public schools should:

- Treat all students, including LGBTQ students, equally
- Apply all policies to LGBTQ students in the same way as applied to other students
- Not single out LGBTQ students for abuse
- Not discriminate based on sex (including your school’s responsibility for stopping sexual harassment)
- Address anti-gay/anti-trans harassment (schools can be held legally accountable for ignoring harassment, abuse or discrimination)
- Post complaint procedures
- Handle all complaints fairly treat Gay-Straight Alliance (GSAs) like any other student club

So:

- Come out when you are ready and be proud of who you are
- Report any abuse including homophobic or transphobic comments, graffiti, etc.
- Form a GSA in your school
- Take a date to the prom (Your school can’t require that only girl-boy couples can go to school dances)

LGBTQ youth and the NYPD

General Tips:

- If you have identification such as a driver’s license, non-driver or school ID, always carry it
- If you are stopped by the police, be honest about your age because minors get special legal protections when dealing with the police
- Try to stay calm and be respectful
- Do not run, even if you did not do anything wrong
- Keep your hands where they can be seen
- Even if you are innocent, don’t touch or resist the officer
- If you leave your school during school hours, try to carry a note, your schedule, or some other proof that you are not skipping school

A Police Officer:

- May stop you and ask questions if they think you are skipping school or are a runaway
- Can also question anyone they reasonably believe is committing a crime, has committed, or is about to commit a crime
- Might ask your name, age, and where you are going (It is your legal right not to answer any of these questions)

If a police officer reasonably suspects that you are carrying a weapon, he or she may pat your clothes down to look for the weapon. If a police officer acts inappropriately (for example by making sexual remarks, touching you in a sexual way, or does more than a basic pat down) tell your lawyer or someone you can trust.

Attachment C:

LIST OF LGBTQ AFFIRMING CLINICIANS ALL NYC BOROUGH³⁵

(Recommended by LGBTQ Advocates)

LGBTQ HEALTH CARE PROVIDERS

Adolescent AIDS Program/Risk Evaluation Program

Children's Hospital at Montefiore Medical Center

Gay and Lesbian Adolescent Health Resource Center (GLAHRC)

111 East 210th St.

Bronx, NY 10467

(718) 882-0232 x. 223

www.adolescentaids.org

M-F, 1:30pm-5pm

STD/HIV testing, treatment, and referrals for comprehensive medical and mental health services for LGBT youth ages 13-24.

Bronx Community Pride Center, Health Link Line

975 Kelly Street, Suite 202

Bronx, NY 10459

718-292-4368

www.bronxpride.org

9am-9pm everyday

Free hotline that offers referrals to LGBT-friendly doctors and other medical, legal, and social service providers. Providers with expertise in transgender health are included.

Community Healthcare Network – Transgender Program

Bronx Health Center

975 Westchester Ave.

Bronx, NY 10459

(718) 320-4466 (Program Coordinator: Renato)

M, Tu, Th, F – 9am-5pm; W – 10am-6pm

Support Groups – M- 2-4pm (Spanish), W – 2-4pm (English)

www.chnyc.org/services/transgender-program/

Offers healthcare services to all transgender people of all ages, including primary healthcare, preventive health services, weekly workshops, support group meetings, mental health counseling, and HIV counseling and testing. Hormone therapy for individuals 18+.

The Door

Adolescent Health Center

555 Broome St.

New York, NY 10013

(212) 941-9090 x. 3221 or x. 3222

www.door.org

³⁵ Provider Agencies should verify if the clinician is a Medicaid participant prior to sending youth for services.

Offers physical examinations, general health care and education, dermatology, nutritional counseling, sexual and reproductive health care, and routine dental services to all young people ages 12-21, as well as counseling services geared toward LGBTQ youth.

H.E.A.T. (Health and Education Alternatives for Teens)

SUNY Downstate Medical & Kings County Hospital Center
760 Parkside Ave (Room 308)
Brooklyn, NY 11226
(718) 467-4446 (for appointments – Richard Weinstein)

www.heatprogram.org

M-F 9am-5pm

Free medical and mental health services, counseling, and HIV/STD testing and support for LGBTQ youth, including hormone therapy for transgender youth ages 13-24.

H.O.T.T. (Health Outreach to Teens)

Callen-Lorde Community Health Center
356 W. 18th St. (between 8th and 9th Aves.)
New York, NY 10011
(212) 271-7212, (212) 271-7200

www.callen-lorde.org/services/hott.html

M, Tu, Th – 10am-8pm; W – 10am-12pm, 1:30pm-8pm (no new patients); F – 10am-4pm; Sat. 10pm-1am

Free or low cost medical and mental health care/counseling, including physical exams, gynecological exams, and STD/HIV treatment and testing to LGBTQ and homeless youth ages 13-24. Hormone therapy available for youth ages 18-24.

The Jim Collins Foundation

P.O. Box 1002
North Branford, CT 06471
(203) 376-8089

www.jimcollinsfoundation.org

Awards grants for transgender people ages 18+ in need of gender-confirming surgery to live a healthy life but without the ability to pay for it.

The Mount Sinai Adolescent Health Center

312 E. 94th St.
New York, NY 10128
(212) 423-3000
<http://www.mssm.edu/research/centers/adolescent-health-center>

Medical and mental health care for adolescents 10-22 years old.

Positive Health Project

301 W. 37th St. (near 8th Ave)
New York, NY 10018
(212) 465-8304 Ext.
www.positivehealthproject.org

M-F – 10am-5pm

Provides healthcare services to transgender people ages 18+, including basic medical care, psychotherapy and counseling, psychiatric referrals, acupuncture, Syringe Exchange Program, and support groups.

South Bronx Health Center for Children & Families

Montefiore Medical Center

871 Prospect Avenue

Bronx, NY 10459

(718) 991-0605 x. 264 (Maria Umpierre)

M-Th – 9am-7:30pm; F – 1pm-6pm

Provides medical care and services to transgender youth, including feminizing or masculinizing hormone therapy. There is no minimum age requirement.

Streetwork Project

Harlem Drop-In Center

209 W. 125th St.

New York, NY 10027

(212) 695-2220

Hours of Operation: Monday Through Sunday (9:00 am - 9:00 pm) Lower East Side Drop-In

33 Essex St.

New York, NY 10002

(646) 602-6404

Hours of Operation: Monday, Tuesday, Thursday, Friday 2:00PM – 7:00PM www.safehorizon.org

Provides services to LGBTQ homeless youth up to age 24, including free medical and psychiatric services, counseling, syringe exchange, HIV prevention, and wellness activities including acupuncture, yoga, and nutritional counseling.

HIV-RELATED CARE

Alianza Dominicana

530 W. 166th St.

New York, NY 10032

(212) 740-1960

<http://www.alianzaonline.org/main/>

M and F – 9am-5pm, Tu, W, Th – 9am-8pm

HIV/STD testing, substance abuse prevention, and counseling services and programs for LGBT youth ages 16-24.

Bellevue Adolescent T.O.P.S. (Teen Outreach Prevention Services)

462 1st Ave., corner of 27th St.

New York, NY 10016

(212) 562-6333

M-F 9am-5pm by appointment only

Support, confidential HIV testing, pre/post test counseling, complete medical evaluation/care, and clinical treatment for youth. Clinic has a liaison with Green Chimneys Children's Services.

Community Health Action of Staten Island

25 Victory Blvd

Staten Island, NY 10301

(718) 808-1389

www.chasiny.org

M-F – 9am-5pm

HIV education, outreach, and health programs for LGBTQ youth.

Gay Men's Health Crisis (GMHC)

224 West 29th Street

New York, NY 10011

(212) 367-1100 or (212) 367-1000

www.gmhc.org

HIV/AIDS prevention, testing, and services for youth of all ages and free syringe access for individuals 18+.

Hispanic AIDS Forum

Manhattan:

213 W. 35th St. (12th floor)

New York, NY 10001

(212) 868-6230

xmorgan@hafnyc.org

Bronx:

967 Kelly St.

Bronx, NY 10459

(718) 328-4188

www.hafnyc.org

E-mail – info@hafnyc.org

HIV/AIDS organization for the Latino community. HIV testing and prevention programs for youth under 24, offering training and leadership services, workshops, counseling, support groups, and special events. Includes counseling and support for transgender women.

Harlem United Community AIDS Center, Inc.

306 Lenox Ave.

New York, NY 10027

(212) 803-2850

info@harlemunited.org

<http://www.harlemunited.org>

Serves people living with HIV/AIDS. Medical/ dental care, mental health services, expensive therapies, alternative medicine. Also provides array of services in prevention, education, supportive housing, HIV testing. See website for info/locations.

AIDS Treatment Data Network/ Housing Works

611 Broadway Room 613

New York NY

10012 United States

(800) 734-7104; (212) 260-8868

<http://www.housingworks.org/heal/medical-and-dental-care>

HW provides case management, treatment and access information, advocacy and counseling, education, and referral services for people with HIV, chronic hepatitis, and other diseases.

Safe Space and Spacemobile

Queens:

89-74 16^{2nd} St. (2nd floor)

Jamaica, NY 11432

(718) 526-2400

www.safespacenyc.org

In addition to drop-in centers below, the Spacemobile travels around the city providing health services.

FOR FURTHER REFERRALS

Center CARE and Y.E.S. (Youth Enrichment Services)

at the LGBT Community Center

208 W. 13th Street

New York, NY 10011

(212) 620-7310

www.gaycenter.org

Provides confidential assessments and referrals to a network of LGBT-affirmative or identified counselors, therapists, psychiatrists, community organizations and agencies, and other resources.

Gay Men of African Descent

103 East 125th St. Suite 7E

New York NY

10035 United States

(212) 828-1697

www.gmad.org

Ali Forney Center

527 West 22nd St., 1st Floor

New York NY

10011 United States

(212) 222-3427

<http://www.aliforneycenter.org/>

AFC is the nation's largest and most comprehensive organization dedicated to homeless LGBT youth. Our goal is to provide homeless LGBT youths, aged 16-24, with the support and services they need to escape the streets and begin to live healthy and independent lives.



**Attachment D:
ACS LGBTQ Incident/Inquiry Form**

Please complete appropriate information. You do not need to have all information indicated for request to be processed.

Type of Request: ☐ Resources ☐ Placement ☐ Harassment ☐ Other

Incident/Inquiry Occurrence: ☐ Internal ☐ External

Client/Family

Date:

Youth Name:	DOB:
Case Name:	Case #:

Source of Referral

Name:	Agency:
Relation to youth:	Telephone #:

Agency Contact Information

Contract Agency:	Site/Location:
Agency Worker:	Telephone #:
Supervisor:	Telephone #:
Director:	Telephone #:

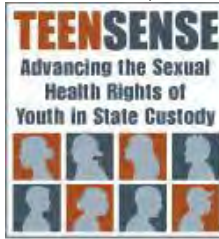
ACS Contact Information

Borough:	Site/Location:
Worker:	Telephone #:
Supervisor:	Telephone #:
Manager:	Telephone #:

Legal Information

FCLS Attorney:	Telephone #:

Narrative Description of Presenting Concern and Requested Service:



MODEL POLICY SEXUAL HEALTH CARE FOR YOUTH IN STATE CUSTODY

In order to appropriately address the sexual health care needs of youth in the state's care, it shall be the policy of **[this agency/jurisdiction]** to guarantee that youth in its **[custody/care]** receive the following health services:

- Health screenings that address both their physical and mental health, including examinations that include their sexual histories and instances of abuse;
- Universal offers of testing for sexually-transmitted infections (STIs), including HIV, that include proper pre-test and follow-up counseling even if the tests are negative;
- Written information, counseling, and treatment related to pregnancy, STIs including HIV, and sexual abuse;
- Written information and regular counseling on the routes, risks, and prevention of STI and HIV transmission, including but not limited to correct use of condoms to prevent pregnancy and disease.
- Ongoing care and discharge planning related to sexual and reproductive health.

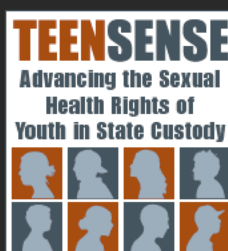
All medical care services shall be conducted in a confidential, culturally competent, and inclusive manner. Youth who are pregnant, gender non-conforming, or lesbian, gay, bisexual, transgender, questioning, or intersex (LGBTQI) shall not be treated differently or receive a lesser standard of care, and shall be offered services consistent with their gender identity and sexual orientation.





Teen SENSE

Model Sexual Health Care Standards for Youth in State Custody



This work is made possible
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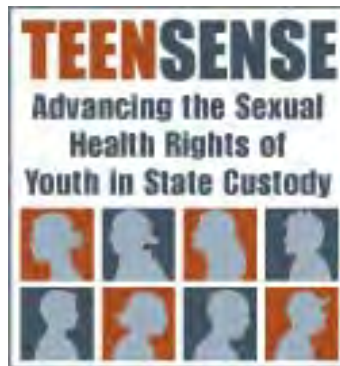
These Standards Have Been Endorsed By:

Administration for Children's Services, New York City
African American Office of Gay Concerns
AIDS Alliance for Children, Youth and Families
BreakOUT!, New Orleans, LA
HiTOPS, New Jersey
Hetrick-Martin Institute
Hyacinth AIDS Foundation
Juvenile Justice Project of Louisiana
National Center for Lesbian Rights
National Coalition of Anti-Violence Programs (NCAVP)
National Organization of Women, New Jersey
National Alliance of State and Territorial AIDS Directors (NASTAD)
Planned Parenthood of Greater Northern New Jersey
SUNY Downstate Medical Center: HEAT Program, Brooklyn, NY
SUNY Downstate Medical Center: FACES Network, Brooklyn, NY
True Colors, Inc. Sexual Minority Youth Services of CT
University of Medicine and Dentistry of New Jersey: Paulette Stanford, MD,
Division of Adolescent and Youth Adult Medicine
University of Medicine and Dentistry of New Jersey: Jump



TEENSENSE

MODEL SEXUAL HEALTH CARE STANDARDS



The Center for HIV Law and Policy • 65 Broadway, Suite 832 • New York, New York 10006
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MISSION STATEMENT

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

To learn more about our organization and access the Resource Bank, visit our website at www.hivlawandpolicy.org.

To contact us:
Email us at info@hivlawandpolicy.org.

Or write to:
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New York, NY 10006
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The development and publication of these standards would not have been possible without the generous and sustained support of the MAC AIDS Fund, Broadway Cares/Equity Fights AIDS, the Arcus Foundation, and the Elton John AIDS Foundation

Teen SENSE

A NATIONAL INITIATIVE TO BRING COMPREHENSIVE SEXUAL HEALTH CARE TO YOUTH IN STATE CUSTODY

Adolescents confined to foster care and juvenile justice facilities are overwhelmingly members of the communities most affected by, and at risk for, HIV/AIDS: low-income youth, Black and Latino youth, lesbian, gay, bisexual, transgender, and questioning youth (LGBTQ), and survivors of violence and other abuse. Empowering these populations to protect their rights and their health lies at the heart of the mission of the Center for HIV Law and Policy (CHLP). While these youth, across the spectrum of sexual orientation and gender, are at greater risk of HIV and other STIs, they overwhelmingly are denied access to appropriate and effective HIV prevention, sexual health education, and sexual and reproductive health care. Where care is provided, it too often ignores or isolates LGBTQ youth and their health needs. To address this crisis, CHLP launched the Teen SENSE (Sexual health and Education Now in State Environments) initiative, a sexual health and HIV prevention initiative grounded in the rights of youth to these services.

Teen SENSE advances the principle that respect and accommodation for all gender expression and sexual orientation is central to HIV prevention, sexual health and prevention from sexual abuse, and that all youth have the right to comprehensive, LGBTQ-inclusive health services that include sexual health care and education when they are confined in state facilities. Comprehensive, LGBTQ-inclusive sexual health care is vital to preserve health, reduce HIV and STI transmission risk, and increase the odds that severely at-risk youth will develop the essential skills and knowledge to protect their sexual health, develop self-respect, and foster tolerance.

Teen SENSE is a multidisciplinary initiative that has engaged experts in adolescent medicine, sexual health education, foster care, and juvenile justice to develop a complete advocacy model and coordinate its implementation. The Teen SENSE program has developed a federal and state legal framework that asserts the affirmative legal right of adolescents to comprehensive, scientifically accurate, LGBTQ-inclusive sexual health care services and education. We have developed model standards for comprehensive, LGBTQ-inclusive sexual health care, education/HIV prevention, and staff training to ensure the safety and sexual health of all youth in state custody. Teen SENSE establishes a powerful legal and human rights framework and the on-the-ground alliances that can make meaningful, appropriate, non-judgmental sexual health care and real HIV prevention a mandated service for youth in state foster care and detention facilities.



MODEL SEXUAL HEALTH CARE STANDARDS: Focusing on the needs of LGBTQ Youth

Executive Summary

The Teen SENSE Model Sexual Health Care Standards are designed to reflect the minimum requirements that facilities should meet in order to appropriately address the sexual health care needs of youth in the state's care. These Standards focus on sexual health care because youth in state custody are at higher risk of STIs, including HIV, yet services to address this risk typically have been inadequate or nonexistent. Youth in out-of-home care rely on the institutions where they are housed to address these needs. While the length of time that a youth remains in state custody may vary significantly, all state custody facilities should provide information on and medical attention to sexual health issues.

According to these standards:

- Youth in state custody should be given screenings that address both their physical and mental health, as well as examinations that include their sexual histories.
- Providers should provide information and treatment related to sexual abuse, pregnancy, and STI transmission and prevention.
- All youth should be offered testing for STIs, including HIV, and given proper follow-up counseling even if the tests are negative.
- Youth who are pregnant, gender non-conforming, or LGBTQ should not be treated differently or receive a lesser standard of care simply because they are in state.
- Facilities should also offer ongoing care and discharge planning related to sexual health.
- All medical care services should be conducted in a confidential, culturally competent, and inclusive manner.

The development and publication of these standards would not have been possible without the generous and sustained support of the MAC AIDS Fund, Broadway Cares/Equity Fights AIDS, the Arcus Foundation, and the Elton John AIDS Foundation.

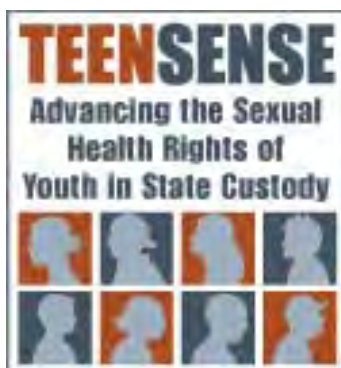


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INTRODUCTION

What are the Model Sexual Health Care Standards?

These Model Sexual Health Care Standards (“the Health Care Standards”) are the product of a comprehensive review of existing materials and an effort to combine the best and most inclusive practices and policies regarding sexual health care for youth in state custody into one document. The Health Care Standards reflect minimum requirements that facilities should meet in order to appropriately address the sexual health care needs of youth in the state’s care. While the Health Care Standards are meant to be applicable to both state foster care and detention facilities, the difference in each custodial situation may give rise to differences in how the Standards will be met. Where the language is not clear, it should be understood that adjustments to care and procurement of treatment should be made for the specific situation and environment at hand.

The Sexual Health Care Standards are intended to be used by facility directors and staff, who have received training consistent with the *Staff Training Standards*, in planning medical protocols, for advocates of youth in care, and providers of healthcare for youth in state custody. These Health Care Standards have been specifically crafted to be useful for medical professionals; they include rationales and implementation suggestions.

The Health Care Standards focus on sexual health care and represent the first comprehensive set of standards that specifically address the critical sexual health care needs of youth in state custody. The focus is due to the high rates of sexual risk behaviors, low rates of condom use, and higher rates of STIs (including HIV) that juvenile detainees experience compared to youth not in state custody.¹ In one study, 20% of juvenile detainees tested positive for an STI.² Because of the focus on sexual health care, the Health Care Standards do not address more general issues such as environmental health and safety, medical care personnel credentialing and staffing, governance and administration, and pharmaceutical operations. For information on these best practices, the Sexual Health Care should be read in conjunction with other standards, such as the National Commission on Correctional Health Care’s Standards for Health Services in Juvenile Detention and Confinement Facilities.

How were the Sexual Health Care Standards created?

The Sexual Health Care Standards integrate numerous writings on the health care needs of youth, particularly youth in state custody, and best practices for providing care that adequately meets their sexual health needs. Among the resources consulted are: the National Commission on Correctional Health Care *Standards for Health Services in Juvenile Detention and Confinement Facilities*, the American Medical Association *Guidelines for Adolescent Preventive Services*, the Region II Male Involvement Advisory Committee (Region II MAC) *Male Reproductive and Sexual Health Clinical Service Guidelines*, the Model Standards Project’s *Creating Inclusive Systems for LGBTQ Youth in Out-of-Home Care*, World Professional Association for Transgender Health *Standards of Care for Gender Identity Disorders*, various

¹ Michelle Staples-Horne et al., *Juvenile Corrections and Public Health Collaborations: Opportunities for Improved Health Outcomes*, in PUBLIC HEALTH BEHIND BARS: FROM PRISONS TO COMMUNITIES 309 (Robert Greifinger ed., 2007).

² *Id.*

materials published by Physicians for Reproductive Choice and Health, and the New York State Office of Children and Family Services *Health Services for Children in Foster Care*.

Teen SENSE takes a comprehensive view of sexual health care, recognizing that medical care, education, and environment are all essential components of sexual health care. The Model Sexual Health Care Standards are one component of CHLP's Teen SENSE initiative. Teen SENSE has also published Model Sexual Health Education and Model Staff Training Standards. These three sets of standards should be read together as interconnected and related components of providing appropriate, comprehensive sexual health care for youth in state custody.

Teen SENSE has also developed a “legal road map,” entitled *Juvenile Injustice: The Unfulfilled Rights of Youth in State Custody to Comprehensive Sexual Health Care*, which lays out the affirmative legal rights of juveniles in state custody to comprehensive sexual health medical services and staff training Standards. The legal road map and Model Standards are advocacy tools designed to be used together to bring regular, consistent, and comprehensive sexual and reproductive health care to the most at-risk, vulnerable, and underserved youth populations.

Considerations for Implementing the Sexual Health Care Standards.

The length of time that youth remain in state custody may vary significantly. Taking into consideration the health needs of youth who are only in state custody for a short period of time (possibly a few hours or one day) it is still important that they receive medical attention regardless of the short duration their stay. At a minimum, all youth must be provided with the following upon entering state custody: Standard 1 (Immediate Health Screening), Standard 2 (Receiving Screening for Transfers), Standard 3 (Initial Examination), and Standard 4 (Initial Mental Health Screening). The remaining standards should be implemented as per the time frame noted.

INITIAL HEALTH ASSESSMENT AND HEALTH MAINTENANCE EXAMINATION

Standard 1: Immediate Health Screening³

Each young person admitted to the state foster care system or youth detention facility must receive an initial health screening within 24 hours of arrival to rule out emergent health needs and contagious diseases, and to evaluate the need to continue current medication. When clinically indicated, the youth should be immediately referred to an appropriate health care facility, which should be noted on the receiving screening form. Immediate health needs should be identified and addressed. Potentially infectious youth should be isolated, but only where necessary. Staff members must promptly report suspected abuse of youth to the appropriate authorities. Youth arriving with signs of recent trauma must be referred immediately for medical observation, treatment, and mental health assessment and related services.

Rationale: This Standard serves to (1) identify and meet any urgent health needs of those admitted and (2) identify and meet any known or easily identifiable health needs that require medical intervention before the health assessment.

Implementation: The health screening should be conducted immediately upon each youth's admission to the facility or foster care system by an admitting staff member who is either a trained medical screener or a health care professional. It must be conducted using a form and language fully understood by the youth, who may not speak English or may have a physical or mental disability. Additionally, it must be conducted in a private setting to ensure confidentiality. Using a health-authority-approved form, the admitting staff member should inquire about and/or observe:

- Current and past illnesses, health conditions, or special health needs
- Past serious infectious disease
- Signs of physical abuse, including sexual abuse
- Recent communicable illness symptoms
- Past or current mental illness, including hospitalizations
- History of or current suicidal ideation
- Legal and illegal drug use and drug withdrawal symptoms
- Current or recent pregnancy
- Other health problems as designated by the responsible physician

If the initial screen indicates existing health issues or risks, the admitting staff member should provide a brief explanation and immediately notify the health care professional on duty, or locate and facilitate the appropriate care if the youth is not in a facility. The youth should remain under observation until the health care professional arrives and determines next steps. If no health issues are identified, the youth will be admitted to the detention facility or the foster care equivalent.

³ See Nat'l Comm'n on Corr. Health Care, *Standards for Health Services* in JUVENILE DETENTION AND CONFINEMENT FACILITIES 60-63 (2004) [hereinafter NCCHC].

Standard 2: Receiving Screening for Transfers⁴

A receiving screening for transfers must be performed by trained medical screeners or health care professionals on all youth received via intrasystem transfers as soon as possible, but no later than two hours after transfer.

Rationale: In transferring a young person from one institution to another, his or her medical care becomes the responsibility of the staff at the new location. Upon arrival, admitting staff need to ensure that no injuries were incurred during transport and that all existing health and medication needs are communicated to the medical staff. Requests for health records from outside medical providers and previous institutions should be made no later than end of the day of admission. If the admission was later in the day and it is not possible to contact previous providers and institutions, the request for health records should be no later than 24 hours after admission.

Implementation: Within two hours of the transfer, the young person should undergo an initial screen. The admitting staff member should review the young person's medical record and proceed with the standards proposed in Standard 1. During the screen, admitting staff should identify any injuries that may have occurred while in transfer or additional health concerns not in the current medical record. If the screen suggests that injury occurred during the transfer process, the admitting staff should record his or her observations and contact the health care professional on duty immediately.

Standard 3: Initial Examination

All youth must receive a complete health assessment and health maintenance examination ("initial examination").

The initial examination must be completed within 12 hours of admission for youth who are:

- Known to have one or more chronic conditions; and/or
- Prescribed medications, but who have no acute problems requiring a medical encounter upon admission

The initial examination must be completed within seven days of admission for youth who are:

- Not known to have any chronic or acute problems/conditions; and
- Not prescribed medications.

Rationale: The initial examination serves as a true assessment of the patient's health status. Through the medical, sexual, and social history, health professionals can build a more comprehensive view of the patient's risk and health needs. Combined with the physical examination, providers become more informed about acute medical problems and need for additional medical tests. Periodic health screening through physical examination and selected laboratory testing provide an opportunity to detect a number of medical conditions in an early, often asymptomatic phase, which permits treatment before significant morbidity develops. Additionally, during the physical exam, youth may benefit from a clinician's reassurance that their physical maturation is normal.

⁴ *Id.*, at 63-64.

Implementation: The initial examination must include the requirements set forth in Standards 6-29 including a medical history, social history; physical examination; STI and HIV counseling; offer of STI and HIV testing; contraception counseling; pregnancy counseling and offer of pregnancy test; and assessment of potential abuse, including sexual abuse. If the youth is in foster care and it is logistically feasible, he or she should be examined by his or her current doctor for the best continuity of care.

Standard 4: Initial Mental Health Screening

All youth must receive a mental health screening within 24-48 hours of admission. Youth with positive screens must receive a mental health evaluation within 14 days.

Rationale: The initial mental health screening is imperative to assess whether the young person is a danger to self or others. Additionally, the screen can uncover existing or undiagnosed mental health conditions requiring care and/or medication.

Implementation: Within 24-48 hours of arrival, a young person should have a mental health screening performed by a licensed social worker or licensed professional counselor. If mental health conditions and/or medication needs are identified, the young person should be referred to the staff psychologist or psychiatrist.

Standard 5: Information on Health Services⁵

Information about the availability of, and access to, health care services must be communicated both orally and in writing to youth within 24 hours of their arrival in the facility in a form and language they understand.

Rationale: Information about health care services is basic to the provision of care in correctional settings and with youth who have been displaced into foster care. Appropriate efforts should be made to ensure that youth understand how they can access such services.

Implementation: Within 24 hours of their arrival, youth should be given written information about how to access emergency and routine medical, mental, and dental health services, the fee-for-service program (if one exists), and the grievance process for health-related complaints. Written information may take the form of a handbook, handout, or postings in housing areas for youth in detention. Special procedures should be in place to ensure that youth with difficulty communicating (e.g., foreign-language speaking, developmentally disabled, illiterate, mentally ill, or deaf) understand how to access health services. Because the admission process may be stressful and overwhelming for incoming youth, it is good practice to provide a follow-up orientation to the health services program after they have settled into the facility or foster care routine.

Standard 6: Sexual History

The initial examination and subsequent annual examinations of youth from ages 11 and up must include a discussion of the youth's involvement in sexual behaviors, in connection with the STI, HIV, history of abuse, and pregnancy counseling recommendations set forth below in Standards 7 and 12-27. Inquiries should include the following issues:

⁵ *Id.*, at 59-60.

- Sexual orientation
- Gender identity
- Age of initiation into sexual activity
- Frequency of sexual activity
- Types of sexual activity (oral, anal, and/or vaginal)
- Use of contraception and motivation for use
- History of forced or coerced sex
- Exchange of sexual activities for money or drugs
- Prior pregnancy, paternity, and outcomes
- History of STI testing
- Symptoms of STIs
- History of HIV testing and knowledge of own HIV status
- Sexual activity while intoxicated or under the influence of drugs

Staff trained to interview youth concerning sensitive topics should discuss these topics in a private, confidential, non-judgmental manner during the course of the examination, in a way that is accepting and normalizing of the full spectrum of sexual identity and behavior. Youth who identify as homosexual, bisexual, transgender, or questioning (LGBTQ) should be asked about feelings of social acceptance or isolation. This especially applies to youth who are in the process of coming out.

Rationale: Youth may be reluctant to provide information about sexual activity, even if they have concerns and fears. Many have symptoms of STIs but refrain from seeking care due to fear, embarrassment, or transience of symptoms. Others are unaware of their STI-status and the fact that many are asymptomatic. However, the high prevalence of unintended pregnancy and STIs among youth demands an aggressive approach on the part of providers. If the topic is broached in a confidential, non-judgmental manner, youth will likely be relieved to have the opportunity to disclose information for themselves and their partners. Information about sexual behavior, STIs, and past pregnancy allow physicians to determine proper medical care, provide information, and refer youth to appropriate support services if needed. Informed youth can significantly contribute to facilitating their partners' access to and use of STI prophylactics, such as latex barriers pre-exposure or antibiotics post-exposure and, for those engaging in sexual activities with members of a different sex, contraceptive measures.

Sexual orientation, and one's acceptance of his or her sexual orientation, is a part of one's identity, self-perception, and self-esteem. As such, it has obvious implications for sexual experiences and behaviors. Unfortunately, homophobia and discriminatory practices encourage youth to keep their behaviors secret. Providers should understand that behavior does not match identity and that youth who identify as heterosexual may engage in same-sex sexual contact, while youth who identify as homosexual may also be having sex with members of the opposite gender. Therefore, providers should use gender-neutral pronouns in discussing partners and discuss specific behaviors rather than identified orientation. Sexual orientation and sexual behavior are not necessarily one and the same.

Obtaining an accurate history in a manner that normalizes same-sex sexual activity has several purposes: youth feel accepted by their provider regardless of sexual orientation; youth who are discriminated against or feel isolated because of their sexual orientation can be referred to appropriate support services; and appropriate tests, such as pharyngeal or rectal cultures, can be more accurately determined.

Implementation: In transitioning from a medical to sexual history, providers should explain why sensitive and explicit questions are going to be asked. Providers should repeat assurances of confidentiality and should make youth aware of the exceptions to confidentiality. Confidentiality issues are subject to state law but often include notifying identified authorities in the cases of potential suicide, homicide, or other harm to self or others.. Providers should inform youth that they have the right to refuse to answer questions.

Providers should maintain awareness of how their own biases may be reflected in verbal and non-verbal cues. Specifically, providers should avoid assumptions and the use of clinical jargon throughout the interview. To obtain the most accurate and useful information, providers are encouraged to ask about specific sexual behaviors instead of asking if the patient is “sexually active.” In discussing “Types of Sexual Activity,” the provider shall take the opportunity to address and answer questions about safe-sex practices for each activity defined. A standardized questionnaire may also be used, as long as confidentiality is stressed; however, this practice is not recommended for questions about sexual orientation because it may yield unreliable results. If possible, health educators should review basic topics; otherwise, written and visual materials can be provided. This “preview” can de-sensitize youth and prepare them for answering questions during the evaluation.⁶

Standard 7: History of Abuse

Youth should be asked about a history of emotional, physical, or sexual abuse by staff trained to interview youth concerning sensitive topics. If abuse is suspected, youth should be assessed to determine the circumstances surrounding abuse and the presence of physical, emotional, and psychosocial consequences, including health risk behaviors. Youth who report symptoms of emotional or psychosocial problems should be referred to a psychiatrist or other mental health professional for evaluation and treatment. Practitioners should be knowledgeable on their state’s mandatory reporting statute and be prepared to report abuse to the appropriate local or state child protection agencies.

In addition to on-site mental health care services, youth shall have easy, confidential access to outside advocates and professionals who provide services to survivors of sexual abuse, for emotional support and other services related to sexual abuse, through, at minimum, 1) written guides that include the addresses, telephone numbers, toll-free hotlines, website addresses, email addresses and contact persons for local, state and national legal and service organizations that assist survivors of sexual abuse and rape crisis centers; and 2) arrangements that ensure private, confidential communications between youth and these advocates and organizations.

Rationale: Youth who have been victimized as children may experience a resurgence of fear and anger when dealing with prospective sexual encounters. These emotions may interfere with the development of a healthy sexual relationship. Those who are ongoing victims of sexual abuse may present to the office or clinic with multiple STIs, pregnancy, and other health issues.

⁶ See generally American Medical Association, *Guidelines for Adolescent Preventative Services* 5 (1997), Recommendation 16, available at <http://www.ama-assn.org/ama1/pub/upload/mm/39/gapsmono.pdf> (last visited September 21, 2011). [hereinafter GAPS]; Region II Male Involvement Advisory Comm., *Guidelines for Male Sexual and Reproductive Health Services: A Tool for Family Planning Providers* 9-12 (2005) (on file with the Center for HIV Law & Policy) [hereinafter Region II MAC].

Implementation: Providers can inquire about sexual abuse or forced sex at the conclusion of the sexual history. It is important to establish rapport and trust with the patient; questions may be presented over several visits if necessary and feasible. If abuse is suspected, the youth should be assessed to determine the circumstances around the abuse and the consequences, whether they are physical, emotional, and/or psychosocial. Youth who report symptoms of emotional or psychosocial problems should be referred to a mental health professional for evaluation and treatment.⁷

Standard 8: Counseling on Anatomy

Youth should have a basic understanding of anatomy and physiology, including knowledge of one's body and how it functions; the essential and accessory organs of one's reproductive system; the stages of puberty; and how the body undergoes both hormonal and physical changes. Subsequent to this instruction, biological male youth should be taught how to perform testicular self-exams, and biological female youth should be taught how to perform breast exams. All adolescents should be taught how to use a condom.

Rationale: Youth must be taught how the body develops and functions in order to distinguish between healthy and unhealthy changes and to understand normal processes that occur during puberty. By understanding their own anatomy and that of their partners, youth can better protect themselves by choosing a method of STI and HIV protection and, where appropriate, pregnancy prevention. With counseling, they will be encouraged to seek out answers to questions and become involved with their own health maintenance. Youth must have access to scientifically accurate information in order to make informed choices about their sexual health care.

Implementation: This information can be presented during a group educational session or given at an individual patient-oriented genital exam and physical. Demonstrations on performing a self-examination, brochures, videos, and charts are also effective tools, but providers should be sensitive to the differences in reading capabilities of the youth in their care.⁸

Standard 9: Pubertal Development Exam and Counseling

Youth should be queried about pubertal development and asked about any concerns they may have about the timing and rate of maturation.

Rationale: Youth initiate the pubertal process at different times and proceed at different rates, which may cause anxiety and worry. Counseling and frank discussion can allow youth to alleviate concerns and identify problems that require additional medical attention.

Implementation: Questions about development can be broached during the course of the physical examination. A standardized questionnaire may also be used, as long as confidentiality is stressed.⁹

Standard 10: Genital Exam

Youth should be examined for ano-genital lesions of the genital tract, abnormal growths, itches, or skin changes in the genital area, and bleeding or irritation. This assessment should include the

⁷ GAPS, *supra* note 6, at 6 (Recommendation 21); Region II MAC, *supra* note 6, at 15.

⁸ Region II MAC, *supra* note 6, at 21-22.

⁹ *See* GAPS, *supra* note 6, at 3 (Recommendation 5); Region II MAC, *supra* note 6, at 9.

youth's history of ano-genital lesions as well as a thorough examination of the genital area. Careful consideration should be given to ano-genital lesions that may be very small or occur inside the anus. Youth should be made aware that ano-genital lesions are not necessarily indicative of sexually transmitted infections, but rather can be part of a more serious problem.

Any ano-genital lesions present must be investigated to ensure they are not of a serious type. Some associate conditions include pruritus ani (itching of the anus), eczema, folliculitis, tinea cruris (jock itch), intertigo (rashes), genital herpes, genital warts (including those associated with HPV and syphilis), pubic lice, cysts, and vaginal infections. Genital exams may be particularly sensitive for youth who are transgender, and care should be taken to use language relating to current genitalia, and to be aware of physical changes that may be taking place if the youth is on hormone therapy.

Rationale: A genital exam is necessary to diagnose and treat health and hygiene problems. Youth may not self-report ano-genital lesions because they may be unaware of them or because they may experience discomfort, embarrassment, low self-worth, or interference with sexual functioning. A comprehensive examination must be completed for clients who may feel uncomfortable talking to the clinician or may be unaware that they have ano-genital lesions.

Implementation for Male Genitalia: Preparation for the male genitalia exam should include:

- Warm hands first
- Make sure there is enough light
- Wear gloves
- Examine patient while he is standing up

The genital exam for adolescent male genitalia should include:

- Inspection:
 - Tanner staging (using a scale to define physical measurements of development based on external primary and secondary sex characteristics)
 - Pubic hair
 - Groin
 - Inner thigh
 - Prepuce
 - Glans
 - Scrotum
 - Discharge
 - Herpes lesions
 - Warts
- Palpation:
 - Testes
 - Epididymis
 - Vas Deferens
 - Inguinal hernia exam

Implementation for Female Genitalia: Preparation for the female genitalia exam should include:

- Warm hands and speculum first
- Make sure there is enough light

- Wear gloves

When indicated, a female genitalia exam should include:

- External exam/inspection of:
 - Tanner staging (using a scale to define physical measurements of development based on external primary and secondary sex characteristics)
 - Pubic hair
 - External genitalia
 - Urethra
 - Lymph nodes
- Speculum exam and inspection of vagina and cervix for discharge, cervical friability, strawberry cervix, foreign bodies, etc.
- Bimanual exam to assess:
 - Cervical motion tenderness
 - Adnexal tenderness
 - Uterine size or tenderness
 - Mass uterine

During the examination, any discomforts, abnormal growths, or itches should be recorded in the youth's medical records. If the lesions are sexually transmitted, information on ways the youth can protect himself or herself from acquiring further infections must be relayed. Youth should also be informed that some types of ano-genital lesions may be difficult to detect and may warrant several different types of detection procedures. They must be encouraged not to feel upset, angry, or ashamed of themselves or their partners. An understanding of the prevention, treatment, and management of ano-genital lesions is most essential. Youth should also be encouraged to check themselves periodically for any type of ano-genital lesions.

Standard 11: Genital Hygiene

All youth should be taught how to appropriately clean the genitalia and the proper bathing/hygiene requirements.¹⁰

Rationale: Proper genital hygiene is an important factor in preventing disease.¹¹

Implementation: Youth should be counseled on proper hygiene for their genitalia and how to check for unusual bumps, discharge, and burning.¹² Youth with female genitalia should be counseled on what discharge is normal and what should be cause for medical attention. The particular risks of douching should be discussed in detail.¹³ Youth with uncircumcised penises should be informed about: smegma, oily secretions that accumulate under the foreskin; balanitis, inflammation of the tip of the penis; and phimosis, the inability of the foreskin to pull down and expose the penis head

¹⁰ Region II MAC, *supra* note 6, at 28.

¹¹ *Id.*

¹² *Id.*

¹³ The effects of douching can include ectopic pregnancies, pelvic inflammatory disease, and changes in vaginal flora. See Jeffrey T. Kirchner, D.O., *Prevalence of Vaginal Douching Despite its Adverse Effects*, in AMERICAN FAMILY PHYSICIAN (2000), available at <http://www.aafp.org/afp/20000201/tips/33.html> (last visited September 21, 2011).

during erections and intercourse. Healthcare providers should feel comfortable in addressing genital-hygiene questions and concerns.¹⁴

Standard 12: STI Testing

Young men and women in state custody should be offered testing for:

- Chlamydia
- Gonorrhea
- Syphilis
- HPV

Rationale: Multiple studies and surveillance projects have demonstrated a high prevalence of STIs in youth in state custody. Testing for chlamydia, gonorrhea, and syphilis at intake offers an opportunity to identify infections, prevent complications, and reduce transmission in the community. It also indicates an increased risk for HIV. Untreated STIs result in damage to various other organ systems and the spread of infections to other sexual partners. Testing for the causative agent assures that proper treatment is provided.¹⁵

STIs disproportionately affect adolescent women. Because of immature cervical immaturity, this population is biologically more susceptible to infection. Additionally, in the majority of cases, STIs in young women are asymptomatic, which can lead to delays in testing and treatment. As a result, women face greater morbidity with untreated infection.

Implementation: Tests should be offered as part of a physical exam, and should include counseling on STI causes, treatment, and prevention. Pre-test counseling should specifically include the following information:

- How STI testing is performed
- The importance of STI testing for treatment
- A discussion of the proper use of latex condoms with water-based lubricants, other latex barriers, and abstinence
- Encouragement for youth to discuss concerns about STIs with their sexual partners and health care providers
- The only way to know if you or someone else is infected with an STI is from testing and a medical exam
- If you think you have an STI, you should stop having sexual intercourse and go to a health care provider for testing, and refer partners to a healthcare provider as well
- If you have been sexually assaulted, you should be tested for STIs
- A discussion of relevant state laws allowing youth to get confidential testing and treatment for STIs without adult consent.
- A discussion of one's right to confidentiality after submitting to an STI test, as well as the state mandated reporting requirements to the local county or state health department or the Centers for Disease Control and Prevention (CDC)
- Confidentiality for youth in foster care and related obligations that need to be reported to a foster care agency. Youth are often concerned with what medical information foster care agencies may acquire from previous medical providers and youth shall be told that their medical

¹⁴ *Id.*

¹⁵ *Id.* at 40.

information may be shared with a foster care agency. Because youth may not want this information to be shared, youth should be made aware that providers do not have to be told that youth are in foster care and therefore providers are under no obligation to report information to the foster care agency.

Additional counseling must be provided in accordance with Standard 19. All youth should be offered testing and provided appropriate counseling for:

Chlamydia:

- *C. trachomatis* urogenital infection in women can be diagnosed by testing urine or swab specimens collected from the endocervix or vagina.
- Diagnosis of *C. trachomatis* urethral infection in men can be made by testing a urethral swab or urine specimen.
- Rectal *C. trachomatis* infections in persons that engage in receptive anal intercourse can be diagnosed by testing a rectal swab specimen.
- Culture, direct immunofluorescence, EIA, nucleic acid hybridization tests, and NAATs are available for the detection of *C. trachomatis* on endocervical and male urethral swab specimens. NAATs are the most sensitive tests for these specimens and are FDA-cleared for use with urine, and some tests are cleared for use with vaginal swab specimens.
- The majority of tests, including NAAT and nucleic acid hybridization tests, are not FDA-cleared for use with rectal swab specimens, and chlamydia culture is not widely available for this purpose.
- Some noncommercial laboratories have initiated NAAT of rectal swab specimens after establishing the performance of the test to meet CLIA requirements.

Gonorrhea:

- Gram-negative diplococci can be considered diagnostic for infection with *N. gonorrhoeae* in symptomatic men. Gram stain should not be considered sufficient for ruling out infection in asymptomatic men.
- Gram stain of endocervical specimens, pharyngeal, or rectal specimens also are not sufficient to detect infection and, therefore, are not recommended.
- Specific diagnosis of infection with *N. gonorrhoeae* may be performed by testing endocervical, vaginal, male urethral, or urine specimens.
- Culture, nucleic acid hybridization tests, and NAAT are available for the detection of genitourinary infection with *N. gonorrhoeae*. Culture and nucleic acid hybridization tests require female endocervical or male urethral swab specimens. NAAT offer the widest range of testing specimen types because they are FDA-cleared for use with endocervical swabs, vaginal swabs, male urethral swabs, and female and male urine. However, product inserts for each NAAT vendor must be carefully examined to assess current indications because FDA-cleared specimen types might vary. In general, culture is the most widely available option for the diagnosis of infection with *N. gonorrhoeae* in nongenital sites (e.g., rectum and pharynx). Nonculture tests are not FDA-cleared for use in the rectum and pharynx. Some NAATs have the potential to cross-react with nongonococcal *Neisseria* and related organisms that are commonly found in the throat. Some noncommercial laboratories have initiated NAAT of rectal and pharyngeal swab specimens after establishing the performance of the test to meet CLIA requirements.

- Because nonculture tests cannot provide antimicrobial susceptibility results, clinicians should perform both culture and antimicrobial susceptibility testing in cases of persistent gonococcal infection after treatment.

Syphilis

- A serologic test for syphilis.

HPV

- Evaluation for human papilloma virus by visual inspection (males and females) and by pap test (females).¹⁶

All youth must be informed, in private, of their test results (both positive and negative) and receive appropriate post-test counseling and treatment in accordance with Standard 13. All test results must remain confidential in accordance with Standards 13 and 43.

Standard 13: STI Treatment

Following a diagnosis of an STI, a treatment plan should be instituted according to guidelines developed by the CDC. The use of condoms must be encouraged.¹⁷ Treatment of common, uncomplicated STIs should be available on-site.¹⁸ Post-diagnosis counseling should be provided.

The HPV vaccines shall also be discussed and offered to all biological female youth. The HPV vaccines prevent cervical cancer, other less common cancers, and most genital warts that are caused by HPV and are licensed, safe, and effective for use by women between the ages of 9-26 years old. The vaccines currently on the market, Gardasil and Cervarix, require three shots over a period of approximately nine months. If biological female youth start the treatment at the facility they must be aligned with follow up care to receive the remainder of the vaccine. Gardasil has also been tested and licensed for use in biological males 9-26 years old.¹⁹ Biological male youth shall also be counseled and offered Gardasil to prevent transmitting HPV to sexual partners. It is imperative that post-vaccine counseling be provided so the youth know when to receive the next shot in the treatment and the importance of completing the three shot session. Youth shall also be counseled on the importance of safe sex to prevent contracting and transmitting other STIs.

Rationale: Untreated STIs result in damage to various other organ systems and the spread of infections to other sexual partners.²⁰ Multiple studies and surveillance projects have demonstrated a high prevalence of STIs in persons entering juvenile detention facilities (see Standard 12). Testing for chlamydia, gonorrhea, and syphilis at intake offers an opportunity to identify infections, prevent complications, and reduce transmission in the community.

Implementation: Those presenting with an exposure to STIs or symptoms of current infection should be provided immediate presumptive treatment and testing should be performed whenever

¹⁶ GAPS, *supra* note 6, at 5-6 (Recommendation 17).

¹⁷ *Id.* See also, Centers for Disease Control and Prevention, *2010 STD Treatment Guidelines* (2010), available at <http://www.cdc.gov/std/treatment/2010/default.htm> (last visited September 21, 2011).

¹⁸ Region II MAC, *supra* note 6, at 40.

¹⁹ See, e.g., Centers for Disease Control and Prevention, *Vaccines: VPD-VAC/HPV/Vaccine FAQ* (2011), available at <http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm> (last visited September 21, 2011).

²⁰ *Id.*

possible to confirm the diagnosis.²¹ Diagnoses must not be disclosed to non-health care staff. Post-diagnosis counseling should include:

- Discussion of appropriate treatment and re-infection
- Discussion of abstinence from sex until patient and partner treatment
- Reinforcement of prevention through safe-sex practices or abstinence
- Discussion of the psychological strain of diagnosis

Treatment and dispensing of medication must be done in a confidential setting and must not be done in a way that makes it obvious what the medication is for; for example, facilities should not dispense all medication except STI medication in front of other youth, which would allow youth to infer whom is receiving STI medication by observing whose medication is dispensed privately. Thus, all medication should be dispensed privately. Youth in foster care should be counseled on how and where to receive their care and medications and given resources to receive this care without foster parent involvement if necessary.

Standard 14: HIV Pre-Test Counseling: risk-assessment

All youth should be HIV risk assessed. Use a very explicit assessment checklist. Ask each youth: “What do you do to protect yourself from HIV/AIDS?”²² The standard of care should be to offer counseling and voluntary testing to each youth (as set forth below in Standard 15). All youth should receive counseling on HIV prevention, including risk factors for HIV, HIV myths, and how to protect themselves against HIV (as set forth below in Standard 19).

Rationale: Reproductive health care settings are a critical conduit to HIV testing and counseling. According to the World Health Organization, at least 75% to 85% of the 39.4 million HIV infections worldwide have been sexually transmitted as of 2003.²³ Therefore, prevention should take place through both primary prevention and secondary prevention. An example of primary prevention would be encouraging HIV-negative youth to use condoms, avoid injection drug use, and not use shared needles. Secondary prevention would entail advising HIV-positive youth to practice safer sex techniques to protect themselves from re-infection, explaining the relative risks of different types of sex (e.g., oral versus anal, receptive versus insertive) to protect their uninfected partners, and explaining how to protect themselves from other STIs their partners may have. It is important to offer the test to all youth, because youth may not accurately report, estimate, or understand their risk.

Implementation: All youth should be given an HIV risk-assessment by asking questions during the taking of a medical history or by giving the youth a questionnaire to complete.²⁴ The risk-assessment should include questions concerning whether the adolescent has engaged in sexual behavior; has been sexually abused; has symptoms of HIV infection; has a history of STIs; has had unprotected sex with multiple sex partners or with partners in high-prevalence jurisdictions and communities (as many females are infected while in relationships with a single partner); has exchanged sex for money, food, housing, or drugs without using protection; has a history of tuberculosis; has injected drugs or shared needles (including needles for hormone injections or tattoos) or other equipment involved in

²¹ *Id.*; GAPS, *supra* note 6, at 5-6 (Recommendation 17).

²² Region II MAC, *supra* note 6, at 28.

²³ *Id.*

²⁴ *Id.*

piercing; has hepatitis C; has used non-injection illegal drugs; or has had a blood transfusion in any other country at a time when blood was not screened for HIV.²⁵

It is also important to understand the youth's literacy skills and cultural sensitivities. Questions concerning sexual behavior or drug use cover sensitive areas. A substance abuse evaluation must be part of the risk-assessment, as abuse of alcohol or drugs impairs judgment in ways that can lead to higher risk behavior for acquiring HIV. Pre-test counseling should focus on teaching skills and not just facts. This includes teaching explicit safe-sex skills, instructing the adolescent on asking sexual partners about STIs and HIV, and being able to identify genital infections on their sexual partner.²⁶

Standard 15: HIV Pre-Test Counseling: Informed Consent

HIV testing should be performed only after informed consent is obtained from the youth.

Rationale: Obtaining informed consent is a legal and ethical requirement for all medical procedures. Despite recent movements to eliminate informed consent requirements, standard practices among youth currently require that there be written informed consent so that youth completely understand for what they are being tested and treated. Because laws regarding informed consent, HIV testing, and treatment vary from state to state, practitioners should be versed in their jurisdiction's laws on informed consent and confidentiality. Practitioners should also educate youth about these laws.

Informed consent requires that a competent patient voluntarily consent to treatment or testing after being informed of the nature of the treatment or testing, possible alternatives, and any risks or benefits to the procedure and its alternatives. It is a process of communication between physician and patient that results in the patient agreeing to undergo a medical procedure.²⁷ As part of informed consent, patients must have any and all questions answered to have a full understanding of the ramifications of any treatment or test before providing voluntary, informed consent.

HIV testing without a patient's informed consent is a particularly egregious violation of their human rights. Unlike many other STIs, HIV is a chronic, life-long condition that requires continual treatment and can lead to legal, social, and economic ramifications. Written informed consent provides documentation of informed consent as a safeguard against the abuse of patients' rights, ensures no one is tested without his or her consent, and helps avoid liability. For many youth, HIV testing may act as a portal to the health care system; ensuring that the experience is voluntary and respectful of their rights will help build a relationship of trust with the health care community and encourage youth to seek appropriate follow up testing and, for those who test positive, treatment.

Implementation: HIV testing should be offered following a risk-assessment and other pre-test counseling and written consent. Pre-test counseling should focus on available treatment and create a positive perspective about long-term prognosis. The pre-test counseling must include the following information in language and concepts that the adolescent can understand:

²⁵ See N.Y. State Office of Children & Family Servs., *Working Together: Health Services for Children in Foster Care* 3-6 (2004), available at http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp (last visited September 21, 2011) [hereinafter WORKING TOGETHER].

²⁶ Region II MAC, *supra* note 6, at 28.

²⁷ Catherine Hanssens, THE CENTER FOR HIV LAW & POLICY, *Legal and Ethical Implications of Opt-Out HIV Testing*, (2007), available at <http://www.hivlawandpolicy.org/resources/view/370> (last visited September 21, 2011).

- HIV testing is voluntary and consent can be withdrawn at any time by telling your health care provider
- The ways in which HIV testing is performed
- Your HIV test includes a test to see if you have an HIV infection and, if you are positive, additional tests to help your doctor decide the best treatment for you and help the health department with HIV prevention programs
- The importance of HIV testing for treatment
- A discussion of the proper use of latex condoms with water-based lubricants, other latex barriers, and abstinence
- Encouragement for youth to discuss concerns about HIV with their sexual partners and health care providers
- The only way to know if you or someone else is infected with HIV is from testing
- If you think you have HIV, you should stop having sexual intercourse and go to a health care provider for testing, and refer partners to a healthcare provider as well
- If you have been sexually assaulted, you should be tested for HIV
- A discussion of relevant state laws allowing youth to get confidential testing and treatment for HIV without adult consent
- HIV testing is important for your health
 - If your result is negative, you can learn how to protect yourself from infection in the future.
 - If your result is positive, you can take steps to prevent passing the virus to others.
 - You can receive treatment for HIV and learn other ways to stay healthy.
- HIV testing is especially important for pregnant women because an HIV-positive woman can pass HIV to her child during pregnancy, birth, or through breastfeeding
 - If you are pregnant and have HIV, treatment is available for you and to prevent passing HIV to your baby
 - If you have HIV and do not get treatment, the chance of passing HIV to your baby is one in four
 - If you get treatment, the chance of passing HIV to your baby is much lower
- If you test positive, the law protects you from discrimination based on your HIV status
- Relevant confidentiality, reporting, and partner notification laws must be discussed
- If you're HIV positive, the earlier you are assessed for treatment, the better your health with HIV will remain.
 - Also, effective treatment when appropriate also can reduce the risk that you will pass HIV to a sexual partner.
- A discussion of one's right to confidentiality after submitting to an HIV test and also the state mandated reporting requirements to the local county or state health department or the Centers for Disease Control and Prevention (CDC)

Standard 16: HIV Test Administration

Following pre-test counseling, all youth should be offered confidential HIV testing with the Rapid HIV Testing and confirmatory test. The option of anonymous testing should be available to youth who (for a variety of reasons, including pending criminal charges or fear of stigmatization) are not comfortable with testing otherwise.

Rationale: If undiagnosed and untreated, HIV can result in serious health problems and is more likely to be transmitted to other sexual partners.²⁸ Due to high rates of sexual risk behaviors and low rates of condom use, youth in state care experience particularly higher rates of STIs, including HIV.²⁹

Implementation: Patients who provide written informed consent should be provided prompt and confidential HIV testing with Rapid HIV Testing and a confirmatory test within two weeks for youth who test positive. Testing must be accompanied by counseling as set forth in Standards 14, 15, and 17. Youth should be able to request this testing at any time. They should be provided with prompt counseling and testing in accordance with this Standard and Standards 14, 15, and 17. Regardless of the results, non-health care staff may not be told of a youth's HIV status without that youth's consent.

Standard 17: HIV Post-Test Counseling

All youth must be promptly informed of their test results—both positive and negative—in a confidential setting and provided appropriate post-test counseling. If youth test preliminary positive from the Rapid HIV Test, he or she must be told what a preliminary positive test means and why confirmatory testing is required. Youth who test preliminary positive must be provided with a confirmatory test to confirm the results.

Rationale: Post-test counseling provides critical information about the test results and the need for follow-up care such as treatment and additional testing. Youth who receive a positive test require counseling that explains what this test means and does not mean, the importance of additional testing, the next steps in their treatment, how to keep themselves healthy, and how to protect partners. These youth also need counseling to de-stigmatize and demystify HIV and to ensure that they are able to protect both their health and their rights, such as their right to keep their results confidential. Youth who receive a negative test result may not understand the significance of this result the “window period,” or the importance of follow-up testing. Without such counseling, they may incorrectly assume that they do not have HIV or are not at risk for HIV or transmitting HIV.

Implementation: All youth who receive an HIV test must be provided, in a private and confidential setting, post-test counseling that includes:

- A comprehensive discussion of what their test results mean
- HIV prevention counseling

Youth who test positive must also receive counseling that includes:

- The need for a confirmatory test and when and how that test will be provided
- Treatment options and a discussion of “next steps” and follow up care in accordance with Standard 18
- Offer of follow-up counseling to deal with feelings (such as fears or concerns) about the test results
- The right not to be discriminated against
- The right to keep the test result confidential

²⁸ *Id.* at 40.

²⁹ Staples-Horne, *supra* note 1, at 309.

- Facility obligations to keep test results confidential and to prevent and respond to any discrimination (including ways in which the youth can report any violation of those obligations)

Standard 18: HIV Treatment

The provider and custodial facility should be prepared for positive HIV test results and develop a mechanism to provide treatment while the youth is still in custody or care, and appropriate follow-up on release into the community.³⁰ Facilities should offer a comprehensive package of health care and support services to meet the multiple needs of youth with HIV.³¹

Rationale: The primary goal for practitioners should be to provide appropriate care that minimizes HIV progression. The determination of HIV treatment and care should be made with the informed consent and understand of the youth, and where applicable, parent or legal guardian. Practitioners should be aware of the HIV confidentiality, treatment and consent laws in their jurisdiction regarding the treatment of minors. HIV treatment should be commenced if the clinician and youth find that ART and other HIV-related medication is appropriate. If untreated, HIV results in serious health problems and is more likely to be transmitted to other sexual partners.³² Due to the high rates of sexual risk behaviors and low rates of condom use, youth in state care experience higher rates of STIs, including HIV.³³

Implementation: Youth who are HIV-positive should receive medical care from specialized pediatric or adolescent HIV/AIDS providers that have 24-hour coverage, seven days a week. It is crucial that detention facilities and responsible foster care parties and families strictly adhere to the medication schedules that are prescribed for the youth. If a youth is not in a residential facility where medications can be routinely distributed, then other drug adherence tactics should be discussed and agreed upon with the youth and/or their foster care family. Facilities must have methods for monitoring and assuring that medication schedules are followed precisely as written. If adherence to the medication schedule is problematic, the prescribing practitioner should be consulted. The custodial facility must also provide the necessary supportive nursing and psychosocial services and training to the youth, including counseling for issues of loss and grief, and counseling to help youth assess the impact of HIV on their sexual development and exploration.³⁴

Treatment and dispensing of medication must be done in a confidential setting and must not be done in a way that makes it obvious what the medication is for; for example, facilities should not dispense all medication except STI or HIV medication in front of other youth, which would allow youth to infer who is receiving STI or HIV medication by observing whose medication is dispensed privately. Thus, all medication should be dispensed privately.

Standard 19: HIV and STI Counseling

Every youth should be assessed for: their knowledge of HIV and STIs; the presence of symptoms in self or partner; the existence of multiple sexual partners for self or partner; the treatment of either

³⁰ *Id.* at 310.

³¹ WORKING TOGETHER, *supra* note 25, at 3-4.

³² See Region II MAC, *supra* note 6, at 40.

³³ Staples-Horne, *supra* note 1, at 309.

³⁴ See WORKING TOGETHER, *supra* note 25, at 3-4.

for an STI; whether barrier methods (i.e.: condoms) are used.³⁵ Counseling should be provided that explains: how HIV is transmitted in clear and precise language, the precise routes and related relative risks of different sexual acts, the consequences of the becoming infected and living with HIV, and the fact that latex condoms and water-based lubricant are effective in preventing STIs, including HIV; reinforcement of responsible sexual behavior for youth who are not currently sexually active and for those who are using condoms, other latex barriers, low-risk and lower-risk sexual conduct, and birth control effectively; and counseling on the need to protect themselves and their partners from pregnancy, STIs, HIV, and sexual exploitation. Latex condoms to prevent STIs, including HIV infection, and appropriate methods of birth control should be made available, as should instructions and training on how to use them effectively.³⁶ Myths and exaggerated beliefs about the risks of HIV transmission should be addressed and debunked.

Rationale: Many youth lack knowledge about STIs and HIV, including how they can contract and transmit them, how STIs and HIV affect their health, and the effective measures for their prevention. Many STIs disproportionately affect youth. Youth in the United States have higher STI rates than teenagers in other developed countries because they have more sexual partners and lower levels of condom use.³⁷ Due to the high rates of sexual risk behaviors and low rates of condom use, youth in state care in particular experience higher rates of STIs, including HIV.³⁸ They need information and education about STIs and HIV, including how to avoid infection and transmission, where to obtain and how to use condoms correctly, and how to talk about STIs and HIV with their partners.³⁹

Implementation: These questions should be included on the medical history completed by the clinician.⁴⁰ A skilled provider should review the information in detail. An opportunity for questions and discussion must be offered.⁴¹ Counseling services may be provided directly by the facility or by agreements with health-related community organizations. Regardless, such services must be readily available and provided by professionals trained and experienced in family planning education, gynecological care, and contraception for adolescents.⁴² Counseling can occur individually or in a group setting.⁴³

Standard 20: Condom Use and Availability

Condoms, both male and female versions, should be made available to all youth, with all youth made aware of their availability. Youth should be instructed that condoms provide protection from some STIs as well as pregnancy. They should be informed and instructed in the correct use of condoms and educated about any common misconceptions.

³⁵ Region II MAC, *supra* note 6, at 27.

³⁶ GAPS, *supra* note 6, at 4 (Recommendation 9).

³⁷ Jacqueline E. Darroch, et al., ALAN GUTTMACHER INST., *Can More Progress Be Made?: Teenage Sexual and Reproductive Behavior in Developed Countries* 6 (2001), [available at](http://www.guttmacher.org/pubs/eurosynth_rpt.pdf) http://www.guttmacher.org/pubs/eurosynth_rpt.pdf (last visited September 21, 2011).

³⁸ Staples-Horne, *supra* note 1, at 309.

³⁹ See Region II MAC, *supra* note 6, at 27.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² WORKING TOGETHER, *supra* note 25, at 3-7.

⁴³ Region II MAC, *supra* note 6, at 27.

Rationale: As aforementioned, teenagers in the United States have higher STI rates than teenagers in other developed countries, most likely due to greater sexual partners and lower levels of condom use.⁴⁴ Each youth needs to know that condoms offer protection against some STIs, including HIV infection. Condoms are essential when there are multiple partners or the sexual history of a partner is not known.

Implementation: A clinician or counselor should first demonstrate proper application and removal of a condom by employing the use of an anatomical model. The professional should then observe the youth place and remove the condom from the model.⁴⁵ This education should include information on the use of water-based lubricants for anal sex as a means of making condoms more effective. The following questions will help address condom-specific issues: Do you know that they make a condom for women? Have you ever used a male or female condom with your partner? Do you ever have trouble putting on a condom?

Standard 21: Substance Abuse and Sexual Behavior Counseling

Youth should be informed of the adverse physiological effects of substance use on sexual development and functioning. Emphasize the importance of responsible sexual behavior with drug and alcohol users, even infrequent, as they are more likely to have unprotected sex.

Rationale: Adolescents who drink or use drugs are more likely to initiate sex at a younger age, to have unprotected sex, to have sex with multiple partners, and to contract STIs.⁴⁶ Moreover, use of alcohol, tobacco, and other drugs (“ATOD”) can cause other health problems.

Implementation: Youth should be educated on predominant types of ATOD use and their physiological consequences on sexual function and development. Educational materials on ATOD use and abuse should be made available at the clinic.⁴⁷

Standard 22: Contraception Use and Availability

Youth should be informed in the nature and proper use of female hormonal and female barrier methods of contraception. They should be instructed on the effectiveness of these methods and on any major significant side effects and related danger signals. Any misconceptions should be addressed. All youth should have access to forms of contraception and assistance that allow them to choose a method that will protect them and their partner from pregnancy, STIs, and HIV. Special care should be taken to introduce all contraceptive choices.

Rationale: All sexually active youth must take responsibility in assuring that contraceptive measures are used correctly and consistently. They must choose the best method of contraception and STI protection for themselves and their partners.

⁴⁴ Darroch, *supra* note 37, at 6.

⁴⁵ Region II MAC, *supra* note 6, at 26.

⁴⁶ Kaiser Family Foundation, *Fact Sheet: Substance Use and Sexual Health Among Teens and Young Adults in the U.S.* (2002) citing *Dangerous Liaisons: Substance Abuse and Sex*, National Center on Addiction and Substance Abuse at Columbia University (1999); AIDS Institute Guidelines, *Substance Use and Dependence Among HIV-Infected Adolescents and Young Adults* (2009), available at <http://www.hivguidelines.org/clinical-guidelines/hiv-and-substance-use/substance-use-and-dependence-among-hiv-infected-adolescents-and-young-adults/> (last visited September 21, 2011).

⁴⁷ GAPS, *supra* note 6, at 4 (Recommendation 10); Region II MAC, *supra* note 6, at 24-25.

Implementation: This information can be presented to youth during a group educational session or a private counseling session. Brochures, videos, and charts can be effective tools.⁴⁸ There should also be resources for providers with directories that can refer patients to locations for contraceptive services and family planning access.

Standard 23: Emergency Contraception

Assess each youth about his or her understanding of the process of fertilization and establishment of a pregnancy. Provide all youth with accurate, complete information on how emergency contraception works and its availability. Young people shall also be informed on the local and state programs on availability of emergency contraception.

Rationale: Many young men and women are unaware of emergency contraception. In the event of a sexual assault or contraceptive failure, emergency contraception provides a second chance to prevent pregnancy.⁴⁹

Implementation: This information can be presented during interviews upon the medical intake process by providing information on how youth can obtain emergency contraception while in custody or in their foster care placements and when they leave custody.⁵⁰ Providers can discuss the option of obtaining a prescription to have on hand for emergencies if they are under the age of 17.⁵¹ Youth should be questioned about their need for post-coital contraception due to contraception failure, sexual assault, sexual spontaneity in relationships.

Ways to engage youth include: Do you ever have unprotected sex with someone of a different sex? Have you ever had a condom break? Do you practice withdrawal as a form of birth control? Do you know how pregnancy occurs? Each client must be instructed that emergency contraception is the only method a couple can use to prevent pregnancy after unprotected vaginal intercourse with someone of a different sex or after a contraceptive “accident.” Youth need to know that this form of contraception (which is more commonly referred to as the Morning After Pill or Plan B) can be used up to 120 hours (5 days) after unprotected sex. However, it is most effective if taken within the first 48 hours. Females should be instructed on how emergency contraception may affect their cycles.

Youth should also be aware of what the local and state laws are regarding accessing emergency contraception. Some states allow accessing emergency contraception with a doctor’s prescription while others require a prescription. Youth must be made aware of their state’s related policies.

Standard 24: Pregnant Youth

Females who test positive for pregnancy must be provided with unbiased and comprehensive options counseling (as set forth in Standard 25) within 24 hours of the diagnosis. Females who test positive for pregnancy should also be assessed for sexual trauma on diagnosis of pregnancy.⁵² If the pregnancy is continued, prenatal care should be provided in coordination with public health

⁴⁸ Region II MAC, *supra* note 6, at 26.

⁴⁹ Staples-Horne, *supra* note 1, at 311.

⁵⁰ Region II MAC, *supra* note 6, at 26; Staples-Horne, *supra* note 1, at 311.

⁵¹ Region II MAC, *supra* note 6, at 26.

⁵² Staples-Horne, *supra* note 1, at 310-11.

agencies, without significant travel from the facility they are currently residing and consistent with the American College of Obstetrics and Gynecology (ACOG) Standards for reproductive health and the birth process.⁵³ If the pregnant youth is discharged from the facility or state care prior to delivery, she should be provided information and referral for continuing obstetric care. If a confined youth decides to terminate the pregnancy, the custodial facility should ensure that the termination is obtained at the earliest gestation possible within the confines of state law on abortions.⁵⁴

Rationale: Studies have revealed that a significant number of young women confined in the juvenile justice system or in state care are pregnant.⁵⁵ They clearly have health needs specific to their pregnancy. The options and standard of care for young women should not be diminished simply because they are in state custody.

Implementation: A facility should have standards and procedures in place to provide immediate assistance to a pregnant youth in its custody. Options counseling must be provided within 24 hours of pregnancy diagnosis to ensure that options are not foreclosed to the youth due to her being in custody. Should the youth choose to terminate the pregnancy, the facility must have standards and procedures to ensure that, this can be achieved at the earliest gestation possible. Coordination with outside health providers, as well as transportation to and from outside facilities, may be necessary and thus standards and procedures should exist to ensure this coordination can be achieved as swiftly as possible. Outside public health providers should also be located nearby to avoid trauma for the pregnant youth who may be shackled in accordance with agency transportation policies.

Standard 25: Pregnancy Options Counseling

Each youth should be instructed and informed about all options available for management of an intended or unintended pregnancy.⁵⁶ Females who test positive for pregnancy must be provided with unbiased and comprehensive options counseling regarding their ultimate choice regarding the pregnancy within 24 hours.

Rationale: All youth, male and female, should understand the options for an intended or unintended pregnancy, as both males and females have a role in the pregnancy.⁵⁷

Implementation: Females should be given options counseling within 24 hours of a positive diagnosis. For males, general information can be presented during a group educational session or a private counseling session. Counseling should include discussion of: the youth's concerns, fears, and wishes; whether she wants to involve the fetus' father in the planning; whether he or she wants to involve his or her parents/guardians or other family members in planning; an objective review and discussion of the alternatives and their implications, including adoption of the baby, pregnancy termination, parenthood, living arrangements, school attendance, and education; and the resources available in the facility and in the community to help him or her implement each alternative.⁵⁸

⁵³ *Id.* at 311; WORKING TOGETHER, *supra* note 25, at 3-9.

⁵⁴ Staples-Horne, *supra* note 1, at 311.

⁵⁵ *Id.* at 310.

⁵⁶ Region II MAC, *supra* note 6, at 27.

⁵⁷ *Id.*

⁵⁸ *Id.* at 311; WORKING TOGETHER, *supra* note 25, at 3-9.

This counseling should explain to the youth the procedures in place to ensure her decision is respected and assisted. She should understand her rights to continue or terminate the pregnancy without pressure or threats from any other person or institution. She should also be comprehensively counseled on adoption options, including familial and open adoption. The counseling should describe to the youth any and all confidentiality laws protecting her should she choose to terminate the pregnancy and whether, under state law, parental notification or consent is required for youth in state custody. If such notification or consent is required, the youth should also be counseled in the judicial or executive bypass procedures available to her and provided assistance in using such a procedure if she chooses to do so.

Youth in state care but not in custody should similarly be provided with options counseling as soon as possible, and should be given additional resources on how to carry out their wishes for the pregnancy within the context of foster care. In particular, they should be counseled on their rights to obtain a termination, adoption, and/or prenatal services without regard for the wishes of their foster family or other possible pressures.

Standard 26: Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Health Concerns

Providers should be aware of the health concerns of LGBTQ youth and should be aware of the relevance of sexual orientation and gender identity on the youth's health status.⁵⁹

Rationale: LGBTQ youth face distinct health challenges, including an increased risk for substance abuse, sexually transmitted disease, sexual assault, and, sometimes seen in the case of young gay males, eating disorders. LGBTQ youth routinely face societal discrimination and isolation as a result of their sexual orientation and gender identity. As a result, they commonly suffer from the effects of chronic stress, which can lead to increased levels of depression and anxiety.⁶⁰ Many LGBTQ youth experience feelings of severe isolation. In fact, LGBTQ youth are two to three times more likely to attempt suicide than their heterosexual peers and account for up to 30% of all completed suicides among teens.⁶¹

LGBTQ youth are particularly vulnerable to sexual victimization while in state custody. According to the 2010 Department of Justice Bureau of Justice Statistics Special Report on Sexual Victimization in Juvenile Facilities, from 2008 to 2009 at least one in ten youth was sexually abused; at least one in ten youth experienced staff sexual misconduct; and LGBTQ youth were ten times more likely to be sexually victimized than heterosexual youth.⁶² Because LGBTQ youth are traditionally marginalized in these facilities, it is particularly important that there be a medical staff

⁵⁹ See generally Physicians for Reproductive Choice & Health, *Gay Lesbian Bisexual Transgender and Questioning Youth* (2009), available at <http://www.prch.org/arshepdownloads> (last visited September 21, 2011) [hereinafter PRCH-LGBTQ]; Staples-Horne, *supra* note 1.

⁶⁰ Shannan Wilber et al., *The Model Standards Project: Creating Inclusive Systems for LGBT Youth in Out-of-Home Care* 6 (2006), available for a fee at https://netforum.avectra.com/eweb/shopping/shopping.aspx?site=cwla&webcode=shopping&shopsearch=lgbt&shopsearchcat=top100products&prd_key=ab74a953-7209-49cf-bc9a-ad5221ea2d41; also on file with Center for HIV Law & Policy.

⁶¹ Region II MAC, *supra* note 6, at 25.

⁶² Bureau of Justice Statistics, U.S. Dep't of Justice, *Special Report: Sexual Victimization in Juvenile Facilities Reported by Youth 2008-2009*, 11 (2010), available at <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2113> (last visited September 21, 2011).

and a medical support system that recognizes the existence and needs of these youth if they are to safely report and be treated for sexual misconduct.

Implementation: While following the requirements set forth in Standard 3, providers treating youth should inquire into sexual behavior and attraction. Where appropriate, they should discuss and inquire into areas in which the youth's sexual behavior could lead to increased health risks. This discussion includes assessment of and referral for mental health concerns (as set forth in Standards 4, 28, and 29), assessment of substance abuse, and the providing of safe-sex counseling.⁶³ There should also be a discussion of whether the youth is facing abuse, harassment, or other types of discrimination within the detention facility or foster care system. If youth are facing abuse, harassment, or other types of discrimination, appropriate action must be taken immediately to assure their safety and to address the abuse.⁶⁴ The remedial action must address the harassment and discrimination by targeting the perpetrators and ensuring a safe environment, rather than by targeting or isolating the LGBTQ youth.

Standard 27: Transgender Youth Health Concerns

"Transgender youth" or "gender nonconforming youth" refers to all those who challenge the socially-accepted definitions and boundaries of sex and/or gender. Transgender youth may be contemplating or already be in the process of transitioning from one gender to another. The health needs of transgender youth must be discussed and addressed in an open, nonjudgmental manner. Providers must also recognize and address the unique physical and mental health needs these youth may have, and the rights of transgender youth to health care related to their gender identities.⁶⁵

Rationale: Puberty is a difficult time for youth struggling with their gender identities because they lack support systems to make sense of their physical changes. These changes may shame or repulse transgender youth, prompting them to attempt to alter their appearance by concealing or injuring unwanted body parts or using hormones without the oversight of a doctor. Transgender youth also are at higher risk for alcohol and substance use to cope with feelings of depression or anxiety. Moreover, fear of ridicule, rejection, or harassment prevents many transgender youth from seeking services in the health care system. As a result, transgender youth may not receive health care on a consistent basis, much less care that addresses their unique health needs.⁶⁶

Implementation: Communication, plans for transition, STI screening, safety and mental health, the use or discontinuation of hormones, silicone injections, ongoing care, and more must all be discussed with youth and addressed by providers. Providers should create a respectful and nonjudgmental environment for gender nonconforming youth. They should encourage a dialogue with youth on their health needs. For example, providers should respect the youth's gender identity and expression, including calling transgender and gender nonconforming youth by the name and

⁶³ PRCH-LGBTQ, *supra* note 59, at 45-49, 54-55, 57.

⁶⁴ Staples-Horne, *supra* note 1, at 314.

⁶⁵ Some states, like New York, have case law related to the treatment and care of transgender young people in state custody. See, e.g., Sylvia Rivera Law Project, *Settlement Reached in Case of Trans Youth Against Juvenile Services*, [available at](http://srlp.org/Rodriguez) <http://srlp.org/Rodriguez> (last visited September 21, 2011).

⁶⁶ WORKING TOGETHER, *supra* note 25, at 3-12.

pronoun that they prefer as well as allowing them to dress in accordance with their identified gender.⁶⁷

Providers should identify a timeline and plans for transition and discuss the possibility of involving the youth's parents. Providers should also determine the youth's perceived safety at the facility, and at home, school, or in their neighborhood.

It is important that providers have experience or training, in addition to cultural competency, when working with transgender youth. Providers may not feel comfortable performing genital exams and other medical exams on transgender youth due to personal biases or other elements. It is imperative that practitioners are trained on the particular health needs of transgender youth, not only to be comfortable treating youth but also to ensure that youth are receiving complete medical attention.

Providers should also discuss issues such as social isolation, abuse, depression, and anxiety. Long-term mental health counseling should be provided. Counseling for transgendered youth should be provided by mental health professionals with experience in transgender issues. This discussion should also address whether the youth is facing abuse, harassment, or other types of discrimination within the facility or the foster care system. If youth are facing abuse, harassment, or other types of discrimination, appropriate action must be taken immediately to assure their safety and to address the discrimination.⁶⁸ Housing and safety of youth is a key issue and should also be addressed.

When addressing the health needs of these youth, providers should discuss the use of hormones to change appearance, including the risks of the unsupervised use of hormones.⁶⁹ The provider should assess whether the patient is obtaining or plans to obtain hormones and, if so, what his or her source is. The provider should discuss the risks of obtaining street hormones, the fact that such hormones are often less pure, and the risks of sharing needles. The general risks and side effects of estrogen and testosterone injections should also be discussed. The provider should introduce the idea of parental consent at 16 years old.⁷⁰

Sudden discontinuation of hormone use often leads to undesired regression of hormonally-induced physical effects and a sense of desperation that may lead to depression, anxiety, and suicidal thoughts or acts.⁷¹ Providers should explain these physical effects to youth who were using hormones before entering state custody, should assess the youth for these changes, and should refer them for counseling where appropriate.

The provider should assess whether the youth is injecting silicone. The provider should discuss the risks of injections and its long-term effects, and should advise them to stop.

A plan for ongoing care that addresses the youth's transition process should be promptly made and put into effect in accordance with Standard 35.

⁶⁷ Wilber, *supra* note 60, at 4.

⁶⁸ Staples-Horne, *supra* note 1, at 314.

⁶⁹ WORKING TOGETHER, *supra* note 25, at 3-12.

⁷⁰ The Endocrine Society, *Clinical Guidelines: Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (2009), available at <http://www.endo-society.org/guidelines/final/upload/Endocrine-Treatment-of-Transsexual-Persons.pdf> (last visited September 21, 2011).

⁷¹ *Id.*

The provider should discuss with male-to-female patients the risks of smoking, particularly tobacco, while taking estrogen. The provider should discuss with female-to-male patients the need for pap smear and pelvic exams, as well as continuing pregnancy risks.

Standard 28: Mental Health Screening

Youth should be asked about behaviors or emotions that indicate recurrent or severe depression or risk of suicide. If suicidal risk is suspected, youth should be evaluated immediately and referred to a psychiatrist or other mental health professional, or else should be hospitalized. Non-suicidal youth with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment.

Rationale: Depressive disorders can have far-reaching effects on the functioning and adjustment of adults and youth. Co-occurring mental and addictive disorders are common. In youth there is an increased risk for substance abuse and suicidal behavior associated with depression. Suicide is a complex behavior that can be prevented in many cases by early recognition and treatment of mental disorders.

Implementation: During physical examination, the diagnostic evaluation should include a complete history of symptoms, including questions about drug and alcohol use as well as thoughts about death and suicide. A history should also include questions about whether other family members may have had a depressive illness and, if treated, what treatments they may have received and which were effective. A diagnostic evaluation should also include a mental status examination to determine if speech, thought patterns, or memory have been affected, as sometimes happens in the case of a depressive or manic-depressive illness.

With youth in particular, it is important to establish a sense of rapport and trust. Explain to the youth the confidentiality requirements as well as any relevant reporting requirements. A psychosocial inventory tool like BiHEADS (Body image, Home, Education, Activities, Drugs, Sex, sexual abuse, and suicide) may be used. Risk of suicide can also be determined by discussing declining school grades, chronic melancholy, family dysfunction, sexual identity issues, physical or sexual abuse, alcohol or other drug abuse, previous suicide attempts, suicide ideation, or suicide plans. It should be noted that men are less likely than women to admit to depression and that doctors are less likely to diagnose and treat it. Depression typically shows up in men as feeling irritable, angry, and discouraged, rather than feeling hopeless or helpless.⁷²

Standard 29: Mental Health Services for LGBTQ Youth

LGBTQ youth should have access to supportive, inclusive, and nonjudgmental mental health services. LGBTQ youth should never be subjected to “reparative” therapy or other interventions designed to change a person’s sexual orientation or gender identity.⁷³

Rationale: While all youth in out-of-home care require access to mental health services as a result of their marginalized status, this need is heightened for LGBTQ youth, who often face societal discrimination and isolation as a result of their sexual orientation and gender identity. LGBTQ youth commonly suffer from the effects of chronic stress as a result of this discrimination and isolation,

⁷² GAPS, *supra* note 6, at 6 (Recommendation 20); Region II MAC, *supra* note 6, at 16.

⁷³ Wilber, *supra* note 60, at 6.

which can lead to increased levels of depression and anxiety.⁷⁴ Many LGBTQ youth experience feelings of severe isolation, and they are two to three times more likely to attempt suicide than their heterosexual peers; they account for up to 30% of all completed suicides among teens.⁷⁵

Implementation: The initial mental health interview discussed in Standard 4 must include an interview that identifies and evaluates risks that LGBTQ youth face. The interviewer should use inclusive language and avoid assumptions about sexual orientation, sexual activity, and gender identity. Youth suffering from anxiety, depression, or harassment should be evaluated and referred to a psychiatrist or other mental health professional for treatment in accordance with Standard 37. It is preferable that ongoing mental health care be provided by a mental health professional with experience working with LGBTQ youth.

⁷⁴ *Id.*

⁷⁵ Region II MAC, *supra* note 6, at 25.

ONGOING CARE

Standard 30: Health Care Services for Youth with Special Needs

A proactive program must exist to provide care for special needs youth who require close medical supervision or multidisciplinary care.⁷⁶ Special needs youth include those with chronic conditions that require regular care. This includes youth with physical disabilities, pregnant youth, youth with serious communicable diseases, and youth with serious mental health needs.

Rationale: The facility is responsible to provide ongoing care that meets the individual needs of each youth; youth with special needs therefore require ongoing health services that meet these needs.

Implementation: The youth must be provided with a treatment plan tailored to his or her individual needs. The treatment plan must be individualized, multidisciplinary, and based on an assessment of the youth's needs, and include a list of long- and short-term goals as well as the methods by which these goals will be pursued. Treatment plans for youth with mental health conditions should incorporate ways to address their problems and enhance their strengths, involve youth in their development, and include relapse prevention risk management strategies. Each youth identified with a need for special care, chronic, or convalescent care will be scheduled to see the physician, physician's assistant, or nurse practitioner at least monthly. The mid-level provider may see the youth if he or she is stable. The physician must evaluate the youth at least quarterly.

Standard 31: Emergency Care

The out-of-home facility must provide 24-hour emergency medical, mental health, and dental services.

Rationale: Emergency care is necessary to deal with sudden, serious health needs. Planning ahead for emergencies can help minimize negative outcomes.

Implementation:

All staff responsible for the supervision of youth will respond to health-related situations within a four-minute response time. Medical staff should be available to provide emergency medical care for youth 24 hours per day, 7 days per week. The on-site medical staff should jointly establish training that includes:

- Recognition of the signs and symptoms of a medical emergency;
- Action(s) required in potential emergency situations;
- Administration of first aid and CPR;
- Methods of obtaining assistance;
- Signs and symptoms of mental illness, retardation and chemical dependency; and
- Procedures for the transfer of youth to medical facilities or health care providers

In the event of a medical emergency, any staff who discover a youth appearing to be unconscious or in medical distress should immediately provide assistance, first aid, CPR, or take other measures

⁷⁶ NCCHC, *supra* note 3, at 97.

appropriate to the observed emergency. Health care staff should be immediately notified of any youth who appears to be unconscious or in medical distress. Health care staff should immediately respond to the scene with the medical emergency response bag, emergency medication box, pulse oximeter and oxygen. Necessary medical care should be provided, to include immediate movement to a hospital. When necessary, emergency medical services (911) may be initiated. As time permits, the on-call physician should be contacted. Emergency care should never be delayed in life-threatening situations.

Standard 32: Annual Exams

All youth remaining at a secure facility over one year should receive an annual physical examination that complies with Standards 3-29.

Rationale: Annual exams are necessary to address emerging and ongoing health needs.

Implementation: Annual exams should comply with the requirements set forth in Standards 3-29. Youth should be given at least 24 hours notice before their annual exam to allow them to prepare questions.

Standard 33: Access to Care

All youth should have prompt access to health care services set forth in Standards 3-29 upon request.

Rationale: Access to health care is necessary to address emerging health needs, including new symptoms or difficulty complying with treatment. Youth may also need counseling on health care needs in order to maintain their health and ensure they properly prevent or treat health care issues such as STIs, HIV, or pregnancy. Sexual abuse or harassment may also generate new physical and mental health concerns. Failure to promptly address these concerns may exacerbate health problems.

Implementation: Youth should be scheduled for requested services within 24 hours of a request, and requested services should be scheduled within two weeks of the request. All health care services should comply with the requirements set forth in Standards 3-29.

Standard 34: HIV Care

Care should be supervised by an HIV specialist who will recommend, initiate and change therapeutic regimens as medically indicated. Facilities should provide youth living with HIV access to a chronic disease program that includes a treatment plan that complies with Standard 18 and regular clinic visits in which the clinician monitors progress, consults with the youth, and, when appropriate, changes the treatment. The program must include patient education for symptom management.⁷⁷

Rationale: Teaching proper management of HIV is essential for positive health outcomes. Youth with HIV benefit from regular clinic visits for evaluation and management by health care practitioners, preferably pediatric or adolescent medicine providers with HIV expertise. By reviewing the patient's history and progress over time, the clinician can optimize the treatment plan. Regular visits and a treatment plan also help ensure compliance by allowing the youth and health care

⁷⁷ *Id.* at 100-02.

provider to address obstacles to compliance such as medication side effects, or a youth's inability to take the medication in a private, confidential setting. Addressing these concerns is critical to ensuring that there is a treatment plan that addresses his or her individual needs and that this plan is being supported by other staff. Teaching youth how to cope with the disease and help prevent complications is also valuable for successful transition to community care.

Implementation: Once goals of therapy have been reached and the patient is stable, routine follow-up care for HIV should be arranged as follows:

HIV Care Quarterly Visit

- Lab – CD4, viral load, complete metabolic profile, and complete blood count if on antiretrovirals; more frequently if toxicity symptoms exist
- Review medication regimen – adherence, reasons for possible non-adherence, side effects
- Interval history – review of symptoms
- Exam – skin, mouth, lymph nodes, chest, abdomen, weight
- Physicians should be sensitive to problems that may interfere with a youth's ability to adhere to a prescribed treatment regimen, and should work with the youth to come up with solutions. If side effects make adherence difficult, a different treatment plan will be necessary. Physicians should also ask the youth whether he or she is given appropriate opportunities to take the medication in private and whether confidentiality is being respected—these issues may interfere with adherence.
- Issues and the importance of confidentiality and respect for patient wishes must be considered along with the legal requirements of the jurisdiction.

Annually

- Routine follow up care should be arranged for any person infected with HIV⁷⁸
- Review medication regimen
- Interval history
- Complete physical exam
- Dilated retinal exam
- PAP smear every 6 months for youth with female genitalia
- Dental exam

Standard 35: Transgender Youth

The management of medical (e.g., medically necessary hormone treatment) and surgical (e.g., genital reconstruction) transgender issues should follow standards developed by the World Professional Association for Transgender Health, Inc.⁷⁹ Determination of treatment necessary for transgender patients should be on a case-by-case basis.

⁷⁸ AIDS Info, *Adult and Adolescent Guidelines* (2011), [available at](http://aidsinfo.nih.gov/Guidelines/GuidelineHTML.aspx?GuidelineID=7&docID=1) <http://aidsinfo.nih.gov/Guidelines/GuidelineHTML.aspx?GuidelineID=7&docID=1> (last visited September 21, 2011); New York State Department of Health AIDS Institute, *HIV Clinical Resource: Ambulatory Care of HIV Infected Adults*, (2010), [available at](http://www.hivguidelines.org/clinical-guidelines/adolescents/ambulatory-care-of-hiv-infected-adolescents) <http://www.hivguidelines.org/clinical-guidelines/adolescents/ambulatory-care-of-hiv-infected-adolescents> (last visited September 21, 2011)

⁷⁹ See World Professional Association for Transgender Health, *Standards of Care* (2001), [available at](http://www.wpath.org/publications_standards.cfm/) http://www.wpath.org/publications_standards.cfm/ (last visited September 21, 2011).

Rationale: Transgender youth have continuous and emerging health care needs that must be addressed promptly and continuously to avoid physical and mental health complications (see Standard 27)

Implementation: Correctional health staff must be trained in transgender health care issues, and outside providers should be located for youth in foster care. Alternatively, they should have access to other professionals with expertise in transgender health care to help determine appropriate management and provide training in transgender issues. Diagnosed transgender patients who received hormone therapy prior to incarceration should have that therapy continued without interruption pending evaluation by a specialist, absent urgent medical reasons to the contrary. Transgender youth who have not received hormone therapy prior to incarceration should be evaluated by a health care provider qualified in the area of transgender health to determine their treatment needs. When determined to be medically necessary for a particular youth, hormone therapy should be initiated and sex reassignment surgery considered on a case-by-case basis. Regular laboratory monitoring should be conducted according to community medical standards.⁸⁰

Standard 36: Sexual Assault

Any confined youth reported or believed to have been sexually assaulted shall be immediately referred to the on-site health care staff for initial screening. Appropriate first aid or emergency care shall be provided and the youth shall be sent to a hospital for further examination, treatment, and collection of forensic evidence.

Rationale: Studies have shown that sexual assault is a serious and common problem for youth in state custody. A recent U.S. Department of Justice study found that nearly one in eight of the youth who participated in the survey reported sexual abuse at their current facility during the previous year.⁸¹ LGBTQ youth reported being sexually abused by another inmate at a rate more than ten times higher than that of youth who identified as heterosexual. Victimized youth usually endure repeated sexual abuse and frequently by multiple perpetrators. Sexual assault, besides being criminal and a violation of youth rights, creates enormous health concerns for youth, including trauma and injury, STIs, HIV, pregnancy, and mental health issues such as Post Traumatic Stress Disorder.

Implementation: Victims of sexual assault must be either referred to a community facility for treatment and the gathering of evidence or be treated in-house. If the youth is in foster care, he or she must be taken to an emergency medical facility immediately, with preference given to a doctor or medical professional with whom the youth feels comfortable. A qualified health care professional must conduct an examination and medical and sexual health history to document the extent of physical injury and determine whether referral to another medical facility is indicated.

With the victim's consent, the examination must include the collection of evidence from the victim using a kit approved by the local legal authority. Prophylactic treatment, including emergency contraception and follow-up care for STIs, HIV, or other communicable diseases must be offered to all victims in accordance with Standards 5, 12-20, and 22-25. Following the physical examination,

⁸⁰Endocrine Society, *supra* Note 70; See generally Nat'l Comm'n on Corr. Health Care, *Position Statement: Transgender Health Care in Correction Settings* (2009), available at <http://www.ncchc.org/resources/statements/transgender.html> (last visited September 21, 2011).

⁸¹Bureau of Justice Statistics, *supra* Note 62.

there must be an evaluation by a qualified mental health professional for crisis intervention and long-term follow up. In the case of confined youth, a report must be made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignment. In the case of youth in foster care, their living situation must be assessed for safety and post-trauma support. There must be an assessment of the victim for potential suicide and/or anxiety disorders or other mental health problems, and a treatment plan for counseling should be created and enacted. Reports as required by law must be filed with the appropriate law enforcement, child protective, and other agencies. Medical evidence may be collected from the victim only with the victim's consent.

A follow-up appointment will be made within three days for the youth with a physician or mid-level provider. At the follow-up appointment, the youth's physical and emotional status will be assessed. The provider will review the records from the outside medical facility to determine if all medical aspects of the evaluation were completed.

Standard 37: Mental Health Care

On-going mental health care services must be available to all youth who require and/or request them.

Rationale: Mental health care is necessary to ensure that youth with mental health problems are able to maintain their best level of health. Youth in state custody are at higher risk for mental health problems. Appropriate treatment is necessary to fulfill the obligation of protecting youth health and safety, as well as rehabilitating youth.

Implementation: Facility behavioral health staff have primary responsibility for the development of behavioral health treatment plans for youth with ongoing mental health treatment needs. Youth on psychotropic medications will be scheduled for monthly mental health chronic care visits completed by a clinician of at least the level of a Registered Nurse. The psychiatrist will evaluate the youth according to the Standards. For youth in foster care, a plan for mental health care and regular treatment should be devised and implemented by the youth, their mental health professionals, advocates, and care providers.

DISCHARGE PLANNING

Standard 38: Discharge Planning⁸²

Discharge planning that appropriately meets the health needs of youth must be provided for youth who will be leaving the facility imminently.

Rationale: Discharge planning is necessary to ensure that youth's health needs are met during the transition to a community provider. Health care staff have a responsibility to ensure ongoing patient care with community providers. Without appropriate discharge planning, youth may be unable to access or maintain appropriate treatment or prevention services. Failure to provide appropriate discharge planning not only compromises the health of the youth, but also the health of the communities which they eventually join. Programs in which health staff contact youth to help them prepare for release are effective in both providing necessary health services and in contributing to medication adherence. Studies indicate that establishing therapeutic relationships with community health staff prior to release and making preparations for return to the community that focus on transition issues also contribute to decreased recidivism.

Implementation: Discharge planning begins on admission and continues throughout the youth's stay. Use of a standardized form facilitates comprehensive discharge planning. Health staff should work closely with any child welfare worker, probation, and parole staff, all while ensuring the youth's confidentiality rights are protected. Only with the youth's permission (or with that of the legal guardian where required) may health staff share necessary information and arrange for transfer of health summaries and relevant parts of health records to community providers or others assisting in planning or providing services upon release. Health staff must coordinate plans with the youth's legal guardian as appropriate, while ensuring that the youth's confidentiality rights are protected. Health staff must arrange for a sufficient supply of current medications to last until the youth can be seen by a community health care provider and arrangements or referrals must be made for follow-up services with community providers. The discharge planning should be explained to the youth, who should also be provided with a written explanation in addition to the names and contact information for community health care providers and sexual health care resources that can provide diagnoses, treatment, and counseling for sexual health care needs.

⁸² NCCHC, *supra* note 3, at 83-84.

COMMUNICATION WITH PATIENTS

Standard 39: Age, Culturally, and Developmentally Appropriate Services

Preventive services and counseling provided should be age and developmentally appropriate.⁸³ Providers should be sensitive to individual and socio-cultural differences, exercising cultural competency in addition to cultural humility.⁸⁴ “Cultural competency” refers to a set of congruent values, behaviors, attitudes, and practices that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.⁸⁵ Building on cultural competency, “cultural humility” puts the onus on the provider to self-evaluate how personal biases may affect service delivery.⁸⁶

Rationale: The concept of cultural competency brings culture into the discussion of the manifestation of disease and notions of health. It encourages providers to learn about the cultures of patients served and fosters respect for cultural differences and diversity. It underscores that culture is dynamic and includes a wide array of identities and backgrounds. It also honors the fact that young adults have a culture unto themselves—recognition of this increases knowledge of how culture influences behaviors and health outcomes and can help providers understand and communicate with adolescent patients. Cultural humility encourages providers to assess how their own bias may manifest in clinical care.⁸⁷

Implementation: To incorporate cultural competence in clinical practice, clinicians can use the “LEARN” model:

- Listen with understanding to the patient’s perception of the problem
- Explain your perceptions of the problem and your strategy for treatment
- Acknowledge and discuss the similarities and differences in these perceptions
- Recommend treatment while remembering the patient’s cultural parameters
- Negotiate agreement, ensuring medical treatment fits into the patient’s cultural framework⁸⁸

To incorporate cultural humility, providers should ask themselves:

- How do you react when confronted with a patient situation that does not fit your expectations?
- Does the situation provoke feelings of anxiety and discomfort?
- Are you able to assess what is going on within yourself as well as within the patient?⁸⁹

Where providers are working in juvenile justice facilities, they should ask these additional questions:

- Am I able to put aside whatever feelings I may have on what this young person may have done to become a juvenile offender?

⁸³ GAPS, *supra* note 6, at 3 (Recommendation 2).

⁸⁴ *Id.*; See Physicians for Reproductive Choice & Health, *Cultural Competency and Adolescents* (2009), [available at http://www.prch.org/arshepdwnloads](http://www.prch.org/arshepdwnloads) (last visited September 21, 2011) [hereinafter PRCH-CULTURAL COMPETENCY].

⁸⁵ *Id.* at 25.

⁸⁶ *Id.* at 29.

⁸⁷ *Id.* at 29-32.

⁸⁸ *Id.* at 26.

⁸⁹ *Id.* at 32.

- Am I able to see this individual as a patient first and foremost?

Standard 40: Effective Youth Communication

Providers should be experienced in treating youth and should be aware of the communication skills that can facilitate or hinder an interview with a youth.⁹⁰

Rationale: The vast majority of youth want information from their healthcare providers regarding pregnancy and STI prevention. However, very few providers actually ask their patients about sexual activity, and even fewer take a full history due to lack of training or personal discomfort.⁹¹ Youth must feel comfortable before disclosing and discussing health behaviors with their providers.

Implementation: Providers should use the following tools for effective communication:

- Use a non-judgmental, non-moralist approach to questioning
- Provide explanations as to why personal questions are being asked
- Use verbal cues and language a youth will understand
 - Use non verbal cues, such as tone, proximity, and gestures, to communicate effectively
 - Use active listening and responding, convey understanding and empathy, elicit and validate emotions
 - Use open-ended questions and allow time for a response
 - Use gender-neutral language when discussing sexuality and relationship issues
 - Discuss privacy policies before asking sensitive questions
 - Disclose reporting requirements to youth early

Providers should avoid the following communication mistakes:

- Making judgmental statements (e.g., “You should...”)
- Using medical jargon
- Asking sensitive questions with others in the room
- Ignoring emotions
- Making or breaking eye contact not consistent with the patient’s culture
- Using culturally inappropriate language
- Using gender stereotypes
- Using gendered pronouns

Standard 41: LGBTQ-Inclusive Interviewing

Each client, irrespective of sexual identity or behavior, should be informed of the full spectrum of behavior and desire. Staff should focus on normalizing the spectrum, including same-sex, opposite-sex, and solitary-sex behavior and desires.⁹² Providers should avoid making assumptions about the gender of a youth’s partners, should use inclusive language in interviews, and should ensure that

⁹⁰ *Id.* at 25.

⁹¹ *See, e.g.*, Region II MAC, *supra* note 6, at 9.

⁹² *Id.* at 25.

interviews are inclusive of LGBTQ issues.⁹³ Providers should not minimize or deny an adolescent’s sexual orientation or gender identity as merely a “phase” through which the youth will pass.⁹⁴

Rationale: Many health care providers, for reasons ranging from lack of training to unaddressed bias and assumptions, too often fail to provide sensitive medical care to LGBTQ youth. LGBTQ youth therefore may tend to decline to disclose their sexual orientation or gender identity out of fear of discrimination.⁹⁵ As a result, the health needs of this population often remain unmet. HIV risk-assessments may be incorrect where young men who have sex with men or young women who have sex only with women decline to disclose this information for fear of judgment. Providers may screen youth for STIs incorrectly based on the assumption that youth engage only in heterosexual activity. Providers may also make assumptions that LGBTQ youth engage only in same-sex behavior when this may not be the case (see Standard 42).

Moreover, youth who have questions about how to practice safe sex with same-sex partners may not feel comfortable asking for this information. This is particularly troubling, given that young men who have sex with men have high rates of HIV infection due to high-risk sexual behavior. Further, failure to provide a supportive, nonjudgmental environment can prevent teens from disclosing problems of isolation, anxiety, and depression. Negative social and emotional factors are often associated with being gay. As aforementioned, many LGBTQ youth experience feelings of severe isolation, and LGBTQ youth are two to three times more likely to attempt suicide than their heterosexual peers. Failure to create a supportive environment in medical care can increase isolation and have real health consequences for LGBTQ youth.

Implementation: During examination and interviews, providers should use inclusive language and avoid assumptions about an adolescent’s sexual behavior or orientation. For example, providers should use gender-neutral pronouns when asking adolescents about their sexual partners or romantic interests.⁹⁶ When discussing sexual activity and health risks, providers should relate them to sexual behavior rather than sexual orientation. For example, rather than ask if a patient is gay, straight, or lesbian, providers should ask the following questions: Have you ever had a sexual relationship with a boy? What about with a girl?

Providers should also be sensitive to gender identity, asking whether patients think of themselves as male, female, both, or another gender. Providers should determine what pronoun patients use to describe themselves.⁹⁷

Standard 42: Sexual Behavior and Identity

Providers should understand that sexual orientation does not necessarily match sexual behavior; adolescents who identify as “straight” may experiment with same-sex partners, and those who identify as “gay” or “lesbian” may have had sexual intercourse with members of the opposite sex, and may continue to do so in the future.

⁹³ Wilber, *supra* note 60, at 6.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ Wilber, *supra* note 60, at 6.

⁹⁷ PRCH-LGBTQ, *supra* note 59, at 17.

Rationale: Providers who speak in terms of identity rather than behavior may make unwarranted assumptions about a youth's sexual activity, and therefore may miss opportunities to address health concerns.

Implementation: Providers should discuss sexual behavior rather than identity. Providers should discuss pregnancy prevention and the availability of emergency contraception to all youth, explaining their reasoning for doing so.

CONFIDENTIALITY AND REPORTING

Standard 43: Reporting and Protecting Confidentiality

In conducting all of the above standards, health providers should be aware of local laws about the reporting of abuse to appropriate state officials, in addition to ethical and legal issues regarding how to protect the confidentiality of the minor patient.⁹⁸

Rationale: Patient confidentiality—of both written health records and verbally disclosed information—must be maintained in order to comply with legal and ethical obligations.

Implementation: Health records must be stored under secure conditions separate from custody records. Access to health records and health information must be controlled by the health authority. If records are transported by non-health staff, they must be sealed. Maintaining confidentiality of health records and information must be included in the orientation program for health staff and must be reviewed periodically.

Health services staff are to be reminded not to discuss patient health information in front of other staff or other youth, including those working in or near the health services area. Non-health staff who observe or overhear a clinical encounter must be instructed that they are required to maintain confidentiality. The facility should have documentation that staff with access to health records have been instructed in the need for confidentiality, including written policies and procedures, memoranda to staff, minutes of meetings, and reviews during roll call or in-services.

The health authority must maintain a current file on the rules and regulations covering the confidentiality of medical information and the types of information that may and may not be shared under local, state, and federal law. Local, state, or federal laws may allow certain exceptions to the confidentiality requirements, and health services staff are required to inform youth at the beginning of a health care encounter when these exceptions apply.

⁹⁸ GAPS, *supra* note 6, at 6 (Recommendation 21); NCCHC, *supra* note 3, at 15-16.

INFORMED CONSENT AND THE RIGHT TO REFUSE TREATMENT

Standard 44: Informed Consent

All health examinations, treatments, and procedures must be governed by the principle of informed consent and must comply with legal requirements for informed consent in the applicable jurisdiction.⁹⁹

Rationale: Youth have the right to make informed decisions regarding their health care. Obtaining informed consent is both a legal and ethical obligation of health care providers.

Implementation: Informed consent laws regarding youth consent and confidentiality vary from state to state and as such practitioners should be versed in the laws in their jurisdiction. Generally, informed consent is the agreement by which a patient agrees to a treatment, examination, or procedure after he or she receives the material facts about the nature, consequences, and risks of the proposed treatment, examination or procedure, the alternatives to it, and the prognosis if the proposed intervention is not undertaken.¹⁰⁰ Clinicians should educate young people about informed consent. Practitioners should also clearly document all decisions related to consent to treatment or testing.

The youth, parent, or legal guardian should have the opportunity to ask questions and receive answers to those questions before giving consent. Policies and procedures should specify informed consent requirements, including circumstances where written informed consent is required. The informed consent of next of kin, guardian, or legal custodian applies when required by law. Practitioners should also clearly document all discussions regarding consent and related medical options.

For invasive procedures or any treatment where there is some risk to the youth, informed consent must be documented in a written form containing the signatures of the patient, legal guardian if required, and health services staff witness. Even where a youth has given “blanket” consent for treatment, written consents are still required for invasive procedures, diagnostic tests, dental extractions, and for HIV testing in accordance with Standard 16.

Staff must be trained to understand and comply with informed consent requirements, and to understand the limited number of exceptions to the requirements (such as life-threatening conditions that require immediate medical intervention for the safety of the patient and emergency care of patients who do not have the capacity to understand the information given), and how to distinguish these exceptions from other medical care.

Standard 45: Right to Refuse Treatment

A youth may refuse specific health evaluations and treatments in accordance with the laws of the jurisdiction.¹⁰¹

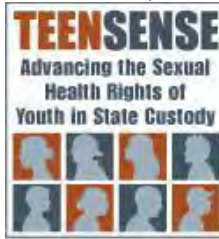
⁹⁹ NCCHC, *supra* note 3, at 136-38.

¹⁰⁰ American Medical Association, *Informed Consent* (n.d.), available at <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page> (last visited September 21, 2011).

¹⁰¹ *Id.* at 138-39.

Rationale: The logical corollary to the right to informed consent set forth in Standard 44 is the right to refuse treatment. Health care providers have the legal and ethical obligation to respect and protect patients' right to refuse treatment.

Implementation: A patient's refusal of care must be an informed decision, with the consequences explained to the youth. Refusal of treatment at any time does not waive the youth's right to subsequent health care. Youth may not be punished for exercising the right to refuse treatment, even when the treatment at issue is a public health matter. In situations where the refusal may seriously jeopardize the patient's health, the individual should be brought to the medical clinic and the risks and benefits of the proposed treatment explained. The health professional can then answer any questions the patient may have. If the patient wishes to decline treatment, he or she should be counseled about the possible consequences of the refusal. Notification of the patient's legal guardian is not required unless the refusal poses a substantial risk to the youth or the youth has a court-appointed guardian where notification is required. Some refusals may result from system disincentives (e.g. holding sick call at a time that conflicts with other important programming) and must be addressed by providing alternatives so that the disincentives are lessened or eliminated.



MODEL POLICY SEXUAL HEALTH EDUCATION FOR YOUTH IN STATE CUSTODY

In order to appropriately address the sexual health needs of youth in the state's care, it shall be the policy of **[this agency/jurisdiction]** to guarantee that youth in its **[custody/care]** receive the following services in order to meet the sexual health knowledge needs of lesbian, gay, bisexual, transgender, questioning, or intersex (LGBTQI) and heterosexual youth in out-of-home custody.

Sexual Health Education services and curricula shall include:

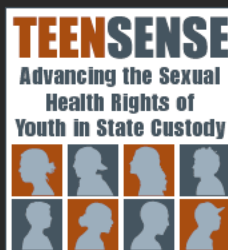
- At least basic information on sexually-transmitted infections (STIs) and HIV transmission in addition to a list of community resources related to pregnancy, STI prevention, sexual violence, and LGBTQI discrimination – regardless of whether a youth is in custody for 24 hours or for over two months;
- Information and discussion on the nature and forms of sexual abuse, harassment, and abuse on the basis of gender identity or sexual orientation, and reporting procedures and protections for young people who are the victims of abuse or harassment;
- Access to information on topics including contraception, reproductive choice, anatomy, and drug use/harm reduction skills that increases in proportion to a youth's time in out-of-home custody;
- Classroom environments and teachers that demonstrate non-judgmental, inclusive attitudes and that create a comfortable space for youth of any gender identity and sexual orientation to learn about all points on the spectrum of gender and sexuality, adopt safer sex practices, and develop levels of understanding and skills that increase sexual health into adulthood while reducing the incidence and tolerance of sexual abuse.





Teen SENSE

Model Sexual Health Education Standards for Youth in State Custody



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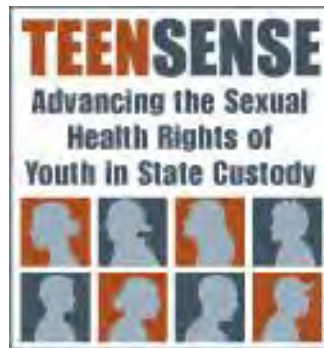
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TEENSENSE

MODEL SEXUAL HEALTH EDUCATION STANDARDS



Mission Statement

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

To learn more about our organization and access the Resource Bank,
visit our website at www.hivlawandpolicy.org.

To contact us:

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The development and publication of these standards would not have been possible without the generous and sustained support of the MAC AIDS Fund, Broadway Cares/Equity Fights AIDS, the Arcus Foundation, and the Elton John AIDS Foundation.

Teen SENSE

A National Initiative to Bring Comprehensive Sexual Health Care to Youth in State Custody

Adolescents confined to foster care and juvenile justice facilities a overwhelmingly are from communities most affected by HIV: low-income youth, Black and Latino youth; gay, bisexual, transgender, and questioning youth (LGBTQ); and survivors of violence and other abuse. Empowering these populations to protect their rights and their health is at the heart of the mission of the Center for HIV Law and Policy (CHLP). While these youth, across the spectrum of sexual orientation and gender, are at greater risk of HIV and other STIs, they overwhelmingly are denied access to appropriate and effective HIV prevention, sexual health education, and sexual and reproductive health care. Where care is provided, it too often ignores or isolates LGBTQ youth and their health needs. To address this crisis, CHLP launched the Teen SENSE (Sexual health and Education Now in State Environments) initiative, a sexual health and HIV prevention initiative grounded in the rights of youth to these services.

Teen SENSE advances the principle that respect and accommodation for all gender expression and sexual orientation is central to HIV prevention, sexual health and prevention from sexual abuse, and that all youth have the right to comprehensive, LGBTQ-inclusive health services that include sexual health care and education when they are confined in state facilities. Comprehensive, LGBTQ-inclusive sexual health care is vital to preserve health, reduce HIV and STI transmission risk, and increase the odds that severely at-risk youth will develop the essential skills and knowledge to protect their sexual health, develop self-respect, and foster tolerance.

Teen SENSE is a multidisciplinary initiative that has engaged experts in adolescent medicine, sexual health education, foster care, and juvenile justice to develop a complete advocacy model and coordinate its implementation. The Teen SENSE program has developed a federal and state legal framework that asserts the affirmative legal right of adolescents to comprehensive, scientifically accurate, LGBTQ-inclusive sexual health care services and education. We have developed model standards for comprehensive, LGBTQ-inclusive sexual health care, education/HIV prevention, and staff training to ensure the safety and sexual health of all youth in state custody. Teen SENSE establishes a powerful legal and human rights framework and the on-the-ground alliances that can make meaningful, appropriate, non-judgmental sexual health care and real HIV prevention a mandated service for youth in state foster care and detention facilities.

MODEL SEXUAL HEALTH EDUCATION STANDARDS

Executive Summary

The Teen SENSE Model Sexual Health Education Standards are designed to reflect the minimum requirements of curricula that meet the sexual health knowledge needs of LGBTQ and heterosexual youth in out-of-home custody. The Model Sexual Health Education Standards include:

- content goals (divided according to the time a youth spends at a state facility),
- instructional characteristics (standards to which classroom environments and practices should adhere),
- and instructor characteristics (which set forth competencies that teachers of sexual health education should possess).

Under these standards, youth in state custody should receive at least basic information on STI and HIV transmission in addition to a list of community resources related to pregnancy, STI prevention, sexual violence, and LGBTQ discrimination – regardless of whether a youth is in custody for 24 hours or for over two months. As a youth's time in state custody increases, so should his or her access to information on topics including contraception, reproductive choice, anatomy, and drug use/harm reduction skills. Classroom environments and teachers themselves should demonstrate non-judgmental, inclusive attitudes that create a comfortable space for youth of any sexual orientation and gender identity to learn about all points on the spectrum of sexual orientation, adopt safer sex practices, and develop levels of understanding and skills that increase sexual health into adulthood while reducing the incidence and tolerance of sexual abuse.

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Introduction

What are the Model Sexual Health Education Standards?

These Model Sexual Health Education Standards are the product of a comprehensive review of existing materials and an effort to combine the best and most inclusive practices and policies regarding sexuality education for youth in state custody into one document. The Standards are not a curriculum; rather, they reflect minimum requirements that curricula should meet in order to appropriately address the sexuality education needs of youth in the state's care. These model standards are intended for use by facility directors, advocates, medical professionals, and direct service providers who have access to state youth facilities and outside facilitators or curriculum writers.

The Model Sexual Health Education Standards are divided into three sections reflecting three interrelated and equally important components of a sexuality education curriculum: (1) Content Goals; (2) Instructional Characteristics; and (3) Instructor Characteristics.

The Content Goals are meant to guide the selection of the curriculum's content by providing the minimum goals that a curriculum should be designed to achieve. The goals are broken down by the amount of time that a young person is in custody. This is to take into account the varying levels of education that can be provided over different courses of time. While these Content Goals do not create a curriculum, any curriculum used must be tailored to achieve these minimum goals.

The Instructional Characteristics provide minimum standards for a curriculum's classroom environment and practices. They also demonstrate principles and standards to which a curriculum must adhere to. Curricula that do not reflect the Characteristics must be modified or abandoned in favor of conforming to the standards. Instructors also must ensure that their methods and attitudes reflect these standards.

The Instructor Characteristics set forth requirements that instructors must possess to be able to teach sexuality education, including knowledge of the content, attitude, and ability to implement the standards.

The Model Sexual Health Education Standards apply to all youth in state custody, from foster care facilities to detention facilities to foster care home placements. The standards should be understood to be minimum requirements that will vary in application and applicability based on the precise circumstances of the youth in state care.

Teen SENSE takes a comprehensive view of sexual health care, recognizing that medical care, education, and environment are all essential components of sexual health care. The Model Sexual Health Education Standards are one component of CHLP's Teen SENSE initiative. Teen SENSE has also published Model Sexual Health Care Standards and Model Staff Training Standards. These three sets of standards should be read together as interconnected and related components of providing appropriate, comprehensive sexual health care for youth in state custody.

Teen SENSE: Model Sexual Health Education Standards

Teen SENSE has also developed a “legal road map,” entitled *Juvenile Injustice: The Unfulfilled Rights of Youth in State Custody to Comprehensive Sexual Health Care*, which lays out the affirmative legal rights of juveniles in state custody to comprehensive sexual health care. The legal road map and Model Standards are advocacy tools designed to be used together to bring regular, consistent and comprehensive sexual and reproductive health care to the most at-risk, vulnerable, and underserved youth populations.

How were the Standards created?

The core of the document is based on materials from the Sexuality Information and Education Center for the United States (SIECUS), *Guidelines for Comprehensive Sexuality Education, K-12* (3rd Ed. 2004); Douglas Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases* (Healthy Teen Network 2007); and various materials published by Physicians for Reproductive Choice and Health, the Equity Project, EngenderHealth, the American Academy of Pediatrics, ANSWER, and Planned Parenthood’s Center for Family Life and Education of Greater Northern New Jersey . We supplemented these materials with recommendations, principles and position statements from a wide range of expert sources, including the Society for Adolescent Medicine, the American Academy of Pediatrics, Physicians for Reproductive Choice and Health, ETR Associates, Cicatelli Associates, HiTops, and Planned Parenthood’s Center for Family Life and Greater Education of Northern New Jersey. The Standards are intended to clearly frame the information and provide a framework for an approach, best practices and policies, and standards of care that comprise comprehensive sexual health and HIV prevention education.

Part One: Content Goals

Part One provides the minimum goals that the content of the curriculum should be designed to achieve. They are organized according to the maximum amount of time that a youth spends in the state's care. Part Two: Instructional Characteristics provides additional information on the curriculum elements and development and should be read in conjunction with this section. Part Three: Instructor Characteristics sets forth the minimum requirements sexual health education instructors providing instruction to youth should possess.

I. For Youth in Custody Up to 24 Hours

Youth must be provided with written material that provides information regarding:

- HIV and sexually transmitted infections (“STIs”).
- How to prevent STI transmission and unwanted pregnancy through correct, consistent condom use, and use of water-based lubricants.

Youth also must be provided information cards that they can keep with them while in custody. The cards should contain community resources for STI testing and treatment, HIV testing and treatment, pregnancy testing and options counseling, sexual health care, sexual violence support services, and support for LGBTQ teens.

II. For Youth in Custody 2-7 Days

Youth must be provided with all resources discussed in Section I.

Youth must be provided with preliminary one-on-one counseling onsite in addition to sexual health care services (including voluntary, written and informed consent for HIV, STI, and pregnancy testing) and referrals for continuing care and counseling. Counseling should be inclusive and should not make assumptions about youth's sexual orientation or gender identity.

Preliminary counseling should include:

- Discussion of HIV and STIs, how they are transmitted, and how transmission can be prevented with the correct and consistent use of condoms, dental dams, and other prophylactic measures.
- The importance of testing and treatment for HIV and STIs.
- Counseling on pregnancy prevention using condoms and contraception.
- Counseling on sexual assault and abuse, with referral to appropriate medical and mental health resources. Special care should be taken to counsel youth on what constitutes sexual abuse; the right to be free of sexual harassment, abuse and assault within state care; and complete information on how to report staff or foster family predation.
- Ample time for questions and answers with the youth.

III. For Youth in Custody 8-30 Days

Youth must be provided with all resources discussed in Sections I and II.

Youth should be provided education and training sufficient to achieve proficiency in the following minimum content areas:

A. Sexually Transmitted Infections

- Youth should be able to identify the prevalence and cause of STIs and health problems that may be caused by untreated STIs, including infertility.¹
- Youth should understand the major symptoms of STIs and that symptoms may be hidden, absent, or unnoticed.
 - Youth should understand that STIs can be transmitted even if a person does not show symptoms of having an STI.
 - Youth should know that there is no way to determine that another person does or does not have an STI other than being tested by a medical professional.
- Youth should be able to identify how STIs are transmitted in both different-sex and same-sex sexual practices and transmission through methods other than sexual contact, such as unsterilized needles and from mother-to-child during pregnancy, birth, and breastfeeding.
 - Youth should be able to identify and debunk myths about STI transmission.
 - Youth should understand the different transmission routes and risks for different STIs.
- Youth should be able to understand and explain that a person can have more than one STI at a time, can get an STI more than once, and that anyone (regardless of age or sexual orientation) can get an STI if he or she has sexual contact with an infected person.
- Youth should be able to understand and explain that STIs can increase the chance of HIV transmission.
- Youth should be able to identify how STIs can affect females and males differently.
- Youth should be able to identify methods of preventing exposure to and transmission of STIs and how different types of sexual contact pose different levels of risk.
 - Youth should have access to male and female condoms in the context of a sexual health care program that includes instruction on all types of condom use for youth of all genders/gender identity and sexual orientation, and that reinforces the benefits of condom use for all sexually-active people.
 - Youth should be able to identify methods of prevention and explain how such methods work, including avoiding sexual activity that poses a risk of disease transmission, proper use of latex condoms and lubricants, dental dams, and latex barriers. Youth should be able to identify and debunk myths about STI transmission and prevention.
- Youth should be able to understand the importance of discussing concerns about STIs with their sexual partner.
- Youth should be able to identify how they can be tested for STIs and understand state laws protecting their ability to receive confidential STI testing.
- Youth should be able to identify the steps to take if they suspect they have an STI.
 - This includes: to stop having sexual intercourse until they are tested and treated by a physician, to promptly go to a healthcare provider for testing and treatment, and to refer sexual partners to a healthcare provider as well.

¹ While not all states classify HIV as an STI, HIV is grouped with STIs in this document for classification purposes.

- Instructors should emphasize that it is never too late to be tested for an STI or to take steps to treat an STI, regardless of when an STI is suspected or diagnosed,
- Youth should be able to understand the need for STI testing if they have been sexually active or sexually assaulted.
- Youth should be able to identify which STIs can be cured, how they are cured, and which STIs can be treated, and the benefits of treatment.
 - Those STIs caused by bacteria, such as gonorrhea, chlamydia, or syphilis can be cured with prescription medication. Others, such as Herpes, can be life-long health conditions.
- Youth should understand that all individuals are deserving of respect and love, and that individuals with STIs are equally able to live satisfying lives. An STI is not a sign that someone has “been bad” or is a bad person.

B. HIV/AIDS

- Youth should understand the nature of HIV and AIDS are and the distinction between them.
 - Youth should also know how HIV affects the body, that it currently is considered a manageable chronic disease, and that HIV can remain asymptomatic for years.
- Youth should be able to identify the bodily fluids that HIV is found in high enough concentrations to lead to possible transmission to another person (primarily blood and semen) and to distinguish these bodily fluids from those in which HIV is not found at all or not found in high enough concentrations to transmit HIV to another person (*e.g.*, saliva, urine, feces, sweat, and tears).
- Youth should be able to identify the ways that HIV is transmitted, the actual transmission risk associated with different types of sexual intimacy, and to identify and debunk myths about HIV transmission. Youth should be able to identify risk factors for HIV, specifically unprotected vaginal and anal sex.
- Youth should be able to identify HIV prevention methods for all sexual practices and to identify and debunk myths about prevention. This should include:
 - The ability to explain the proper use of condoms, lubricant, dental dams, and latex barriers during vaginal, oral, and anal sex.
 - The ability to explain how abstinence, sex with condoms, and sexual contact other than vaginal or anal sex can prevent HIV transmission.
 - The ability to understand how being on effective medical treatment greatly reduces the risk that a person with HIV will pass on the virus to another.
 - The ability to explain how the proper use of clean, sterile needles as opposed to reusing needles can prevent exposure to and transmission of HIV.
- Youth should understand the HIV testing process, state laws that protect their right to obtain a test without parental consent, state laws protecting their right to informed consent and counseling, and the ability to obtain access to treatment.
- Youth should be able to explain the concept of a “window period” following infection during which a person may still test negative though he/she may be HIV positive.
- Youth should understand the importance of testing if they have engaged in receptive anal or vaginal sexual activity, been sexually assaulted, or shared drug injection equipment..
- Youth should understand that at present there is no cure for HIV or AIDS, but recognize that treatment is available, that it can improve the health and prolong the life of people living with HIV, and reduce the risk that a person with HIV will pass the virus on to someone else.
 - Youth should understand that those undergoing treatment and who work to stay healthy can live for a very long time.

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- Youth should be able to identify and discuss the harms of discrimination against people living with HIV.
- Youth should be informed of support groups for people living with HIV/AIDS and their loved ones.

C. Pregnancy

- Youth should be able to identify how pregnancy occurs and understand that pregnancy can happen anytime a female has unprotected vaginal intercourse with a male.
 - They should be able to identify and debunk myths about pregnancy prevention.
- Youth should understand the importance of prenatal care and should be informed of applicable state laws that may allow them to access pregnancy tests, prenatal care, and abortion services without parental consent or notification.

D. Prevention Skills

- Youth should be engaged in a frank discussion of their right to bodily autonomy in all situations.
 - They should know about their legal rights to refuse or consent to medical care, and their absolute right to be free from unwanted sexual contact in relationships, including from family members, other youth, and staff at detention or foster care facilities.
- As part of this conversation, youth should discuss the right to refuse any contact, including sexual, and should discuss and explain the importance of respecting another person's refusal and having your own refusal respected.
- In terms of relationships, youth should understand the concepts of negotiation, compromise, the issues that cannot be compromised, and how this concept applies to sexual practices and limits.
 - Youth should understand the importance of effective negotiation and how power inequalities in a relationship can have a significant effect on the health and safety of the individuals in the relationship and can affect negotiating power between the parties.
 - Harm reduction in negotiating safer sex should be discussed in detail, with priority given to concrete advice on less dangerous activities and negotiating condom use.

E. Sexual Orientation

- Youth should understand that:
 - Sexual orientation refers to a person's physical and/or romantic attraction to an individual of the same and/or different gender,
 - Sexual orientation falls across a spectrum, and that one's understanding and identification of his/her sexual orientation may change over the course of his/her lifetime.
 - Youth should understand that sexual orientation is only one aspect of who a person is.
 - Youth should also understand that gay and lesbian romantic relationships are just as fulfilling as heterosexual relationships, and that LGBTQ people form families and have children.
- Youth should understand that LGBTQ and heterosexual people come from all countries, cultures, races, ethnicities, socio-economic backgrounds, and religions.
- Youth should understand that scientific theories have concluded that sexual orientation cannot be changed by therapy or medicine.
- Youth should be able to identify discrimination against, rejection, and harassment of LGBTQ youth by peers, family, schools, and others and the effects that such behavior can have on LGBTQ youth.

- Such effects include making LGBTQ youth afraid to identify as LGBTQ and increasing the risk of depression, dropping out of school, homelessness, and substance abuse among LGBTQ youth.
- Youth should understand that people of all sexual orientations deserve respect and have the right to express their sexual orientation and identity. Youth should be able to discuss strategies for reporting harassment of themselves or others based on sexual orientation.
- Youth should be able to identify and discuss the concepts of heterosexism, internalized homophobia, and how such phobias can contribute to LGBTQ adolescent isolation.
- Youth should understand the concept of coming out and why coming out can be important to an individual.
- Youth should be able to identify the additional challenges and threats LGBTQ youth of color may face due to both racism and homophobia.
- Youth should understand how intolerance and discrimination against LGBTQ youth can lead to increased mental health difficulties, such as depression, risk of suicide, and increased substance abuse among LGBTQ youth.
- Youth should understand that the majority of LGBTQ youth lead normal, productive lives and develop resilient adaptations to social biases and mistreatment.

F. Gender Roles & Gender Identity

- Youth must be able to define gender roles, gender identification, and gender stereotypes.
 - Youth should understand that gender identification may include male, female, or other (e.g. intersex, cross-gender, etc.) identification.
 - Gender expression may not necessarily match gender identity.
 - Youth should also understand that the way a person expresses his or her gender does not necessarily have anything to do with whether that person is heterosexual, gay, lesbian, or bisexual.
- Youth should understand and be able to recognize and describe the following definitions and concepts:
 - Transgender: “Transgender” describes people whose internal sense of gender (gender identity) doesn’t match what society expects of them based on their biological sex. Transgender is also used as a general term to describe many different identities that exist such as “transsexual,” “drag king,” “drag queen,” “crossdresser,” “genderqueer,” “shapeshifter,” bigendered,” and “androgynous.” Transgender people are often described as: Male-to-female (M-to-F), or Female-to-male (F-to-M), or by the gender they currently identify with (“male identified” or “female identified”).
 - Transsexuals: described people who have had, are in process of, or are planning sex-reassignment surgery. They may also use hormonal means to change parts of the body to match their own understanding of gender without having a complete genital sex-reassignment surgery.
 - Androgynes: describes androgynous presentation. Androgynous behavior combines both genders or is gender-neutral.
- Youth should be able to understand the concept of gender identity as something that may change over the course of an individual’s lifetime, and that transgender people report experiencing conflict over gender assignment throughout childhood and adolescence.
- Youth should understand that gender identity is just one part of who a person is and discuss the need to respect people of all gender identities.

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- Youth should be able to identify gender discrimination, harassment, and violence, discuss the harms of discriminating against someone because of their gender identity, the impact that it has on individuals, and the need to report discrimination to a trusted adult, school official, or law enforcement authority.
- Youth should be aware that there is some federal, state, and local legal protection from discrimination based on gender identity, and youth should be aware of the laws in the city and state in which they reside.

G. Sexual Violence, Abuse, and Harassment

- Youth should be able to define the following concepts, recognize them in the various forms and circumstances in which they occur, discuss their consequences:
 - Sexual abuse
 - Sexual harassment/harassment based on perceived sexual orientation or gender identity
 - Sexual assault
 - Domestic violence
 - Sexual coercion
 - Rape
- Youth should understand how a person who has been the victim of any of the acts listed above can report such acts to the appropriate authorities and can benefit from support and counseling.
 - Youth should know that all acts of sexual abuse, violence, and harassment, including verbal harassment and abuse, are against the law, and that they have legal recourse.
 - Youth should know that sexual abuse is never appropriate or acceptable in any setting (including foster care homes, detention facilities, school, etc.).
 - Youth should also know that there are many different people that they can report such abuse to (*i.e.*: doctors, police, teachers, school counselors, etc.).
 - Youth should know both the moral and legal reasons why they should never be perpetrators of sexual violence, abuse, or harassment. They should know that they are still legally responsible for their behavior even if such behavior occurs while in state detention facilities.
 - Youth should know how to report abuse while in a detention facility, including abuse perpetrated by other youth.
 - Youth should be assured that they will be protected from violence, abuse or retaliation in the event that they report sexual abuse by a staff member or other youth, regardless of whether they are themselves the targets of such abuse. Youth should be informed of how those who report abuse will be protected from subsequent harm related to such reports.
- Youth should be able to identify what steps to take if they have been the victims of sexual assault, the benefits of seeking medical and mental health care if they have been the victim of sexual assault, and how they can seek this type of care after a sexual assault.

H. Facility & Community Resources

- Instructors should provide youth with community resources and contact information for additional information on all issues discussed.
 - This should also include resources for further inquiry into topics regarding sexuality, sexual health, violence, relationships, discrimination, and LGBTQ issues and questions.

IV. For Youth in Custody 1-2 Months

Youth must be provided with all resources discussed in Sections I, II, and III.

Youth should be provided education and training sufficient to achieve proficiency in the following additional minimum content areas:

A. Specific STIs:

- Youth receive education and information with regard to the following STIs:
 - Chlamydia
 - Gonorrhea
 - Syphilis
 - Human Papillomavirus (HPV)
 - Genital Herpes
 - Hepatitis B
- This information and education must be sufficient to provide youth with an understanding of the following information and concepts for each STI:
 - Prevalence among demographics relevant to the specific youth (*e.g.*, youth, youth in the state or region)
 - Whether it is caused by bacteria or virus
 - Symptoms and whether the STI can be asymptomatic
 - Complications that can result from infection
 - How STIs can be transmitted and transmission myths
 - How transmission can be prevented through abstinence; use of condoms, dental dams, or latex barriers during specific sexual practices; use of clean needles; and through any other applicable methods
 - How youth should be offered testing for STIs, the importance of testing, and information should be provided summarizing state laws that allow youth to be tested without parental consent or notification of results
 - The cures, treatment, or vaccines available for STIs and the importance of treatment to avoid future complications

B. Risk Continuum for Pregnancy, STIs, and HIV

- Youth should be able to identify the risk of HIV transmission, HPV, herpes, and other STIs in the sexual practices listed below. Instructors should emphasize the distinctions between the categories and discuss what each category means in terms of statistical risk. If “typical use” or “actual use” statistics are used with regard to condom use, “perfect use” statistics should also be mentioned.
- Even in cases where someone is exposed to HIV through sex or a needle, a 28-day course of anti-retroviral drugs, known as post-exposure prophylaxis (n-PEP) appears effective in preventing infection.
- In using the Risk Continuum, instructors should be sure to emphasize youth’s opportunities to protect themselves rather than use fear-based tactics. Terms such as “insertive” and “receptive” should be explained to youth.

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Risk Continuum:

- Little or No Risk:
 - Abstinence; hugging, massage; masturbation; fantasy; phone sex; dry kissing; cyber sex; unshared sex toys; and having sex with a monogamous and uninfected partner
 - Sexual stimulation of another using one's hands; giving a man oral sex without putting the head of his penis in one's mouth; giving or receiving oral sex with a condom, dental dam, or plastic wrap; receiving oral sex without a barrier; sharing sex toys with cleaning or use of a new condom; and tongue kissing
 - Insertive or receptive vaginal sex with a condom and insertive anal sex with a condom
- Possible Risk:
 - Receptive anal sex with a condom
 - Receptive anal or vaginal sex with someone who is HIV-positive but is on effective medication and has an undetectable viral load.
- Known Risk:
 - When discussing risk, instructors should make it clear that individual risk is affected by many factors, e.g., whether one or both partners has had an STI, whether a person with HIV is on effective treatment and has no detectable viral load, and so on.
 - Giving oral sex without a condom, dental dam, or plastic wrap (noting that it is safer if there is no ejaculation in the mouth and there is no known risk for women who have sex with women)
 - Sharing sex toys without cleaning or use of new condom
 - Insertive anal sex without a condom and insertive vaginal sex without a condom
 - Receptive anal sex without a condom and receptive vaginal sex without a condom

C. Contraception

- Youth should understand what contraception is, that it can help prevent pregnancy, and that some, but not all, also reduce the risk of certain STIs.
- Youth should be able to weigh the risks and advantages of contraception methods and understand that a responsible and knowledgeable adult (such as a physician) can help them select a method of contraception.
- Youth should be familiar with how contraception can be integrated into a relationship.
 - They should be able to discuss the differing views on contraception depending on religion, cultural values, and personal values.
- Youth should be able to identify the following contraception methods and know that they are available “over the counter,” without a visit to a health care provider:
 - Male condoms
 - Female condoms
 - Spermicides in their different forms
- Youth should be able to identify their effectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages.
- Youth should understand how birth control pills and other commonly used forms of hormonal contraception work and that they are available by prescription from a health care provider.
 - They should understand that most cities have sexual health clinics, such as Planned Parenthood, where young people can get counseling, sexual health exams, and prescriptions for birth control at reduced prices.

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- They should be able to identify their effectiveness or ineffectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages.
- Youth must be provided with information on health care providers they can visit within the facility and outside the facility to obtain contraception.
- Youth should understand how emergency contraception (EC) works and that a visit to a health care provider is required to obtain such contraception until they are 17 years old.
 - They should be able to identify EC's effectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages. Youth must be provided with information on health care providers they can visit within the facility and outside the facility to obtain EC. Youth should understand the distinction between EC and the abortion pill, and that EC will not end a pregnancy.
- Youth should understand the concept of delaying sex (i.e. sexual abstinence) and how it can prevent unwanted pregnancy, STIs, and HIV.
 - They should understand and be able to discuss the benefits and challenges of abstinence, how people can give and receive sexual pleasure without intercourse, and how to have a romantic relationship and express feelings without intercourse.
 - Youth should understand the concept of sexual limits and the importance of discussing such sexual limits with their partners.

V. For Youth in Custody Over 2 Months

Youth must be provided with all training and resources discussed in Sections I, II, III, and IV.

Youth should be provided education and training sufficient to achieve proficiency in the following additional minimum content areas:

A. Anatomy & Development:

- Youth should be able to identify and understand the functions of the following anatomy: the nipples, urethra, urethral opening; buttocks, anus, penis, testicles, scrotum, sperm, seminal fluid, uterus, cervix, ovaries, fallopian tubes, and ovum.
- Youth should understand how the reproductive systems work, including the process of male sperm production, erection, and ejaculation, and the female process of ovulation and menstruation.
- Youth should understand that sex is not binary, that not all bodies follow this pattern, and that all bodies are deserving of respect.
 - Youth should understand what it means to be an intersex individual.²

² “‘Intersex’ is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male. For example, a person might be born with external female genitalia but the internal anatomy of the person has male genitalia. Or a person may be born with genitals that seem to be in-between the usual male and female types—for example, a girl may be born lacking a vaginal opening, or a boy may be born a scrotum that is divided so that it has formed more like labia. Or a person may be born with mosaic genetics, so that some of her cells have XX chromosomes and some of them have XY.” Intersex Society of America, *What is Intersex?* (2010), available at http://www.isna.org/faq/what_is_intersex (last visited September 29, 2011).

B. Sexuality & Healthy Relationships

- Youth should be able to understand the concept of sexuality as the expression of human sexual feeling, and a natural, healthy part of being human.
 - Youth should be able to discuss the concept of sexuality as including how a person feels about his or her body, whether a person feels masculine or feminine or somewhere in between, the way a person dresses, the way a person moves, how a person speaks, the way a person acts and feels about other people, and who the person is attracted to and falls in love with. This list is meant to be inclusive, not exclusive. Youth should be able to address other aspects of sexuality that are not listed above.
 - Youth should understand that sexuality is multifaceted and has biological, social, psychological, spiritual, ethical, and cultural dimensions.
 - Youth should understand that most people, regardless of biological sex, gender, age, ability, and culture are sexual beings, though sexual expression is not necessarily a significant part of some people's lives.
 - Youth should be able to identify how sexuality can be more rewarding and positive when expressed in a non-exploitive way.
 - Youth should understand that sexuality is experienced in a variety of ways at different stages and points in people's lives. And that everyone has their own way of expressing their sexuality to others and every person has their own way of feeling or experiencing it for themselves.
- Sexuality, Society, and Culture:
 - Sexuality & Society: Youth should be able to discuss the messages society gives them about how they are supposed to act, date, and sexually behave; how these messages can often conflict with messages from their family and community; how these messages may differ depending on their gender and age; and how these messages contribute to peer pressure. Youth should understand the diversity of views on sexuality and the importance of making independent decisions. Youth should practice the ability to critically evaluate messages from different sources and establish guidelines for their own behavior.
 - Sexuality & the Media: Youth should be able to discuss and describe the profound effect media has on sexual information, values, and behavior; ways in which the media's portrayal of sexuality is realistic and unrealistic; and the messages they have received from television, movies, music videos, and on the internet and whether these messages are accurate. Youth should be able to identify stereotypes reflected in the media and how these stereotypes can negatively affect them and their opinion about certain groups of people, including LGBTQ individuals, and gender roles.
 - Sexuality & Religion: Youth should be able to discuss and describe how various religions' views about sexuality affect people's sexual attitudes, behaviors, and sexual decision-making and the conflict that can occur between peoples' values and religious beliefs in the context of sexuality. Youth should understand how gender roles and beliefs about sexual orientation have historically been affected by religion and how, although LGBTQ people have historically been excluded from many religious congregations, a growing number of congregations now openly welcome members of the LGBTQ community. Youth should be encouraged to discuss ways that religion has affected their feelings about sexuality or the feelings of someone they know.
 - Sexuality and the Law: Youth should be familiar with the U.S. laws governing sexual and reproductive rights. This particularly pertains to the following:

- The Supreme Court has ruled that, to a certain extent, people have the right to make personal decisions concerning sexuality and reproductive health matters, such as abortion, contraception, sterilization, and engaging in same-sex sexual relationships.
- State laws govern the age of consent for sexual behaviors.
- Some states and cities have passed laws banning discrimination on the basis of sexual orientation. Youth should be familiar with relevant laws in their city or state.
- The Supreme Court recently ruled that state laws restricting certain types of sexual behavior between consenting adults are unconstitutional. Consenting adults, regardless of gender or sexual identity, cannot be prosecuted for engaging in a sexual relationship.
- Courts across the United States are currently debating legal issues concerning same-sex marriage.
- Public nuisance behavior, such as exhibitionism and voyeurism, are illegal in most states.
- Prostitution is illegal in all states except for Nevada.
- Child pornography – a visual depiction of a minor engaging in sexually explicit conduct – is illegal in all states.
- Some federal and state laws protect individuals from harassment in jobs, schools, and state institutions if the harassment is based on the individual's sex, their identified or perceived sexual orientation, or gender identity.

C. Pregnancy & Pregnancy Options

- Youth should be familiar with their legal and civil rights regarding pregnancy as a minor.
 - They should be familiar with the state and federal laws that allow them to receive confidential medical care and, to the extent true in their jurisdiction, make decisions regarding the continuation or termination of their pregnancy.
- Males should be aware of their rights, and their legal responsibilities relating to pregnancy.
- All youth should be made aware of specific services available to them, and, depending on the laws and regulations in their jurisdiction, the right to obtain care without the consent of their parents or foster parents.
 - Prenatal Care: Youth should be familiar with what prenatal care entails and why it is important.
 - Specifically, youth should be familiar with the benefits of exercise, healthful foods, visits to a healthcare provider and testing and treatment for STIs and HIV, and the potential harms of alcohol, tobacco, drugs, and STIs and HIV. Women who are pregnant or considering becoming pregnant should take care of their reproductive health and seek prenatal care.
 - Pregnancy Options: Youth should be able to identify all options available to a woman who has an unwanted pregnancy. These options include parenting, adoption, foster care, and abortion.
 - Youth should be familiar with how adoption works according to state law. They should be provided the names and contact information of adoption resources.
 - Abortion:
 - Youth should understand what an abortion is, that it is performed by a healthcare provider, and that it is generally very safe and rarely interferes with a woman's ability to become pregnant or give birth in the future. Youth should be able to identify facts and myths about abortion safety.
 - Youth should be able to distinguish between surgical and medical abortion and to distinguish abortion from emergency contraception.

- Youth should be familiar with constitutional and state law protections of a woman’s right to have an abortion and a minor’s right to have an abortion.
 - If state law requires parental notification or consent with a bypass mechanism, youth should be familiar with these requirements and the bypass mechanism. Youth should be familiar with their own state’s abortion limitations based on the length of the pregnancy, as well as exceptions to these restrictions. Youth should also be familiar with laws protecting their confidentiality in obtaining an abortion.
- Youth should be familiar with possible state legal protections preventing others—including parents and partners—from forcing a woman or minor to have an abortion against her will.
- Youth should be familiar their rights regarding abortion access and payment while in custody. This is a complex set of legal rights that vary greatly according to state law, and youth should be made familiar with the laws in their state.

D. Contraception

- Youth should be able to identify the contraception methods listed below. They should know that the contraception methods are available by prescription from a health care provider. Youth should also be able to identify their effectiveness for pregnancy prevention, STI and HIV prevention, and other advantages and disadvantages. If phrases such as “perfect use” and “typical use” are used in discussion, they should be explained to the youth so that they are not potentially misleading.
 - Condoms
 - Birth Control Pills
 - Birth Control Injections
 - Birth Control Patch
 - Birth Control Ring
 - Intrauterine Contraceptives (IUC)
 - Implants (Implanon)
 - Emergency Contraception
 - This form of contraception can be used up to 120 hours (5 days) after unprotected sex. It is more commonly referred to as the Morning After Pill or Plan B.

E. Reproductive Coercion

- Youth should be engaged in a thorough discussion of reproductive coercion.
 - They should understand that no person may force another person to become pregnant or stay pregnant against their own will.
 - Youth should understand that any pressure to become pregnant, whether through verbal threats, physical aggression, or birth-control sabotage, is a violation of their rights.

F. Communication Skills

- Youth should be able to explain and apply the components of effective communication and to explain the importance of effective communication and being an advocate for their own needs.
- Youth should be able to identify different communication styles, and to distinguish effective and ineffective communication tactics.
- Youth should understand how to apply effective communication skills in various circumstances including sexual relationships, friendships, and with health care providers.

G. Drug Use/Harm Reduction Skills

- Youth should be able to identify that drugs and alcohol can significantly influence one's behavior and decision-making skills. The effects of drugs and alcohol can lead to unintended, negative consequences.
- Youth should be able to identify factors that cause individuals to use drugs and alcohol.
- Youth should be able to identify and apply ways to make responsible decisions about drug and alcohol use.
- Youth should be able to discuss ways to reduce their risk behaviors if they are using drugs and alcohol. Particular discussion should surround the use of intravenous drugs, and the need to use clean needles. Youth should be provided with information about where to acquire clean needles.
- Youth should also be able to identify facility or community resources if they chose to stop using drugs or alcohol and they would like help getting clean.

H. Paternity, Child Support, and Coping as a Young Parent

- Paternity, Public Assistance, and Child Support:
 - Youth should be able to identify what paternity is, how it can be established, and the benefits and rights a father, mother, and child may gain when paternity is established.
 - Youth should be able to identify the legal responsibilities of parents and the resources available to young parents to learn the skills needed to support their children.
 - Youth should be able to describe the impact that establishing paternity can have in terms of public assistance, such as welfare, and for child support and visitation. Youth should be able to distinguish the differences between child support and visitation rights.
- Coping as a Young Parent:
 - Youth should be able to describe the importance of parents having a positive relationship both with their child and the person caring for their child, and best practices for achieving this.
 - For parents who are youth in detention, they should be able to identify the importance of telling children where they are when they are in state custody. Subsequently, they should have information on how to deal with children's reactions to their detention. In preparation for release, they must have information regarding how to prepare to be reunited with their children and their responsibilities for their children.
 - Youth should be able to identify positive and negative parenting behaviors, including the importance of being respectful to the other person caring for their child, listening to their child, creating a written parenting plan, not criticizing the other parent or caretaker to the child, and not fighting with the other parent or caretaker in front of the child.
 - Youth should be able to discuss anger management strategies, and the difficulties and rewards of breaking the potential cycle of violence within their families. They should be given clear resources for parenting help and strategies within their community.

Part Two: Instructional Characteristics

Part One outlined the minimum goals that the curriculum's content should be tailored to achieve. Part Two provides guidance on how to select and implement a curriculum that ensures this content is presented effectively. Part Two also identifies goals that should be achieved in the curriculum and should be addressed by the instructors. Effective teaching requires not only the right curriculum content, but also a safe, inclusive environment. The teaching methods used should also help youth understand and apply new information as well as change attitudes and behavior. This section outlines elements that will help prepare and execute an effective curriculum.

I. Curriculum Characteristics

The curriculum should:

- Convey the information set forth in Part One in a comprehensive and scientifically accurate manner.
- The curriculum should focus on the following goals: preventing STIs, HIV, and unwanted pregnancy; decreasing sexual abuse while increasing the reporting and detection of such abuse; promoting an accurate understanding of the nature and importance of sexual orientation and gender identity; and providing a supportive, healthy, and inclusive environment for LGBTQ youth.
- Focus clearly on the goals:
 - The majority of lessons, activities, and facts should support achieving the goals.
 - The curriculum should clearly and accurately inform young people about STIs, HIV, becoming pregnant (or impregnating another), sexual abuse, and issues surrounding sexuality and sexual orientation.
 - The curriculum should clearly and accurately inform young people about the health, psychological, and long-term consequences of STIs, HIV, unintended pregnancy, sexual abuse, and discrimination based on one's sexual orientation or gender identity.
 - The curriculum should include activities that motivate young people to protect themselves from STIs, HIV, and unintended pregnancy. It should also include information about identifying and reporting sexual abuse.
- Focus on specific behaviors to achieve goals:
 - Examples of specific behaviors that lead directly to achieving goals include, but are not limited to: abstinence, condom use, dental dams, STI testing and treatment, HIV testing and treatment, access to contraception, understanding one's anatomy and being able to identify healthy versus unsafe and physically harmful relationships, and building and demonstrating respect for persons of all sexual orientations.
- The curriculum must address, in tangible ways, the actual experiences of the youth in state care. The curriculum must recognize that the risk-taking done on a daily basis by these youth, while often alarming, can make sense in the context of their real and perceived choices. The youth need practical resources on how to manage existing conditions and the repercussions of sexual assault, homelessness, sex work, drug use and pregnancy.
- Instructors must address violence and harassment perpetrated by youth and adults against LGBTQ youth.

- Educators should – in a non-accusatory manner – discuss why a range of behaviors, from teasing to outright assault, is detrimental. Instructors should also discourage youth from taking a “sidelines” attitude when witnessing harassment and violence.
- Programs must not ignore issues of sexism, racism, and homophobia as they relate to sexual violence.
 - Effective sexual assault prevention programs must address broader issues of societal contempt for women, people of color, and LGBTQ people.
 - Sexual assault of men should also be addressed, and it should not be assumed that men could never experience assault themselves.
 - Young people should also be educated as bystanders in recognizing sexual assault and intervening in a safe manner.
- Instructors must have trauma training, and should be hyper aware of the effect of their lessons on the participating youth. The curriculum and instructors should assume that most, if not all, of the risk behaviors and risk traits exist within their classroom or instructional setting. HIV and STI infection, a history of sexual assault, LGBTQ persons, and pregnancy are all likely to be present in the group of youth.
 - Every effort should be made to make lessons informative and non-judgmental, and no youth should ever be singled out to share his/her personal experience unless that information is readily volunteered by the youth.

II. Teaching Characteristics

A. Environment

- The curriculum should create a safe social environment for youth to participate. If the social environment does not feel safe to participants, they are much less likely to actively engage, express their views, ask questions, or internalize the important messages of the curriculum. The following steps should be taken to ensure a safe social environment:
 - The institution should have policies providing for confidentiality during sexuality education instruction. These confidentiality policies would apply to any and all staff present as well as youth.
 - Staff should be well-versed in confidentiality policies and should face penalties for violation of confidentiality. The rules of confidentiality among youth and staff, as well as a clear explanation of what information must be legally reported, should be explained to all youth and staff at the beginning of instruction and when any new youth or staff member is present.
 - Spend sufficient time at the beginning for introductions, icebreakers if necessary, and establishing group ground rules (e.g. one person talks at a time, no put-downs, what is said in the room stays in the room, etc.).
 - Provide adequate opportunities for all youth to participate.
 - Encourage facilitators to praise youth and provide positive reinforcement where appropriate.

B. Instruction Methods

- Employ instructionally-sound teaching methods that actively involve the participants and help participants personalize the information.
 - Examples: Short lectures, class discussion, small group work, brainstorming sessions, role plays, videos, stories, live skits, simulations of risks and practicing strategies to avoid risk, competitive games, forced-choice activities, surveys of attitudes and intentions, problem solving activities, and condom demonstrations.

- Employ activities, instructional methods, and behavioral messages that are appropriate to the youth's culture, developmental age, and sexual experience.
- Cover topics in a logical sequence.

C. Curricula and Instructors Should Adhere to the Following Principles:³

- Young people need and deserve respect.
 - This includes an appreciation for the difficulty and confusion of adolescence and of the many factors that have contributed to the problems that youth – particularly youth in state custody – face.
 - Youth are deserving of respect and should be treated in a respectful manner and tone.
- Youth need to be accepted.
 - Instructors must listen to and hear what young people have to say, even if the instructor disagrees with what is being said.
 - In general, it is more effective to explore the possible pitfalls of youth attitudes than for an instructor to tell them what youth ought to believe and do.
- Youth learn as much, if not more, from each other as from adults.
 - Often, if instructors let youth talk, allow them to respond to each other's questions and comments and ask for their advice, youth feel empowered and take responsibility for their own learning.
 - It is much more powerful for a peer to challenge another youth's attitude than for an adult to do so.
- Open, honest, scientifically correct information and communication about sexuality is essential.
 - For most of their lives these youth have gotten the message that sex is hidden, mysterious, and something that should not be discussed in a serious and honest manner. Limiting what youth can talk about and using vague language perpetuates this secrecy and mystery.
- A positive approach to sexuality education is the best approach.
 - Both the risks and pleasures of sex should be acknowledged in a balanced way. Sex should be associated both with things grave and serious and with things open, playful, and humorous.
 - Offer a model of what it is to be sexually healthy rather than focusing on what is sexually unhealthy.
- Young people have a fundamental right to sexuality education.
 - Young people have a right to know about their own bodies, how they function, and about the sexual changes that are occurring to them now and will continue throughout their lifetimes. They have a right to have their questions answered.
- Youth who have explored their own values and attitudes and have accurate information are in the best position to make healthy decisions about their sexual lives.
- All sexual orientations and gender identities must be acknowledged.
 - Some youth are, or think they may be lesbian, gay, bisexual, or transgender. It is important to create an environment that recognizes the needs of these often isolated and invisible youth.
 - Teaching frankly about sexual orientation and gender identities benefits all youth because it allays fears about same-sex feelings or gender identity that many of them experience.

³ Planned Parenthood of Greater N. N.J., *Principles of Sexuality Education* (2001) (adapted from Steve Brown & Bill Taverner, *Streetwise to Sex-Wise: Sexuality Education for High Risk Youth*) (on file with CHLP; [available for cost at http://www.plannedparenthood.org/greater-northern-nj/book-details-30042.htm](http://www.plannedparenthood.org/greater-northern-nj/book-details-30042.htm) (last visited September 30, 2011)).

Part Three: Instructor Characteristics

Set forth below are the minimum requirements that sexual health education instructors providing instruction for youth in custody should possess. Instructors are encouraged to exceed these minimum requirements, and to receive continuing education beyond what is set forth below to ensure that their knowledge is up-to-date and relevant.

I. Knowledge of Content

Instructors must have completed relevant undergraduate, graduate, or professional development coursework that has provided them significant training in the following topics:

- Adolescent development
- Basic sexuality education
- Anatomy and reproduction, including:
 - General sexual health
 - STIs and HIV/AIDS, including testing, transmission, symptoms, treatment, and all prevention methods.
 - Pregnancy and contraception
 - Puberty
 - Sexual response
 - LGBTQ health issues
- Gender identity
- Sexual assault, including training on recognizing the facts and risks of sexual assault; staff predation; and the provision of aid to those who have been sexually assaulted recently or in the past.

II. Attitudes & Values:

Instructors must have completed relevant undergraduate, graduate, or professional development coursework and significant training in the following:

- Homophobia reduction, including
 - Inclusive language
 - Challenges facing LGBTQ youth, including the difficulties in coming out
 - Gender stereotyping reduction
- Group facilitation and activity-based learning

Instructors must have completed a Sexual Attitude Reassessment seminar.

Instructors should demonstrate personal qualities of effective teachers, including, but not limited to:

- Willingness and enthusiasm for teaching this subject area.
- Belief that sexual adjustment is an important aspect of total personality adjustment.
- Comfort with one's own sexuality, sexuality in general, and topics to be covered.
- Clarity on one's own personal code of ethics and values.
- Open-minded and non-judgmental attitude with respect to values, attitudes, beliefs, and behaviors that may differ from the instructor's own.

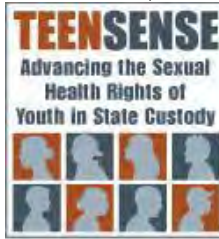
Teen SENSE: Model Sexual Health Education Standards

- Respect for different cultural and religious values and beliefs.
- Ability to relate effectively to youth, with honesty, warmth, and sensitivity.
- Willingness to learn and enthusiasm, rather than hostility, to new information and teaching methodologies.

III. Methods

Instructors must demonstrate familiarity with, and the ability to design and implement lesson plans that achieve the content goals in, Part One and use the methods described in Part Two. This includes having skills regarding:

- Using appropriate communication and teaching techniques, such as role playing, brainstorming, large and small group processing, and cooperative learning.
- Creating an effective, functional learning environment that develops and enhances youth's motivation to learn



MODEL POLICY

TRAINING FOR YOUTH FACILITY STAFF: ENSURING COMPETENCE THAT INCLUDES THE RIGHTS AND NEEDS OF LGBTQ YOUTH

It shall be the policy of **[this agency/jurisdiction]** to provide relevant training to all staff of foster care, detention, and other government operated and regulated youth facilities that equips the staff to understand and protect the health and well-being of all youth, regardless of the youth's gender identity or sexual orientation.

Staff at every level of child welfare, juvenile justice, and other youth agencies – including but not limited to medical and social service providers, security personnel, and staff of educational, food service, and athletic programs – shall be trained on the rights of all youth to health, sexual and reproductive services, autonomy, safety, and freedom from all forms of discrimination and harassment. Staff training shall also reflect the need for universal staff competence in communicating with and advising all youth.

At the conclusion of training staff shall be able to:

- Identify the effects of stigma or discrimination on lesbian, gay, bisexual, transgender, or questioning (LGBTQ) or HIV-positive youth's health;
- Understand their responsibilities to provide comprehensive physical and mental health services to all youth in a respectful manner;
- Maintain confidentiality and an atmosphere of safety and acceptance;
- Ensure access to services and social events consistent with LGBTQ youth's interests and communities with which they identify;
- Abide by the relevant laws and agency policies established to support all youth; and
- Explain procedures for reporting and responding to youth and staff complaints about conduct that is in conflict with these policies.

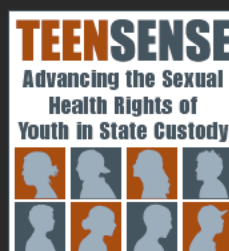




Teen SENSE

Model Staff Training Standards

Focusing on the Needs of LGBTQ Youth in State Custody



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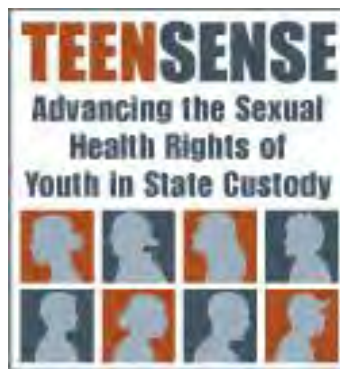
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True Colors, Inc. Sexual Minority Youth Services of CT
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MODEL STAFF TRAINING STANDARDS:
Focusing on the needs of LGBTQ Youth



Mission Statement

The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

We support and increase the advocacy power and HIV expertise of attorneys, community members and service providers, and advance policy initiatives that are grounded in and uphold social justice, science, and the public health.

We do this by providing high-quality legal and policy materials through an accessible web-based resource bank; cultivating interdisciplinary support networks of experts, activists, and professionals; and coordinating a strategic leadership hub to track and advance advocacy on critical HIV legal, health, and human rights issues.

To learn more about our organization and access the Resource Bank,
visit our website at www.hivlawandpolicy.org.

To contact us:

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The development and publication of these standards would not have been possible without the generous and sustained support of the MAC AIDS Fund, Broadway Cares/Equity Fights AIDS, the Arcus Foundation, and the Elton John Foundation.

Teen SENSE

A National Initiative to Bring Comprehensive Sexual Health Care to Youth in State Custody

Adolescents confined to foster care and juvenile justice facilities are overwhelmingly members of the communities most affected by, and at risk for, HIV/AIDS: low-income youth, Black and Latino youth, lesbian, gay, bisexual, transgender, and questioning youth (LGBTQ), and survivors of violence and other abuse. Empowering these populations to protect their rights and their health lies at the heart of the mission of the Center for HIV Law and Policy (CHLP). While these youth, across the spectrum of sexual orientation and gender, are at great risk of HIV and other STIs, they are overwhelmingly denied access to appropriate and effective HIV prevention, sexual health education, and sexual and reproductive health care. Where care is provided, it too often ignores or isolates LGBTQ youth and their health needs. To address this crisis, CHLP launched the Teen SENSE (Sexual health and Education Now in State Environments) initiative, a sexual health and HIV prevention initiative grounded in the rights of youth to these services.

Teen SENSE advances the principle that respect and accommodation for all gender expression and sexual orientation is central to HIV prevention, sexual health and prevention from sexual abuse, and that all youth have the right to comprehensive, LGBTQ-inclusive health services that include sexual health care and education when they are confined in state facilities. Comprehensive, LGBTQ-inclusive sexual health care is vital to preserve health, reduce HIV and STI transmission risk, and increase the odds that severely at-risk youth will develop the essential skills and knowledge to protect their sexual health, develop self-respect, and foster tolerance.

Teen SENSE is a multidisciplinary initiative that has engaged experts in adolescent medicine, sexual health education, foster care, and juvenile justice to develop a complete advocacy model and coordinate its implementation. The Teen SENSE program has developed a federal and state legal framework for the right of adolescents to comprehensive, scientifically accurate, LGBTQ-inclusive sexual health care services and education. We have developed model standards for comprehensive, LGBTQ-inclusive sexual health care, education/HIV prevention, and staff training to ensure the safety and sexual health of all youth in state custody. Teen SENSE establishes a powerful legal and human rights framework and the on-the-ground alliances that can make meaningful, appropriate, non-judgmental sexual health care and real HIV prevention a mandated service for youth in state foster care and detention facilities.

MODEL STAFF TRAINING STANDARDS: Focusing on the needs of LGBTQ Youth

Executive Summary

The Teen SENSE Model Staff Training Standards are designed to ensure that all staff of foster care, detention, and other government operated and regulated youth facilities are equipped to understand and protect the health and well-being of all youth, regardless of sexual orientation or gender identity. These standards should serve as a guide for staff at every level of child welfare and juvenile justice agencies, from medical service providers to security personnel, who should be trained on the rights of all youth to freedom from all forms of discrimination, and to health, sexual and reproductive autonomy, and safety. The standards also reflect the need for universal staff competence in communicating with and advising all youth.

Under the Model Staff Training Standards, staff's responsibilities include: being able to identify the effects of stigma or discrimination on LGBTQ or HIV-positive youth's health; understanding their responsibilities to provide comprehensive physical and mental health services to all youth in a respectful manner; maintaining confidentiality and an atmosphere of safety and acceptance; ensuring access to services and social events consistent with LGBTQ youth's interests and communities with which they identify; and abiding by the relevant laws and agency policies established to support all youth.

The development and publication of these standards would not have been possible without the generous and sustained support of the MAC AIDS Fund, Broadway Cares/Equity Fights AIDS, the Arcus Foundation, and the Elton John Foundation.

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Introduction

What are the Model Staff Training Standards?

These Model Staff Training Standards are the product of a comprehensive review of existing materials and an effort to combine the best and most inclusive practices and policies regarding youth sexual health care into one set of interrelated standards. The Staff Training Standards are intended to help facility directors and trainers ensure that training curricula for staff at juvenile detention and foster care facilities include the minimum amount of information that will allow staff to adequately understand and respond to the needs of all youth in their custody, including lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth.

Unlike the Teen SENSE Model Sexual Health Care and Model Sexual Health Education Standards, which address the needs of both heterosexual and LGBTQ youth, the Model Staff Training Standards are focused on the particular needs of LGBTQ youth. LGBTQ youth are disproportionately represented in state foster care and detention facilities and often face harassment, physical and emotional abuse, and are ostracized by other youth and the adults charged with their care. The Model Staff Training Standards address the general lack of understanding about sexual orientation and gender identity, and the need for youth facility staff to be culturally competent in LGBTQ issues to prevent abuse and harassment.

The Teen SENSE Standards emphasize that comprehensive sexual health care must be integrated throughout a youth's stay while in the custody of the state. Youth in state custody, including LGBTQ youth, are more likely to engage in behaviors that put them at risk of acquiring HIV and other STIs. A variety of factors likely contribute to this increased vulnerability, including a past history of sexual abuse and physical trauma, limited access to health care, and little or no sexuality education.¹ Transgender youth in foster care and state detention facilities typically have unique health needs, especially if they have been receiving hormone therapy. Access to sexual health care is a fundamental part of the essential health care to which youth in state custody have a right under state, federal and international law. In turn, sexual health safety requires that all staff at every level of a state foster care or detention facility understand and respect the needs of these young people and how they, as staff, can help to address those needs.

Teen SENSE has also developed a "legal road map," entitled *Juvenile Injustice: The Unfulfilled Rights of Youth in State Custody to Comprehensive Sexual Health Care*, which lays out the affirmative legal rights of juveniles in state custody to comprehensive sexual health care. The legal road map and Model Standards are advocacy tools designed to be used together to bring regular, consistent and comprehensive sexual and reproductive health care to the most at-risk, vulnerable, and underserved youth populations.

¹ See Linda A. Teplin et al., *HIV and AIDS Risk Behaviors in Juvenile Detainees: Implications for Public Health Policy*, 93 Am. J. Pub. Health 906, 910 (2003); American Academy of Pediatrics, Committee on Adolescence, *Health Care for Children and Adolescents in the Juvenile Correctional Care System*, 107 Pediatrics 799 (2001).

How were the Standards created?

The core of the document is based on materials from the National Commission on Correctional Health Care, *Standards for Health Services in Juvenile Detention & Confinement Facilities*, Standard Y-C-09 (2004); Physicians for Reproductive Choice & Health (“PRCH”), Adolescent Reproductive Education Health Program (“ARHEP”), *Gay, Lesbian, BiSexual, Transgendered & Questioning Adolescents*, Power Point Presentation (2006); Child Welfare League of America, *Best Practice Guidelines for Serving LGBTQ Youth in Out-of-Home Care* (2006); and the National Center for Lesbian Rights, *The Legal Rights of Young People in State Custody* (2006). These Standards are not a curriculum, but rather reflect minimum requirements that curricula should reflect in order to appropriately meet the needs of youth in the state’s care.

Standards for Staff Training

I. Goal

To ensure that training curricula designed for staff at state foster care and youth detention facilities meet basic standards regarding the health and well-being of all youth in state custody, regardless of sexual orientation or gender identity.

II. Target Audience

Staff *at every level* of child welfare and juvenile justice agencies, including all administrative staff, medical and mental health providers, direct care staff, social workers, contractors, security personnel, and any other employees or volunteers who may have contact with youth in custody.

III. Core Components of Comprehensive Staff Training Programs

1. Training Protocol Standards

Training sessions will:

- Be provided to all members of target audience at initial orientation and at designated intervals thereafter to reinforce concepts.
- Take into account the professional roles, professional and life experience, education, and learning styles of participants.
- Use principles and practices of adult learning and active training to create effective training programs.

2. Training Outcome Standards

These standards are designed to help trainers develop staff training curricula that address the many general and sexual health care needs of youth, particularly LGBTQ youth, in state custody. In order for staff training to be effective, training programs for juvenile justice and child welfare staff should help participants become able to:

- Protect the rights of all youth, including LGBTQ and HIV-positive youth, in state custody.
- Describe the correlation between the effects of stigma based on sexual orientation or gender identity and the reasons why some youth may be in custody.
- Explain the meaning and immutability of sexual orientation, gender identity, and gender expression as an inalienable part of individual and human identity and self-worth.
- Explain the detrimental effects that homophobia and transphobia have on health outcomes for LGBTQ youth.
- Implement agency policies and practices that support healthy, safe, age-appropriate exploration and expression of sexual/gender identity for all youth.

- Provide for the privacy and confidentiality of all youth, including LGBTQ and HIV-positive youth.
- Provide for the safety of all youth, including LGBTQ and HIV-positive youth.
- Apply rules regarding sexuality and sexual or gender-related behavior equally to all youth.
- Engage respectfully with LGBTQ youth's gender identity and expression.
- Ensure that LGBTQ youth have knowledge of and access to services and/or social events consistent with their interests and geared toward the community with which they identify.
- Use appropriate and respectful terms to identify youth of all sexual orientations and gender identities.
- Make referrals and provide resources as necessary for sexual health care and treatment.
- Appreciate and understand the need for these competencies and make an investment in the process.
- Ensure that the specific health care needs of transgender youth are met.

IV. Content Areas

In order to meet educational objectives, trainings should cover the following content areas at a minimum:

- Law and policy;
- Diversity/cultural awareness/vocabulary;
- Identity/sexuality/gender formation;
- Effects of homophobia/transphobia/heterosexism;
- Importance of appropriate sexual health education;
- Understanding, identifying, preventing, and reporting sexual abuse by staff or other youth.

V. Educational Objectives²

1. Protect the rights of all youth, including LGBTQ and HIV-positive youth, in state custody.

Youth are particularly vulnerable to rights abuses, either because they do not fully understand their own rights, or because they feel – or actually are – powerless to assert them. This is especially true for youth in state custody. Staff must understand, respect, and protect the rights of youth in their care.

To demonstrate competency, participants will be able to:

- Understand their legal and ethical responsibilities to treat all youth, including LGBTQ and HIV-positive youth, fairly and with respect.
- Identify the state, federal, and international rights of youth in state custody.³

² See National Center for Lesbian Rights, *LGBTQ Youth in the Juvenile Justice System* (2006) and *The Legal Rights of LGBTQ Youth in the Child Welfare System* (2006), available at http://www.nclrights.org/site/PageServer?pagename=issue_youth_docsDownloads#fcjj (last visited Sept. 16, 2011).

- Articulate application of state laws and policies prohibiting discrimination based on sexual orientation and gender identity to youth in state custody.
- List at least three ways professionals can protect the rights of all youth in custody.

2. Describe the correlation between the effects of stigma based on sexual orientation or gender identity and the reasons why some youth may be in custody.

Youth who identify as LGBTQ are more likely than other youth to become homeless. LGBTQ youth also are more likely to be harassed and ostracized at school, leading to truancy. These factors make LGBTQ youth more likely to end up in foster care or engage in conduct that may lead to their detention.

To demonstrate competency, participants will be able to:

- Indicate understanding of the societal, familial, and developmental challenges confronting LGBTQ youth in and out of custody and the relevance of these issues in meeting the individualized needs of LGBTQ youth in custody.
- Indicate understanding of social alienation experienced by some LGBTQ youth and especially youth who fall loosely into an “at risk” category.
- List three reasons why LGBTQ youth are at risk for (1) child welfare system involvement, (2) dropping out of school, (3) homelessness, and (4) serving time in juvenile detention facilities.

Please refer to the Appendix for more information on sexuality, sexual orientation, and gender roles, and identity.

3. Explain the detrimental effects that homophobia and transphobia have on health outcomes for LGBTQ youth.

As a result of stigma, fear, and a history of mistreatment, LGBTQ youth are less likely to be engaged in regular health care, which leads to poor health outcomes.

To demonstrate competency, participants will be able to:

- Indicate understanding of difficulties and prejudices facing LGBTQ youth in and out of custody.
- Articulate the negative effects trauma and stigma have on adolescent development.
- List at least three negative health outcomes that LGBTQ youth who have been rejected by their families are at greater risk of experiencing compared to LGBTQ youth who have not faced family rejection.
- List three factors that may improve health outcomes for LGBTQ youth.
- Demonstrate understanding of the facts of, and reasons why, LGBTQ youth in custody are at greater risk of sexual abuse and other violence.

³ See The Center for HIV Law and Policy, *Juvenile Injustice: The Unfulfilled Rights of Youth in State Custody to Comprehensive Sexual Health Care* (2010), available at <http://www.hivlawandpolicy.org/resources/view/565> (last visited Sept. 16, 2011).

4. Implement agency policies and practices that support healthy adolescent development of gender identity and sexuality.

Once policies are adopted by the policy makers within the agency authorized to oversee state foster and detention facilities, staff within the facility must understand how to implement the policies. In order to accomplish this, staff must develop sensitivity to LGBTQ youth. Staff must not only support, but also encourage, LGBTQ youth to embrace their own sexual/gender identity.

To demonstrate competency, participants will be able to:

- Indicate a sensitivity to and understanding of age-appropriate adolescent sexuality and gender expression.
- Articulate to youth the agency's rules indicating what conduct is not allowed in state facilities with respect to the treatment of other youth on the basis of sexual orientation.
- Identify at least three ways in which the agency supports youth in appropriate expression of sexuality and/or gender identity.
- Differentiate between instances of non-consensual sexual abuse and consensual sexual activity between youth.
- Articulate to youth the forms of sexual abuse, how to identify abuse, and how to report it safely.
- Demonstrate an understanding of agency policies and practices regarding sexual orientation and gender expression.
- Indicate an understanding of youth developmental stages, including the ways in which trauma and stigma experienced by some youth can interfere with these development stages.
- Provide ongoing, interactive, and youth-appropriate programs on sexuality and gender
- Provide a safe environment for youth to ask questions and gather information.
- Identify the reporting procedures for infractions of agency policies and the ways to which infractions are responded.

5. Provide for the privacy and confidentiality of all youth, including LGBTQ and HIV-positive youth.

Youth in state custody are less likely to seek needed services if they are concerned that their privacy will be violated. To encourage youth to access services, staff must maintain confidentiality and understand why it is imperative to do so. This is also important for LGBTQ youth who may feel or be vulnerable to violence if their sexual/gender identity is disclosed to others within the facility.

To demonstrate competency, participants will be able to:

- Offer private and confidential counseling, meetings, and medical interventions (including medication distribution) to all youth.
- Maintain confidential records for all youth and know who has access to these records.

- Articulate the relevance of state and local confidentiality laws to their work with LGBTQ youth.
- Discuss with youth their rights to privacy and confidentiality.
- Identify procedures for ensuring the confidentiality of all youth's health status and conditions, particularly HIV/AIDS.

6. Provide for the safety of all youth, including LGBTQ and HIV-positive youth.

As a result of dynamics within a state detention or foster care facility, some youth may be vulnerable to harassment or violence. Because these youth are in the care of the state, the state has an obligation to provide for their safety and protect them from harm. Staff must understand which conduct is inappropriate, how to address inappropriate or potentially abusive staff interactions with youth, when to intervene, and how to address the situation without punishing the person who was the subject of the harassment or violence.

To demonstrate competency, participants will be able to:

- Provide all youth with safety and protection as required by law.
- List sub-populations of youth who may be additionally vulnerable to sexual or physical assault in state facilities.
- Demonstrate awareness of what constitutes emotional abuse that is sometimes directed particularly at LGBTQ youth.
- Identify at least two strategies that can be used to respond to situations in which one youth is verbally harassing or threatening another youth because of sexual orientation and/or gender identity.
- Describe how professionals can provide safety to LGBTQ and HIV-positive youth in custody without resorting to isolating the youth, which is in violation of the youth's rights.
- Identify ways to detect and eliminate an individual youth's risk of sexual abuse or assault.
- Respond to all complaints of physical and sexual abuse (including abuse allegedly perpetuated by professionals) in a timely and appropriate manner.
- Differentiate between instances of non-consensual sexual abuse and consensual sexual activity between youth.

7. Engage respectfully with LGBTQ youth's gender identity and expression.

Staff who are uncomfortable with expressions of gender that are outside what is considered to be the norm are more likely to treat youth with varying gender identities in a way that is not supportive or respectful. For example, calling youth by derogatory names (including "fag" or "faggot" or referring to something as "gay" in a derogatory manner) is unacceptable behavior. Unequal or disrespectful treatment, whether intentional or inadvertent, can never be tolerated.

To demonstrate competency, participants will be able to:

- Indicate a sensitivity and understanding of how all youth express their gender.
- Provide a safe environment for youth who have a non-conforming gender identity.
- Encourage youth to respect the gender identity of transgender and gender non-conforming youth.

- Use a transgender youth's preferred name and pronoun when referring to that youth.
- Explain the difference between sexual orientation and gender identity.
- List at least three things staff can do to show respect for a youth's gender identity.

8. Ensure that LGBTQ youth have knowledge of and access to services and/or social events consistent with their interests and geared toward the community with which they identify.

LGBTQ youth often face isolation and depression due to society's response to their sexual and gender identity. Youth should have access to and knowledge of supportive communities and service providers for counseling and related resources.

To demonstrate competency, participants will be able to:

- Familiarize themselves with LGBTQ issues and the basic counseling skills needed to offer resources to in-custody youth with questions or concerns.
- Identify community-based healthcare programs, including mental health care, that are competent to work with LGBTQ youth and available to youth with whom participants interact.
- Identify at least one accessible local supportive service agency or organization for LGBTQ or HIV-positive youth.

9. Use appropriate and respectful terms to identify youth of all sexual orientations and gender identities.

Using terms that validate a youth's sexual or gender identity demonstrates an understanding and sensitivity toward the issues youth struggle with and will likely lead to better outcomes for those youth because they feel respected.

To demonstrate competency, participants will be able to:

- Indicate knowledge of LGBTQ terminology and definitions.
- Demonstrate the ability to use LGBTQ terminology and definitions in their work with young people.

10. Make referrals and provide resources as necessary for care and treatment.

LGBTQ youth, particularly transgender youth and HIV-positive youth, may have particular health care needs. As a result, these youth must have access to medical care in a timely matter. All information surrounding the visit, including reason for the visit and diagnosis, must remain confidential.

To demonstrate competency, participants will be able to:

- Provide timely and ongoing medical care and treatment, including counseling and mental health care, unique to transgender youth.

- Ensure the availability of private and confidential counseling, meetings, and medical interventions (including medication distribution) to all youth.
- Identify procedures to maintain the confidentiality of records for youth.
- List at least three examples of when referrals should be made to a supportive service agency or network for LGBTQ identified or HIV-positive youth.
- Identify at least one supportive service agency or network for LGBTQ identified or HIV-positive youth.

11. Meet the specific health care needs of transgender youth

Transgender youth have unique health care needs that often go unmet due to institutional ignorance, fear, stigma, or discrimination. By law, however, state facilities are obligated to provide medically appropriate and culturally sensitive health care to all youth, including transgender youth, who are in their custody. Specifically, when a state takes custody of a juvenile, it has an obligation to ensure the health and safety of juveniles in its care.⁴

To demonstrate competency, participants will be able to:

- Understand legal responsibilities to provide appropriate medical and mental health care to all youth, including transgender youth.
- Understand state, local or facility rules or policies for the housing of transgender youth, and recognize why some youth's gender presentation may diverge from that of the majority at the facility.
- Demonstrate the ability to identify competent medical and mental health professionals who can evaluate and provide treatments to transgender youth in state custody.
- Understand the importance of implementing the treatment recommendations made by a medical professional with expertise in providing care to transgender youth.
- Identify at least three steps professionals should take to ensure that transgender youth in custody are receiving the medical treatments they need from supportive providers with expertise in this area.

12. Appreciate and understand the need for these competencies and make an investment in the process.

⁴ See, e.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982), where the Supreme Court held that those who are in state custody but have not been convicted of a crime are entitled to an even more protective standard of care than those convicted of a crime. Although the Supreme Court has not explicitly applied *Youngberg* to minors in custody, the reasoning of *Youngberg* applies at least equally to these minors, of whom the state assumes custody through civil proceedings. This more protective standard applies even to those in juvenile detention facilities because, when a minor commits an act that constitutes a crime if committed by an adult, the minor is adjudicated delinquent in a civil action rather than convicted of a crime (See *DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 189, 209 n.9 (1989)). Because juvenile institutions are legally deemed “noncriminal and nonpenal” in nature, “juveniles . . . who have not been convicted of crimes, have a due process interest . . . which entitles them to closer scrutiny of their conditions of confinement than that accorded convicted criminals.” *A.J. v. Kierst*, 56 F.3d 849, 854 (8th Cir. 1995) (internal quotations omitted). Indeed, the Constitution in general provides youth in state custody with stronger protections than civilly committed adults. As the Eighth Circuit has stated, “the evolving standards of decency against which courts evaluate the constitutionality of conditions certainly provide greater protections for juveniles than for adults.” See *Kierst*, 56 F.3d at 854.

If staff members are going to follow through with concepts explained at trainings, they must understand why what they are learning is important and be able to demonstrate a commitment to supporting the youth in their care.

To demonstrate competency, participants will be able to:

- Articulate their legal and ethical responsibilities to treat all youth fairly and with respect.
- Understand the positive impact that educated and sensitive adults can have on youth in state custody.
- Understand that youth will follow the positive example of staff members as easily as they will follow disrespectful behavior by staff.

Appendix:

Sexuality and Healthy Relationships, Sexual Orientation, and Gender Roles and Identity

This section provides supplemental materials for staff and trainers on key information pertaining to sexuality, sexual orientation, and gender roles and gender identity. The following was adapted from the Teen SENSE Model Sexual Health Education Standards.

Sexuality and Healthy Relationships

- Staff should be able to understand the concept of sexuality as the expression of human sexual feeling and a natural, healthy part of being human.
 - Staff should be able to discuss the concept of sexuality as including how a person feels about his or her body, whether a person feels masculine or feminine or somewhere in between, the way a person dresses, the way a person moves, how a person speaks, who the person is attracted to and falls in love with and the way a person acts and feels about other people in general. Staff should be able to address other aspects of sexuality that are not listed above, as this list is not meant to be exclusive.
 - Staff should understand that sexuality is multifaceted and has biological, social, psychological, spiritual, ethical, and cultural dimensions.
 - Staff should understand that most people, regardless of biological sex, gender, age, ability, and culture are sexual beings, though sexual expression is not necessarily a significant part of some people's lives.
 - Staff should be able to identify how sexuality can be more rewarding and positive when expressed in a non-exploitive way.
 - Staff should understand that sexuality is experienced in a variety of ways at different stages and points in people's lives, and that everyone has his or her own way of expressing his or her sexuality to others and feeling or experiencing it for himself or herself.

Sexuality, Society, and Culture

- Sexuality & Society:
 - Staff should be able to discuss the messages society gives youth about how they are supposed to act, date, and sexually behave; how these messages can often conflict with messages from their family and community; how these messages may differ depending on their gender and age; and how these messages contribute to peer pressure. Staff should understand the diversity of views on sexuality and the importance of making independent decisions.
 - Staff should practice the ability to critically evaluate messages from different sources and establish guidelines for their own behavior.
- Sexuality & the Media: Staff should be able to discuss and describe the profound effect media has on sexual information, values, and behavior; ways in which the media's portrayal of sexuality is realistic and unrealistic; and the messages youth have received from television, movies, music videos, and on the internet, including whether these messages are accurate.
 - Staff should be able to identify stereotypes reflected in the media and how these stereotypes can negatively affect them and their opinion about certain groups of people, including LGBTQ individuals, and gender roles.

- **Sexuality & Religion:** Staff should be able to discuss and describe how various religions' views about sexuality affect people's sexual attitudes, behaviors, and sexual decision-making and the conflict that can occur between people's values and religious beliefs in the context of sexuality.
 - Staff should understand how gender roles and beliefs about sexual orientation have historically been affected by religion and how, although LGBTQ people have historically been excluded from many religious congregations, a growing number of congregations now openly welcome members of the LGBTQ community. Staff should be encouraged to discuss ways that religion has affected their feelings about sexuality or the feelings of someone they know.
- **Sexuality and the Law:** Staff should be familiar with the U.S. laws governing sexual and reproductive rights. This particularly pertains to the following:
 - The Supreme Court has ruled that, to a certain extent, people have the right to make personal decisions concerning sexuality and reproductive health matters, such as abortion, contraception, sterilization, and engaging in same-sex sexual relationships.
 - State laws govern the age of consent for sexual behaviors.
 - Some states and cities have passed laws banning discrimination on the basis of sexual orientation. Staff should be familiar with relevant laws in their city or state.
 - The Supreme Court recently ruled that state laws restricting certain types of sexual behavior between consenting adults are unconstitutional. Consenting adults, regardless of gender or sexual identity, cannot be criminally prosecuted for engaging in a sexual relationship.
 - Courts across the United States are currently debating legal issues concerning same-sex marriage and many states have passed same-sex marriage bills.
 - Public nuisance behavior, such as exhibitionism and voyeurism, are illegal in most states.
 - Prostitution is illegal in all states except for Nevada.
 - Child pornography – a visual depiction of a minor engaging in sexually explicit conduct – is illegal in all states.
 - Some federal and state laws protect individuals from harassment in jobs, schools, and state institutions if the harassment is based on the individual's sex, identified or perceived sexual orientation, or gender identity.

Sexual Orientation

- Staff should understand that:
 - Sexual orientation refers to a person's physical and/or romantic attraction to an individual of the same and/or different gender,
 - Sexual orientation can fall across a spectrum, and that one's understanding and identification of his/her sexual orientation may change over the course of his/her lifetime. Staff should understand that sexual orientation is only one aspect of who a person is. Staff should also understand that gay and lesbian romantic relationships are just as fulfilling as heterosexual relationships and that LGBTQ people may form families and have children just as successfully as heterosexual people.
 - Staff should understand that LGBTQ and heterosexual people come from all countries, cultures, races, ethnicities, socio-economic backgrounds, and religions, and that scientific theories have concluded that sexual orientation cannot be changed by therapy or medicine.

- Staff should be able to identify discrimination against, rejection of, and harassment of LGBTQ youth by peers, family, schools, and others. Staff should also be able to identify the effects such behavior can have on LGBTQ youth. Such effects include causing LGBTQ youth to be afraid to identify as LGBTQ and at increasing risk of depression, dropping out of school, homelessness, and substance abuse.
- Staff should understand that people of all sexual orientations deserve respect and have the right to express their sexual orientation and identity. Staff should be able to discuss strategies for reporting harassment of themselves or others based on sexual orientation.
- Staff should be able to identify and discuss the concepts of heterosexism, internalized homophobia, and how such phobias can contribute to LGBTQ adolescent isolation.
- Staff should understand the concept of coming out and why coming out can be important to an individual.
- Staff should be able to identify the additional challenges and threats LGBTQ youth of color may face due to both racism and homophobia.
- Staff should understand how the above listed challenges can lead to increased mental health difficulties, such as depression and increased substance abuse among LGBTQ youth. Staff should understand that, despite these challenges, the majority of LGBTQ youth lead normal, productive lives and develop resilient adaptations to social biases and mistreatment.

Gender Roles & Gender Identity

- Staff must be able to define gender roles, gender identification, and gender stereotypes. Staff should understand that gender identification may include male, female, or other (e.g. intersex, cross-gender, etc.) identification. Gender expression may not necessarily match gender identity. Staff should also understand that the way a person expresses his or her gender does not necessarily have anything to do with whether that person is heterosexual, gay, lesbian, or bisexual.
- Staff should understand and be able to recognize and describe the following definitions and concepts:
 - **Transgender**: “Transgender” describes people whose internal sense of gender (gender identity) doesn’t match what society expects of them based on their biological sex. Transgender is also used as a general term to describe many different identities that exist such as “transsexual,” “drag king,” “drag queen,” “crossdresser,” “genderqueer,” “shapeshifter,” bigendered,” and “androgynous.” Transgender people are often described as: Male-to-female (M-to-F), or Female-to-male (F-to-M), or by the gender they currently identify with (“male identified” or “female identified”).
 - **Transsexuals**: described people who have had, are in process of, or are planning sex-reassignment surgery. They may also use hormonal means to change parts of the body to match their own understanding of gender without having a complete genital sex-reassignment surgery.
 - **Androgynes**: describes androgynous presentation. Androgynous behavior combines both genders or is gender-neutral.
- Staff should be able to understand the concept of gender identity as something that may change over the course of an individual’s lifetime, and that transgender people report experiencing conflict over gender assignment throughout childhood and adolescence.
- Staff should understand that gender identity is just one part of who a person is and discuss the need to respect people of all gender identities. Staff should be able to identify gender

discrimination, harassment, and violence, discuss the harms of discriminating against someone because of their gender identity, the impact that it has on individuals, and the need to report discrimination to a trusted adult, school official, or law enforcement authority.

- Staff should be aware that there is some federal, state, and local legal protection from discrimination based on gender identity, and youth should be aware of the laws in the city and state in which they reside.

APPENDIX 4

HUMAN SERVICE STANDARD CONTRACT

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

AGREEMENT dated ____ between the CITY OF NEW YORK ("CITY") acting by and through its Department of _____ ("Department"), having an office located at _____, and _____ ("Contractor") a [not-for-profit][for-profit] corporation having its principal office located at _____.

[AGENCIES MAY INSERT APPROPRIATE WHEREAS CLAUSES. THE FOLLOWING CLAUSES ARE ILLUSTRATIVE RATHER THAN REQUIRED.]

WHEREAS, Contractor provides services to _____; and

WHEREAS, the Department procured those services through [or insert other procurement method here or provide whatever description of the procurement process the agency chooses] and

WHEREAS, Contractor, having been awarded the Contract, is ready, willing and able to perform;

NOW, THEREFORE, the parties agree as follows:

ARTICLE I — DEFINITIONS

Section 1.01 Definitions

The following words and expressions, or pronouns used in their stead, shall, wherever they appear in this Agreement, be construed as follows, unless a different meaning is clear from the context:

A. "Board of Directors" or "Board" means the board of directors, board of trustees or a similar body vested with the duty and responsibility for management and oversight of Contractor's affairs as they relate to its performance under this Agreement.

B. "Budget" shall mean the line-item costs and/or the performance based measures or fee-for-service rate schedule attached hereto as Appendix C.

C. "City" shall mean The City of New York.

D. "Commissioner" or "Agency Head" shall mean the head of the Department or his or her duly authorized representative. The term "duly authorized representative" shall include any person or persons acting within the limits of his or her authority.

E. "Comptroller" shall mean the Comptroller of the City of New York.

F. "Contractor" shall mean the entity entering into this Agreement with the Department.

G. "Department" shall mean the City agency that has entered into this Agreement.

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

H. “Fiscal Agent” shall mean an entity (if any) retained by the Department, or retained by the Contractor at the direction of the Department, to issue payments to third parties on behalf of the Contractor or otherwise to assist the Contractor in the administration of its financial affairs.

I. “Fiscal Manual” shall mean a set of instructions provided by the Department to the Contractor documenting the applicable policies and procedures of the Department for Contractor to use in such matters as record-keeping, bookkeeping, reporting, invoicing and claiming, budgeting, cost allocating, procurement and payroll, as may be amended by the Department. The Fiscal Manual is incorporated by reference and may be found online at [Department’s website]. The Fiscal Manual is not intended to amend the material terms of this agreement with respect to either the Scope of Work, or the terms and conditions of this document or Appendix A.

J. “Law” or “Laws” shall mean the New York City Charter (“Charter”), the New York City Administrative Code (“Admin. Code”), a local rule of the City of New York, the Constitutions of the United States and the State of New York, a statute of the United States or of the State of New York and any ordinance, rule or regulation having the force of law and adopted pursuant thereto, as amended, and common law.

K. “State” shall mean the State of New York.

ARTICLE II — TERM OF AGREEMENT

Section 2.01 Term. The term of this Agreement begins on [] for a period of [] () years through [].

Section 2.02 Renewal. The Department, in its sole discretion, may renew this Agreement [insert # of renewals] for a period of [insert # of years] for each renewal. The Department, in its sole discretion, reserves the right to modify the length of the renewal term listed above, provided that the total term of this Agreement after the exercise of all of the options to renew shall not exceed [] () years. All renewals shall be on substantially the same terms and conditions contained in the Agreement. Any renewal will not be effective unless and until the renewal is registered pursuant to New York City Charter §328. The Department shall renew this Agreement by giving written notice to the Contractor prior to the expiration date of this Agreement and prior to the expiration date of any renewal option. The Department will endeavor to give the Contractor notice ninety (90) days prior to renewal. Failure to give notice at least 90 days prior to renewal shall not impair the Department’s right to exercise its option to renew and shall not invalidate an option exercised by the Department.

Section 2.03 Future funding. Since the period of performance contemplated by this Agreement involves performance by the Contractor in a subsequent City fiscal year(s), funding for this Agreement is subject to the appropriation of funds for such subsequent City fiscal year(s). Contractor also understands that the Department is under no obligation to continue its funding after the expiration of the term of this Agreement.

ARTICLE III — SCOPE OF WORK AND BUDGET

Section 3.01 Scope of work.

A. **Services and Activities.** Contractor shall provide the services and activities in program areas or programs listed and described in the Scope of Work attached hereto as Appendix B.

B. **Healthy food environment.** The City aims to reduce the prevalence of chronic disease, such as obesity, diabetes and cardiovascular disease, by improving dietary intake of its citizens. Accordingly, in addition to the services set forth in Appendix B, the Contractor shall make best efforts to distribute to any staff members providing services to program participants under the Agreement and to program participants funded in whole or in part by this Contract, any healthy food promotional materials provided to the Contractor by the Department.

C. **New York City Food Standards.** This paragraph applies only if this Agreement includes a requirement that the Contractor supply food to program participants as a material part of the client services funded by the Department. The City aims to reduce the prevalence of chronic disease, such as obesity, diabetes and cardiovascular disease, by improving dietary intake of its citizens. Accordingly, the Contractor shall provide a healthy food environment in connection with the client services provided under this Agreement by complying with the attached New York City Agency Food Standards with regard to the provision of food to program participants under this Agreement, including compliance with the New York City Food Standards for beverage vending and food vending machines (<http://www.nyc.gov/html/doh/html/cardio/cardio-vend-nutrition-standard.shtml>) for any vending machines to which program participants are granted access.

Section 3.02 Budget. Contractor shall provide such services and activities in accordance with the Budget. Contractor may request modifications to the Budget in the manner prescribed in the Fiscal Manual.

Section 3.03 Payment. The Department shall pay the Contractor an amount not to exceed \$_____ (_____ dollars) for all services provided under the Agreement. Payment shall be made in accordance with the Budget and the Fiscal Manual. *[The Department must insert a provision stating the terms of payment (e.g., deliverables, unit prices, line item budget reimbursement)].* This Agreement shall not obligate the Department beyond the dollar amount designated as the maximum contract amount in the absence of a duly executed written contract amendment registered pursuant to section 328 of the New York City Charter.

Section 3.04 Cost allocating and duplication.

A. **Duplication.** Contractor represents and warrants that the work to be performed under this Agreement shall in no way duplicate any work performed under other agreements between the City and Contractor, nor under any agreement with any other governmental funding source, except upon the express written permission of the Department. Costs attributable to the program and not paid for by the City are not duplication (e.g. program enhancements, unreimbursed portions of staff salaries) but are subject to the cost allocation provisions set forth below. Noncompliance with this Section shall constitute a material breach of this Agreement.

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

B. **Cost allocation plan.** Contractor shall accurately and equitably allocate costs which are attributable to the operation of two or more programs among such programs, or which are costs attributable to two or more governmental funding sources, by a method which represents the benefit of such costs to each program or funding source. The Contractor shall upon commencement of services or as soon thereafter as practicable develop and deliver to the Department a cost allocation plan for the Department's approval.

C. No cost allocation plan shall be approved by the Department unless such a plan:

1. Relates to allowable costs as defined in applicable laws, regulations and policies of the federal, State and City governments;
2. Relates to costs necessary for the Contractor's performance pursuant to this Agreement;
3. Fairly and accurately reflects the actual allocable share of such cost with respect to this Agreement;
4. Is developed in accordance with generally accepted accounting principles; and
5. Is accompanied by such supporting documentation as the Department deems necessary to evaluate the plan.

D. A cost allocation plan approved by the Department may be modified with the written approval of the Department.

E. Notwithstanding any provision in this Section to the contrary, the Department further reserves the right to withhold any payments to the Contractor for allocated costs in the event that the Department determines that the cost allocation plan is unsatisfactory in whole or in part, or determines that such allocated costs have been incorrectly determined, are not allowable, or are not properly allocable pursuant to this Agreement and or approved cost allocation plan.

Section 3.05 Cost Of living increases. Where the Contractor's industry has experienced an increase in costs (*e.g.*, salary, wage or fringe benefit cost of living increases, a change in the prevailing or living wage, a renegotiated collective bargaining agreement, an industry-wide increase in the Producer Price Index (PPI) for fuel or energy) that exceeds the Budget, and the Office of Management and Budget (OMB) or another independent agency has determined in writing that additional funds will be made available to a City agency for the class of contracts pursuant to which the Contractor provides the same or substantially similar services, then the Department shall reimburse the Contractor for such increases in costs to the extent that such increases have been authorized by the City for contracts within such class of contracts and to the extent that funds are appropriated for such purposes. Any cost of living increase will not be effective unless and until an amendment to the contract is registered pursuant to New York City Charter §328.

ARTICLE IV — FISCAL PROCEDURES

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

Section 4.01 Cooperation and compliance. Contractor hereby agrees to fully cooperate and comply with the Fiscal Manual on all fiscal matters related to this Agreement.

Section 4.02 Accounts

A. Contractor shall establish and maintain one or more separate accounts for the funds obtained from or through the City of New York related to this and all other agreements with the City, and shall maintain records for such account to track and clearly identify the funds obligated through this Agreement.

B. Contractor shall notify the Department of the name, locations and account numbers of all bank accounts in which any funds pursuant to this Agreement are maintained, and of any change in the name, location, or account numbers of such accounts within five (5) days of such establishment or change. Such bank shall have a branch located in New York City unless otherwise approved by the Department.

C. Contractor shall notify the Department of the names, titles, and business addresses of such persons authorized by the Contractor to receive, handle or disburse monies under this Agreement, including the company name and company address where such persons are not employees of the Contractor. Such notification must be in writing and furnished to the Department within five (5) days from the execution of this Agreement, and within five (5) days from any subsequent change or substitution of authorized signatories.

Section 4.03 Advance. The amount of any advance to be paid to Contractor under this Agreement shall be determined solely by the Department in accordance with its Fiscal Manual and any applicable Comptroller directives. The funds shall be used exclusively for the payment of expenditures and obligations authorized by and properly incurred pursuant to the Budget.

Section 4.04 Financial records, reporting and invoicing. Contractor shall submit financial reports and invoices to the Department in accordance with the terms of the Fiscal Manual. Any supporting documents required to be maintained by this Agreement or the Fiscal Manual shall be made available for inspection and reproduction by the Department, the City Comptroller, and such other persons as authorized by the Department, including the Inspector General for the Department and the Department of Investigation. Contractor acknowledges that repeated failure to submit required financial reports within the time limits prescribed may result in termination of this Agreement.

Section 4.05 Procurement requirements.

A. **Procurement records.** Contractor shall retain proper and sufficient bills, vouchers, duplicate receipts and documentation for any payments, expenditures or refunds made to or received by Contractor in connection with this Agreement. Contractor may maintain a petty cash fund in accordance with the Fiscal Manual, however, no expenditures may be made from such fund for procurements valued in excess of \$1,000. Contractor shall make all procurement expenditures in excess of \$1,000 by check or credit card.

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B. Extent of competition required. Contractor shall retain records which detail the method of procurement, the basis for selection or rejection of a contractor, consultant or supplier and the basis for the contract price. If federal or State Laws require procurement methods other than those set forth herein, then Contractor shall also comply with such procurement methods.

1. Contractor must solicit and document at least three (3) written estimates for any payment made or obligation undertaken in connection with this Agreement for any purchase of goods, supplies, or services (including but not limited to consulting services) for amounts in excess of \$25,000. The monetary threshold applies to payments made or obligations undertaken in the course of a one (1) year period with respect to any one (1) person or entity. Payments made or obligations undertaken will not be artificially divided in order to avoid the requirements of this paragraph.
2. For any payment made or obligation undertaken in connection with this Agreement for any purchase of goods, supplies, or services (including but not limited to consulting services) for amounts between \$5,000 and \$25,000, Contractor shall conduct sufficient market research and/or competition to support its determination that the price of such purchased goods, supplies, services or equipment is reasonable. The monetary thresholds apply to payments made or obligations undertaken in the course of a one (1) year period with respect to any one (1) person or entity. Payments made or obligations undertaken will not be artificially divided in order to avoid the requirements of this paragraph.
3. The City may retain the services of a Group Purchasing Organization (GPO) to facilitate the purchase of supplies or other items. If the City retains such a GPO, the Department may direct Contractor to utilize the services of such GPO. If the Contractor is directed by the Department to use the GPO or if the Contractor becomes a member of and makes purchases through the GPO retained by the City with or without the City's direction, Paragraph B shall not apply to those purchases and the procurement requirements will be satisfied through the use of the GPO.

C. Equipment. If so directed by the Department, title to all equipment or other property purchased at a price in excess of \$5,000 with funds obtained through this Agreement shall be in the name of the City of New York. Contractor shall properly maintain and keep in good repair all equipment acquired with funds obtained through this Agreement. Contractor shall dispose of such equipment in the manner provided in the Fiscal Manual or as otherwise directed by the Department, and shall maintain detailed records concerning such dispositions. At the Department's request, Contractor must execute a UCC-1 to evidence the Department's interest in equipment purchased at a price in excess of \$25,000 and to enable the Department to perfect that interest by filing or otherwise.

D. M/WBE suppliers. Contractor is encouraged to utilize businesses and individual proprietors listed on the NYC Online Directory of Certified MWBE Businesses, available at www.nyc.gov/sbs, as sources for its purchases of goods, supplies, services and equipment using funds obtained through this Agreement. Contractor is also encouraged to utilize businesses and individual proprietors owned/operated by people with disabilities as sources for its purchases of goods, supplies, services and equipment using funds obtained through this Agreement.

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

E. Disputes with suppliers. Contractor, without recourse to the City or the Department, shall be responsible for the settlement and satisfaction of all contractual obligations and administrative issues arising out of any procurement or leasing contracts paid with funds obtained through this Agreement.

Section 4.06 Limitation on use of funds.

A. Proper purposes. No funds obtained through this Agreement shall be spent for any expense not incurred in accordance with the terms of the Agreement. All such funds shall be administered in accordance with the Fiscal Manual.

B. Real property. No funds obtained through this Agreement shall be spent for the purchase of any interest in or improvement of real property, unless included in the Budget or otherwise authorized in writing by the Department.

C. Disallowed costs. Any cost found by the Department, the City or any auditing authority that examines the financial records of the Contractor to be improperly incurred shall be subject to reimbursement to the City. Failure to make said reimbursement shall be grounds for termination of this Agreement.

Section 4.07 Recoupment of disallowances, improperly incurred costs and overpayments.

The Department may, at its option, either require the Contractor to reimburse the Department or withhold for the purposes of set-off any monies due to Contractor under this Agreement up to the amount of any disallowance or improperly incurred costs resulting from any audits of Contractor, and/or the amount of any overpayment to Contractor with regard to this Agreement or to any other agreement between the parties hereto, including any agreement(s) that commenced prior to the commencement date of this Agreement. Prior to the imposition of withholding for the purposes of set-off, the Department will provide the Contractor with an opportunity to be heard upon at least ten (10) days prior written notice.

Section 4.08 Failure to spend funds. In the event that Contractor fails to spend funds for any part of the Budget within the time indicated therein (i.e., the fiscal year unless otherwise indicated) or at the level of expenditures indicated therein, the Department reserves the right, in its discretion, to recoup any funds advanced and not spent. If Contractor fails to spend funds in the budget, the Department reserves the discretion to reduce the budget going forward to account for the expected future level of expenditures.

Section 4.09 Provisions Applicable When Fiscal Agent Disburses Funds To Contractors

A. Payment by Fiscal Agent. Where the Department has retained a Fiscal Agent to make payments to third parties on behalf of Contractor, then the Contractor is obligated to use the Fiscal Agent to make payment to third parties at the Department's direction, including for the purchase of such goods, supplies, services and/or equipment made by Contractor under this Agreement. Where the Department directs that Contractor utilize a Fiscal Agent, Contractor shall not pay any obligations on its own behalf except to the extent specifically allowed by this Agreement and the Department's Fiscal Manual.

B. Payroll processing by Fiscal Agent. In the event that a Fiscal Agent is processing the Contractor's payroll, Contractor shall deliver to the Fiscal Agent signed and dated time and attendance records for each staff member and consultant to be paid under this Agreement, in the form required and

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

delivered at the time required by the Fiscal Agent and the Department's Fiscal Manual. Subject to the Department's approval, the Fiscal Agent shall prepare the payroll checks and supporting materials based on the documents submitted.

C. Fiscal Agent documentation. Upon reasonable request and approval by the Department, Contractor shall have the right to inspect any fiscal documents relating to this Agreement as may be maintained by a Fiscal Agent, if applicable. Contractor may request from the Department copies of any or all the following documents relating to the funds to be provided hereunder, with said documents to be furnished by the Fiscal Agent, subject to the Department's approval, within a reasonable time of the request: monthly budget and expenditure reports; budgets and budget modifications; and audit reports, where available.

ARTICLE V — RECORDS, DELIVERABLES, AUDITS AND REPORTS

Section 5.01 Records to be maintained. In addition to any other records required to be maintained and/or provided for inspection pursuant to this Agreement, Contractor shall maintain and make available to the Department for inspection, upon reasonable request, the following documents: tax returns; audit reports; all programmatic records and accounts maintained in connection with this Agreement, including program, research and other reports and publications prepared in connection with this Agreement; all financial books, records and accounts reflecting payments made by Contractor for petty cash expenditures in connection with this Agreement; all applicable licenses and permits; Board member lists and all minutes and attendance sheets (dated and signed) for meetings of the Board of Directors and any of its committees responsible for the oversight of the program(s) funded under this Agreement; certificate of incorporation and by-laws; all other contracts related to providing services under this Agreement, to which Contractor is a party and the contract terms coincide, in whole or in part, with the term of this Agreement; and any other records or materials reasonably requested at such reasonable times and places and as often as may be reasonably requested. Contractor shall permit the Department and its authorized representatives including the Department's Inspector General, the Comptroller of the City of New York, the New York City Department of Investigation, or their designees, or other interested federal, State or City agency representatives, to attend all meetings of the Board of Directors and to be present at the program site(s) to observe the work and activities being performed in connection with this Agreement.

Section 5.02 Deliverables and reports. Contractor shall submit the deliverables and periodic reports required by this Agreement, in accordance with the Scope of Work attached hereto. Contractor shall administer such assessment tools, collect and report such data, maintain records, make reports and take such other actions as may be directed by the Department.

Section 5.03 Audit disclaimers. If any audit of Contractor's records shall include a Disclaimer of Opinion relating to any contract with the Department or other funding sources, said Disclaimer shall be ground for termination of this Agreement.

Section 5.04 Federal audit requirements. If applicable, the Contractor shall fulfill the audit requirements of the Federal Office of Management and Budget Circular A-133, "Audits of Institutions of Higher Education and Other Non-Profit Organizations," and shall provide such audit to the Department within thirty (30) days after its receipt of the final audit by the Contractor from the preparing accountant.

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Section 5.05 State charities registration and audit requirements. If the Contractor is required by New York State law to register with and make annual filings to the Charities Bureau of the New York State Department of Law, timely compliance with such requirements shall be deemed a material term of this Agreement. Contractor shall make available to the Department all such filings, including any audit and/or financial report required to be submitted with such filings, within thirty (30) days of receiving such final audit or financial report from its preparer, and in no event later than ten (10) days following the filing of such audit or financial report with the Charities Bureau.

Section 5.06 Additional audit and financial reporting requirements.

A. If any Contractor is exempt from making annual filings to the Charities Bureau of the New York State Department of Law, the Contractor will, at direction of City, provide the City with annual disclosure reports equivalent to those filings that Contractor would have filed with the State had they been required to file. As of the effective date of this Agreement, the requirements are as follows:

1. Contractors with gross revenues between \$100,000 and \$250,000 in any fiscal year shall file an annual financial statement with the Department, which includes an independent certified public accountant's review report in accordance with the "statement on standards for accounting and review services" issued by the American Institute of Certified Public Accountants. The financial statement shall be prepared in conformance with generally accepted accounting principles (GAAP), including compliance with all pronouncements of the Financial Accounting Standards Board and the American Institute of Certified Public Accountants that establish accounting principles relevant to not-for-profit organizations.

2. Contractors with gross revenues in excess of \$250,000 shall file with the Department an annual audit report by an independent certified public accountant. Said audit report shall contain an opinion, signed by such certified public accountant that the financial statements are presented fairly in all material respects and in conformity with GAAP, including compliance with all pronouncements of the Financial Accounting Standards Board and the American Institute of Certified Public Accountants that establish accounting principles relevant to not-for-profit organizations, and that the financial sheet and balance sheet present fairly the financial operations and position of the organization. The financial report must be signed by the president or other authorized officer and the chief fiscal officer under penalties of perjury that the statements are true and correct to the best of their knowledge.

B. Contractors receiving funds pursuant to this Agreement in excess of \$1,000,000 will, at direction of City, provide to the Department an audit report from an independent certified public accountant containing an opinion that the Contractor has appropriately allocated costs in accordance with the terms of the Agreement, including that the costs have not been improperly double-charged between multiple City and/or State contracts or between multiple governmental funding sources. The Contractor may satisfy this requirement by including the appropriate analysis in any audits required pursuant to Section 5.04 or 5.05.

C. The Contractor must submit all required audit and financial reports under this Section to the Department within thirty (30) days after receipt of the final audit from its accountant, but in any event no later than twelve (12) months after close of the audit period, or such longer period as determined by the

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Department. The audit and financial reports shall comply with the applicable provisions in the Fiscal Manual throughout the term of this Agreement, including terms mandating the audit period and frequency of such audits and reports.

D. The Department may in its sole discretion conduct its own programmatic or financial audits of the Contractor.

ARTICLE VI — PERSONNEL PRACTICES AND RECORDS

Section 6.01 Definition of employee. The term "employee" as used in this Article shall be limited to salaried personnel and shall include neither consultants under contract to the Contractor to provide specified services nor participants in the program who are being paid as trainees.

Section 6.02 Compensation of key employees and Board of Directors.

A. Key employee list. Contractor shall submit to the Department within thirty (30) days of the execution of this Agreement and at the beginning of each new fiscal year a list of its key employees, which shall include the Executive Director, Chief Financial Officer, Chief Operating Officer, or the functional equivalent of such positions, and the senior financial and programmatic supervisory personnel involved directly or indirectly in the performance of this Agreement. For each listed employee, Contractor shall provide the current total compensation (including all benefits), all sources of the employee's total compensation, whether from this contract or another City, State, Federal or private source, and the dollar amount of compensation from each such source.

B. Vacancies. Contractor shall notify the Department in writing within ten (10) days of their occurrence any appointments to or resignations from the positions of Executive Director, Chief Financial Officer and/or Chief Operating Officer, and/or the senior programmatic supervisory personnel or the functional equivalent of such positions.

C. Board compensation. Contractor shall submit to the Department within thirty (30) days of the execution of this Agreement and at the beginning of each new fiscal year a listing of all members of its Board of Directors and identify any of its members who receive compensation in any form, including but not limited to salary, stipend, per diem payments and/or payments for services rendered, from the Contractor or its affiliates, together with the amount of any such compensation, regardless of the source of its payment, and a description of its purpose.

Section 6.03 Collective bargaining. Contractor acknowledges that neither the City nor the Department is responsible or shall be liable for any obligations contained in any agreement into which Contractor or a representatives of Contractor has entered concerning the collective bargaining rights or benefits of its employees paid in full or in part by funds provided through this Agreement. Furthermore, Contractor agrees to abide by all applicable Laws governing the use of funds in connection with union activities.

Section 6.04 Recruitment and hiring of staff.

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A. Maintenance of skilled staff. Contractor shall maintain sufficient personnel and resources, including computer technology, to deliver the services described in the Scope of Work and perform necessary administrative functions throughout the term of this Agreement, including but not limited to: program evaluation; program monitoring; program research and development, including the preparation of reports required by this Agreement; fiscal reporting, review, audit, and close-out of the Program; and implementation of any corrective actions required by the Department.

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B. Background checks.

1. The Contractor shall be responsible for the recruitment and screening of employees and volunteers performing work under the Agreement, including the verification of credentials, references, and suitability for working with clients and participants. Where consistent with State and federal law, if directed by the Department, the Contractor will undertake the fingerprinting of employees and volunteers, including applicants, in accordance with instructions from the Department.

2. The Contractor shall comply with Article 23-A of the New York State Correction Law and Section 296(15) and (16) of the New York State Executive Law when considering an applicant's prior criminal convictions in determining their suitability for employment. In accordance with Article 23-A, nothing in this Agreement shall be construed to limit a Contractor's authority to withdraw conditional offers of employment for any lawful reason, including the determination that the candidate has a conviction that bears a direct relationship to the duties and responsibilities of the position sought, or their hiring would pose an unreasonable risk to property or to the safety of individuals or the general public.

3. With respect to any employment governed by Article 23-A of the Correction Law or Section 296 of the New York State Executive Law, except where the Contractor obtains prior written approval from the Department, the Contractor shall not ask questions regarding an applicant's prior criminal convictions, juvenile delinquency adjudications, or youthful offender adjudications on any preliminary employment application documents or ask questions about an applicant's prior criminal convictions, juvenile delinquency adjudications, or youthful offender adjudications before or during the first interview with the applicant.

4. Consistent with the requirements of Executive Law §296(15) and (16), following the first interview, the Contractor may ask applicants to disclose their prior criminal convictions and any arrests or criminal accusations that are pending and have not been terminated in favor of the applicant. Agencies shall limit their review and consideration of an applicant's criminal convictions to (i) an individual's felony convictions in the state of New York or in any other jurisdiction; (ii) an individual's unsealed misdemeanor convictions in the state of New York or in any other jurisdiction; and (iii) any pending charges against the applicant. Consistent with State law, past arrests not leading to a criminal conviction shall not be considered. (Please note that, pursuant to Section 380.1 of the Family Court Act, juvenile delinquency adjudications are not criminal convictions. Also, pursuant to Section 720.35(1) of the Criminal Procedure Law, a youthful offender adjudication is not a criminal conviction.) In addition, the Contractor may request a waiver from the Department of any provision of this Section and be permitted to ask relevant questions pertaining to the qualifications to hold a specific position, upon demonstrating the need for such waiver.

5. Notwithstanding any other provision of this Section, if the Contractor is hiring for positions requiring licensure, including positions such as interns and apprentices for such licensed positions (e.g. prospective attorneys), the Contractor may ask applicants the same questions asked by the licensing body, in accordance with New York State law. In addition, if the Contractor is hiring for positions where certain convictions or violations are a bar to employment in that position under Law, the Contractor may ask questions about those convictions or violations.

6. Where practicable, the Contractor shall provide for the review by a supervisor of a decision not to hire based on prior criminal convictions.

C. Drug-free workplace.

1. Contractor shall conspicuously post at any facility at which activities funded in whole or in part through this Agreement occur, a statement notifying all staff that the manufacture, distribution, dispensing, unauthorized possession, and unauthorized use of controlled substances are prohibited and specifying the actions that will be taken against employees for violation of such prohibition (the “Drug-Free Workplace Policy”). Contractor shall provide a copy of the Drug-Free Workplace Policy to each staff member as part of his or her initial employment orientation with Contractor, and shall inform such staff member that compliance with the terms of the Drug-Free Workplace Policy is a mandatory condition of employment or retention of employment. Contractor shall provide the Department with a written certification that its Facility complies with the Drug-Free Workplace Policy prior to commencement of services funded through this Agreement.

2. Contractor shall provide an on-going drug-free awareness program to inform all staff about the dangers of drug abuse in the workplace; the Contractor’s enforcement of its Drug-Free Workplace Policy; the availability of drug counseling, rehabilitation and employee assistance programs; and the penalties that may be imposed upon staff and clients or participants for violating the Drug-Free Workplace Policy.

3. Contractor shall require staff members to notify Contractor in writing of his/her arrest or conviction for violation of a criminal drug statute occurring in the workplace no later than five (5) calendar days after such arrest or conviction. Contractor shall thereafter notify the Department within ten (10) calendar days of Contractor’s receipt of the above-described notice of conviction from a staff member or of the date Contractor otherwise received actual notice of such conviction.

4. Contractor shall take one of the following actions within thirty (30) calendar days of receiving notice of such a conviction with respect to any staff member so convicted: (a) appropriate personnel action, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or (b) requiring such convicted staff member both to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, State, or local health, law enforcement, or other appropriate agency, and to make a good faith effort to continue to abide by the Drug-Free Workplace Policy.

ARTICLE VII — PROGRAM FACILITY

Section 7.01 Suitability. Contractor shall maintain all facilities used for the provision of services funded in whole or in part through this Agreement, whether owned, leased, or used pursuant to an in-kind agreement or arrangement, whether permanent or temporary, in a condition suitable to provide services pursuant to this Agreement.

Section 7.02 Signage. Upon request by the Department, and consistent with applicable Laws and applicable lease and license requirements, Contractor will prominently display signs inside and outside the facility(ies) used for the program indicating such information as the program name, its sponsorship by the Department, the program activity and the days and hours of operation. In addition,

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Contractor shall prominently display inside the facility(ies) all signs, provided by the Department, if any, advising of any of the Contractor's obligations with regard to Equal Employment Opportunity laws.

Section 7.03 Security and emergency plan.

A. Prior to the commencement of services under this Agreement, Contractor shall adopt, implement, and instruct staff regarding a written plan to provide for the safety and security of clients, participants, staff, and the Contractor's facility, including procedures to follow during emergencies. Contractor shall maintain a current file of emergency contacts for each client and participant, which shall include the names, addresses, telephone numbers, and locations where such contacts can be reached. A security plan applying to all of Contractor's operations rather than specifically to the City-funded operations shall be sufficient to comply with the terms of this requirement. The Contractor shall cooperate with the City during any emergency affecting the Contractor's services and/or facilities.

B. In the event that a State of Emergency (SOE) is declared by the Mayor of the City, the City may suspend Contractor's normal operations until further notice. No damages shall be assessed for suspension of normal services during this time. All other terms and conditions of this Agreement shall remain in effect, except as modified by a contract amendment registered pursuant to Charter §328 or other appropriate contract action. The Contractor may, at the request of and in a manner determined by the Department, assist the Department in carrying out emergency procedures during a State of Emergency. Emergency procedures shall remain in effect until the Mayor has determined that the SOE has expired. In consideration thereof, the City agrees to indemnify the Contractor against all claims by third parties arising out of the actions of its employees during the SOE that are directed by the City and not otherwise required to be performed under this Agreement, except for those arising out of the employees' gross negligence or intentional misconduct.

ARTICLE VIII — CENTRAL INSURANCE PROGRAM

Section 8.01 Availability. If offered to Contractor by the Department, participation in the City-sponsored Central Insurance Program (CIP) plan shall satisfy Contractor's responsibility to obtain any of the types of insurance provided under such CIP plan. The Department may facilitate the provision of this insurance plan as a convenience for Contractor and for the protection of the City. Provision of these plans through the Department is in no way an admission by the Department or the City of liability for acts, omissions or negligence of Contractor or its employees.

Section 8.02 Cancellation. The Department reserves the right to cancel or modify any CIP plan offered to Contractor as it deems advisable, and at such time as it deems advisable, in its sole discretion. In such event, or in the event of cancellation by the insurers, the Department will promptly notify Contractor. Contractor must maintain all required insurance at all times during the term of this Agreement either through participation in the CIP plan or through insurance obtained separately by the Contractor.

Section 8.03 Notification concerning occurrence of incidents. If Contractor is enrolled in the CIP plan, upon the occurrence of any injury to any client/participant, employee, volunteer, officer, visitor, or any other person, in conjunction with the services funded in whole or in part through this Agreement, and/or of any damage to the facility or any damage to or theft of equipment purchased with funds paid

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under this Agreement, Contractor shall provide telephone notice to the Department within twenty-four (24) hours of the incident, followed by a written report on the approved Incident Report Form to be delivered to the Department within three (3) business days.

ARTICLE IX — REPRESENTATIONS AND COVENANTS OF CONTRACTOR

Section 9.01 Eligibility. Contractor represents and warrants that it has complied and continues to comply with the eligibility requirements set out in the solicitation document (e.g., the request for proposals) under which it proposed for and was awarded this Agreement. Any material change in the eligibility compliance information supplied in Contractor's contract proposal must be reported to the Department within a reasonable time thereof. Failure to do so will be deemed a material breach of this Agreement and could result in termination of this Agreement.

Section 9.02 Program services.

A. Except where expressly set forth in the Scope of Work and approved by the Department, Contractor represents and warrants that eligibility for admission to the services funded through this Agreement shall not be restricted on the basis of race, color, creed, national origin, alienage or citizenship status, gender, gender identity, sexual orientation, disability, marital status, arrest or conviction record, status as a victim of domestic violence, lawful occupation, and family status.

B. Contractor further represents and warrants that no clients or participants shall be charged a fee or required to make any other payment or purchase or participate in any activity designed to raise funds as a condition of eligibility for or participation in the services funded through this Agreement, except as required by law or unless a waiver of this provision is approved in writing by the Department. Waivers may be considered under the following conditions: (i) Contractor's total costs for the Services set forth in the Scope of Work exceed the total value of the Agreement; (ii) Contractor's fees for Services and/or the arrangements made to include those participants unable to pay such fees are deemed reasonable and appropriate by the Department; and (iii) the fees are set at a level that does not discourage or impede participation by members of the community to be served by the services.

Section 9.03 Allegations of abuse or maltreatment. Contractor will notify the Department within twenty-four (24) hours of promptly determining that reasonable cause exists to suspect that any of Contractor's administrators or staff, including both paid and volunteer, has abused, maltreated, neglected, assaulted or endangered the welfare of any program participant. In addition, if such reasonable cause is found, the Contractor shall take appropriate action to remove the person from the proximity of program participants while the matter is being investigated by the Contractor. The term abuse shall mean the infliction of physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ. The term maltreatment shall mean (i) treatment that results in serious physical injury other than by accidental means, or (ii) neglect or failure to exercise a minimum degree of care that impairs, or places in imminent danger of being impaired, the physical, mental or emotional condition of a program participant. Contractor shall provide telephone notice to the Department within 24 hours of determining that reasonable cause exists, followed by a written report, to be delivered to the Department within three (3) business days. Compliance with this

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

reporting requirement does not satisfy any other legally mandated reporting of abuse, such as to the New York State Central Registry (SCR).

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

ARTICLE X — MISCELLANEOUS

Section 10.01 Headings. The article and paragraph headings throughout this Agreement are for convenience and reference only and the words contained therein shall in no way be deemed to define, limit, describe, explain, modify or add to the interpretation or meaning of any provision of this Agreement or the scope or intent thereof, nor in any way affect this Agreement.

Section 10.02 Order of priority. During the term of the Agreement, conflicts between the various documents shall be resolved in the following order of precedence, such documents constituting the entire Agreement between the parties:

- Standard Human Services Agreement (this document);
- Appendix A (General Provisions Governing Contracts for Consultants, Professional, Technical and Human Client Services);
- Appendix B (Scope of Work);
- Appendix C (Budget); and
- Fiscal Manual.

ARTICLE XI— SUPPORTIVE SERVICES AND TECHNICAL ASSISTANCE

Section 11.01 Availability of supportive services and technical assistance. At its sole discretion, the City may provide, either directly or through its designee, technical assistance to Contractor in such areas as: (1) program planning, development, coordination and dissemination of information; (2) preparation of reports and materials required by the City and/or other governmental entities with jurisdiction over Contractor's activities relating to the operation of services funded through this Agreement; (3) compliance with applicable Laws, guidelines and administrative memoranda; and/or (4) issues or matters affecting Contractor's performance under this Agreement.

Section 11.02 Training. At its sole discretion, the City may provide, either directly or through its designee, training/technical assistance to Contractor's employees and Board members, relating to the management and operation of the program funded through this Agreement. If training and/or technical assistance is made available, Contractor must commit appropriate employees and board members to attend/participate at training sessions, as instructed by the City or its designee. Failure to do so may negatively affect Contractor's performance rating, which could in turn lead to termination of this Agreement.

Section 11.03 Capacity Building and Oversight (CBO) Review for not-for-profit Contractors. If requested by the Department, the Contractor must complete the Mayor's Office of Contract Services (MOCS) Capacity Building and Oversight (CBO) Review process. As part of that process, the Contractor must submit specified documents to the CBO unit of MOCS, which then conducts an evaluation of the Contractor and its operations for compliance with the terms of its contracts, its own by-laws, internal fiscal controls, applicable laws and regulations, and best practices in not-for-profit organization administration. The specified documents may include, but are not limited to, the Contractor's Internal Revenue Service ("IRS") determination of tax exemption, the most recent IRS Form 990 filing; the most recent audited financial statement (including the auditor's letter to the

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management), the functional budget for the current fiscal year in the format approved by the Board of Directors, an organizational chart identifying key staff by title, a copy of the most recently-approved Board Minutes, the by-laws of the corporation, a roster of the membership of the Board of Directors and a list of Board committees, the Contractor's current policies and procedures as adopted, and any other organizational documents, whether or not they are specifically required to be maintained pursuant to this contract or applicable laws and regulations. In the course of the CBO review process, MOCS may make recommendations to the Contractor, request the Contractor to take certain remedial actions and/or to implement certain policy changes. Any such recommendations, and the Contractor's responses thereto, will be provided to the Department for its consideration and any appropriate actions under this contract.

Section 11.04 Disclaimer. The technical assistance and training that the Department, in its sole discretion, may provide to Contractor shall not be construed to be a condition precedent to Contractor's obligation to provide the services funded through this Agreement in accordance with the Scope of Work.

ARTICLE XII – APPENDIX A

Section 12.01 Appendix A. The attached Appendix A, “General Provisions Governing Contracts for Consultants, Professional, Technical, Human and Client Services” is incorporated and made a part of this Agreement.

IN WITNESS WHEREOF, the parties have duly executed this Agreement on the date first above written.

CITY OF NEW YORK

By:

CONTRACTOR

By:

Title:

Fed. Employer I.D. No. or Soc. Sec. No.

Approved as to Form and
Certified as to Legal Authority

APPENDIX 4 – STANDARD HUMAN SERVICE CONTRACT

Acting Corporation Counsel

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ACKNOWLEDGEMENT BY CITY

STATE OF NEW YORK)

:ss:

COUNTY OF NEW YORK)

On this ____ day of _____ 20 ____, before me personally came _____, to me known and known to me to be _____ of the NEW YORK CITY DEPARTMENT OF [INSERT NAME], the person described in and who is duly authorized to execute the foregoing instrument on behalf of the Commissioner, and he/she acknowledged to me that he/she executed the same for the purpose therein mentioned.

Notary Public or Commissioner of Deeds.

ACKNOWLEDGMENT OF CONTRACTOR IF A CORPORATION

State of _____ County of _____ ss:

On this ____ day of _____ 20 ____ before me personally came _____, to me known, who, being by me duly sworn did depose and say that he/she resides at _____; that he/she is the _____ of the corporation described in and which executed the foregoing instrument; and that he signed his name to the foregoing instrument by order of the directors of said corporation as the duly authorized and binding act thereof.

Notary Public or Commissioner of Deeds.

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ACKNOWLEDGMENT OF CONTRACTOR IF A PARTNERSHIP

State of _____ County of _____ ss:

On this _____ day of _____ 20 _____ before me personally came _____ to me known, who, being by me duly sworn did depose and say that he/she resides at _____; that he/she is _____ partner of _____, a limited/general partnership existing under the laws of the State of _____, the partnership described in and which executed the foregoing instrument; and that he/she signed his/her name to the foregoing instrument as the duly authorized and binding act of said partnership.

Notary Public or Commissioner of Deeds.

ACKNOWLEDGMENT OF CONTRACTOR IF AN INDIVIDUAL

State of _____ County of _____ ss:

On this _____ day of _____ 20 _____ before me personally came _____ to me known, who, being by me duly sworn did depose and say that he/she resides at _____, and that he/she is the individual whose name is subscribed to the within instrument and acknowledged to me that by his/her signature on the instrument, said individual executed the instrument.

Notary Public or Commissioner of Deeds.

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Public Assistance Hiring Commitment Rider for HRA, DHS, and ACS

A. Except as otherwise provided by subsection G below, Contractor agrees as a condition of this Agreement, to hire at least one Public Assistance Recipient ("PA Recipient") for each \$250,000 in value of this Agreement, or to the extent that the Contractor enters into other contracts with the Department of the City, for each \$250,000 of the cumulative value of contracts of the Contractor during the term of this Agreement.

B. Such hiring shall be for full-time employment of at least a minimum of thirty-five (35) hours per week. The rate of pay shall be at least 20% above the federal minimum wage, and the duration of the employment shall be for at least one (1) year. In the event that a replacement of a PA Recipient is made by the Contractor during the one (1) year, such replacement shall not count as an additional employee toward Contractor's hiring requirement set forth herein.

C. Within thirty (30) days of the commencement date of this Agreement ("commencement date") or fifteen (15) days following notice from the Department that a request for an exemption from the provisions of this Rider has been denied, Contractor shall submit, on forms specified by the Department, information and specifications for the position(s) available.

D. The Contractor may at its option request the assistance of the Department in identifying potential employees. In such case, the Department will refer PA Recipients to the Contractor for employment interviews.

E. Contractor shall hire the number of employees agreed upon pursuant to this Section within ninety (90) days of the commencement date or such longer period as may be specified, in writing, by the Department.

F. In the event Contractor fails to hire the required number of PA Recipients within the required time period, or fails to pay and retain such employees pursuant to the above requirements, Contractor shall pay to the Department or the Department may at its option, deduct from monies due or become due to Contractor, the amount of nineteen dollars and eighteen cents (\$19.18) per employee for each calendar day for which such PA Recipient(s) is/are not employed by Contractor as required by this Article. Such amount is hereby fixed and agreed as liquidated damages.

G. Contractor may apply to the Department for exemption from all or part of the requirements of this Article. Any application for an exemption must be made before the expiration of thirty (30) days after the commencement date of this contract, or any subsequent contract as discussed in subsection 1 herein, and shall be in the form specified by the Department. Exemption may be granted upon a showing that the operation of this Section will constitute an extreme hardship, within the sole discretion of the Department; or to any Contractor not employing twenty (20) or more employees at a place of business within the City of New York.

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LANGUAGE ASSISTANCE RIDER FOR HRA

Language Assistance Services. The Contractor shall provide free language assistance services to limited English proficient individuals.

A. Service Delivery. When a limited English proficient individual seeks or receives benefits or services from a Department Contractor, the Contractor shall provide promptly language assistance services in all interactions with that individual, whether the interaction is by telephone or in person. The Contractor shall meet its obligation to provide prompt language assistance services by ensuring that limited English proficient individuals do not have to wait unreasonably longer to receive assistance than individuals who do not require language assistance services.

B. Translation. Where an application or form requires completion in English by a limited English proficient individual for submission to a state or federal authority, the Contractor shall provide oral translation of such application or form as well as certification by the limited English proficient individual that the form was translated and completed by an interpreter. The Contractor shall make all reasonable efforts to provide language assistance services in person by bilingual personnel. The Contractor shall screen bilingual personnel and interpreter personnel for their ability to provide language assistance services. The Contractor shall translate all documents into every covered language, as indicated in subsection 2, below. The Contractor shall provide annual training for bilingual personnel and interpreter personnel and ensure that they are providing appropriate language assistance services.

1. Notices. Upon initial contact, whether by telephone or in person, with an individual seeking benefits and/or services offered by the Contractor, the Contractor shall determine the primary language of such individual. If it is determined that such individual's primary language is not English, the Contractor shall inform the individual in his/her primary language of the right to free language assistance services. The Contractor shall post conspicuous signs in every covered language at all of its offices informing limited English proficient individuals of the availability of free language assistance services. The Contractor shall provide in all application and recertification packages a notice advising participants that free language assistance services are available at its offices and where to go if they would like an interpreter. This notice shall appear in all covered languages.

2. Covered Languages. "Covered Languages" shall mean Arabic, Chinese, Haitian Creole, Korean, Russian or Spanish. Nothing in this section shall preclude a Contractor from providing language assistance services beyond those required in this section.

**CONTINUITY OF OPERATIONS PLAN RIDER: TO BE USED FOR THOSE PROGRAMS
WHERE CONTINUATION OF SERVICES IN THE IMMEDIATE AFTERMATH OF AN
EMERGENCY IS ESSENTIAL FOR PUBLIC HEALTH OR SAFETY**

Prior to the commencement of services under this Agreement, Contractor shall submit for the Department's review and approval a written Continuity of Operations Plan (COOP) for its business which indicates its ability to continue the provision of essential services to the Department in the event that a State of Emergency is declared by the Mayor. The vendor should seek guidance from the Department on how to develop a COOP plan. A COOP plan includes, but is not limited to: the identification of an alternate site of business; appointment of alternate personnel for identified essential staff; development of protocols for the safekeeping of vital business records; and, a transportation contingency plan for its employees.

APPENDIX 5

SITE VISIT CHECKLIST

APPENDIX 5 - PROGRAM SITE CHECKLIST

Proposers proposing their own facilities must have the following items below, further description of these requirements can be found in the Juvenile Justice Limited Secure Placements Quality Assurance Standards (Appendix 1) – these requirements must either be in place at the proposed LSP site or included as part of the facility start-up plan.

- A) Homelike – non-correctional/institutional designed facility
- B) Indoor Recreation Space (or access to indoor recreation space) – 100 square feet per youth
- C) Outdoor Recreation Space
- D) Space for educational services
- E) Library space
- F) Space for family visiting and space for visitors to secure their belongings
- G) Space for medical, dental and psychiatric services
 - (i) Medical exam room must contain a sink
- H) Each Living Unit (12 youth maximum per unit) must contain the following:
 - (i) Sleeping Area
 - 1. Individual bedrooms
 - 2. If requesting dormitory style sleeping areas, there must be a clear line of sight to maintain eyes-on supervision of youth
 - 3. Direct sunlight
 - 4. Desk and Chair in room
 - 5. Storage Space for youth's personal belongings
 - 6. 35 Square Feet of Unencumbered space per room (per youth if in dormitory area)
 - (ii) Dayroom
 - 1. Each living unit must have a dayroom in close proximity to unit sleeping area.
 - 2. Direct sunlight
 - 3. Seating for every youth and staff member
 - 4. 35 square feet of unencumbered space per youth
 - (iii) Bathrooms
 - 1. Each living unit must contain a minimum of 2 sinks, 2 toilets, and 2 individual showers for use by youth in the unit.
 - (iv) Clinical Space
 - 1. Each living unit must have private clinical space.
- I) Suicide Resistant design features
 - (i) Bedrooms must have collapsible clothes hangers
 - (ii) Bathrooms must have collapsible shower fixtures
 - (iii) Suicide resistant doorknobs and fixtures
- J) Perimeter
 - (i) Fence/Plan for Fence
 - (ii) CCTV
 - (iii) Motion activated perimeter lighting
 - (iv) Designated entry and exit point(s)
- K) Interior Doors with locking capacity
- L) Closed Circuit Television CCTV Monitoring Throughout Common Areas in the Facility
- M) Control Room area to monitor CCTV and facility entry and exit
- N) Doors
 - (i) Steel hollow core fire rated
 - (ii) Vision panel on all interior door
- O) Generator
- P) Facility must be wired for internet
- Q) Food storage and preparation space
- R) Storage space – including a janitorial storage closet

APPENDIX 6

DOCUMENTS TO BECOME AN OCFS AUTHORIZED AGENCY

Dear:

We understand that you are interested in providing foster care services to children in New York State. We are pleased to enclose the following information regarding the processes both to obtain New York State Office of Children and Family Services (OCFS) approval to incorporate for this purpose, as well as to obtain an operating certificate to operate a residential child care facility in New York State. We encourage you to immediately initiate a thorough needs assessment to verify not only the need for the type of program that you propose to operate, but the commitment of local departments of social services to place children in your care, and to pay the rate established for such services.

Enclosed are “Guidelines: Instructions for Applicants for Certificates of Incorporation and Operating Certificates for Residential Care Facilities for Children in New York State.” The Guidelines Booklet lists the steps necessary to develop an institution, group residence, group home, or agency boarding home. Also included are two applications:

- **Application for NYS OCFS Approval of Proposed Certificate of Incorporation**
- **Application Cover Sheet for Operating Certificate Request (DSS-2981)**

Regulations related to the type of program you wish to operate are also enclosed. OCFS regulations governing the care of children in foster care indicate specific circumstances under which a child may be placed in foster care, the circumstances determining the type of care, as well as the frequency of contacts a social worker must have with each child and family. OCFS regulations also state that each child must have a specific plan for achieving permanency in their lives; either through return to their family, adoption or independent living, and the time period and circumstances governing these plans. It is important to review the regulations so you will know the kinds of services you must provide, the circumstances that determine actions and decisions, and some of the types of record keeping and reporting that are required. OCFS will monitor your compliance with applicable statutes and regulations on an ongoing basis through the application processes and beyond.

1. Application for NYS OCFS Approval of Proposed Certificate of Incorporation

The first step to operating in New York State is submission of the **Application for NYS OCFS Approval of Proposed Certificate of Incorporation** to the appropriate Regional Office. OCFS completes comprehensive reviews in three primary areas before granting its approval for an agency to incorporate to provide child care services. Your primary contact throughout this process is the Regional

Office staff person. Your Regional Office liaison will coordinate and track your submission of various components of your proposed operation and will work closely with you to achieve compliance with relevant statutes and regulations. The three broad areas to be reviewed are as follows:

- **Program Plan**

The Regional Office will review all components of an agency's proposed Program Plan. The Program Plan is a comprehensive and detailed accounting of the policies and procedures by which your proposed agency will operate. The Program Plan includes, but is not limited to, a description of the foster care population to be served, a description of the presenting problems of children to be served, intake criteria, organizational structure and staffing, and the services to be provided to children and their families including medical, educational, and clinical services. The Regional Office will issue a Program Plan Compliance Statement when it is satisfied that all elements of your proposed program as submitted and reviewed are in full compliance with relevant statutes and regulations.

- **Fiscal Viability**

The Rate Setting Unit of OCFS will confirm the fiscal viability of an agency. They also make decisions and recommendations regarding the establishment of rates to be paid for services provided by your agency. There are five elements required for the fiscal review:

1. Program Narrative summary submitted by your agency including:
 - A general program description.
 - Staff description.
 - Description of children to be served.
 - Description of how children are to be educated. (This may require a separate approval from the New York State Education Department.)
 - Description of how the medical needs of children are to be met. (This may require a submission through your Regional Office contact to the New York State Department of Health.)
2. A current CPA report or a copy of the most recent federal tax return.
3. A projected program budget completed on forms obtained from the Rate Setting Unit. Forms must be obtained directly from the Rate Setting Unit by calling (518) 402-0096.
4. Current letters of support from all relevant local district departments of social services including:
 - A statement of need from the district for the specific program to be provided.
 - A commitment that the district will refer children to the program.
 - A commitment that the district will pay the established rate for the program.
5. A compliance statement issued from the appropriate Regional Office stating that the **Program Plan** as submitted meets all applicable statutes and regulations.

The Rate Setting Unit will issue a statement of fiscal viability when it has completed its review.

▪ **Counsel's Office Issuance of the OCFS Approval Document Authorizing Agency Filing of Certificate of Incorporation with the Secretary of State**

Counsel's Office of OCFS will review your proposed certificate of incorporation (or amendment) document for content and format. Once Counsel's Office has received a **Program Plan Compliance Statement from the appropriate Regional Office**, and the **Fiscal Viability verification from Rate Setting**, and the proposed certificate of incorporation or amendment is in proper form, an approval document will be issued. The OCFS approval document and your proposed certificate of incorporation document must then be filed with the Secretary of State. The Secretary of State will issue a filing receipt. It is your responsibility to provide a copy of the filing receipt and a certified copy of the filed documents with the Secretary of State to Counsel's Office of OCFS as proof that the incorporation process has been completed.

2. Application Cover Sheet for Operating Certificate Request (DSS-2981)

The process for submission of the **Application Cover Sheet for Operating Certificate Request (DSS-2981)** parallels that of the approval of incorporation process but will be site or facility specific in its focus. An operating certificate is issued to an authorized agency to provide specific services at a specific site. Again, the first step is submission of the Application for Operating Certificate to the appropriate Regional Office. Again, OCFS will complete reviews of your program in the same three broad areas. Much of the programmatic and fiscal material provided by your agency during the OCFS approval of proposed certificate of incorporation process is relevant to, and forms the foundation for, issuance of an operating certificate:

- **Program Plan:** The Regional Office will continue to review and to assist you in the refinement of your Program Plan with an emphasis on the fire and building safety and other physical plant requirements of the proposed location of your facility. A series of inspections of your proposed facility will be conducted. The Regional Office will issue a compliance statement with regard to your application for an operating certificate when it is satisfied that all elements of your proposed program and facility location are in compliance with relevant statutes and regulations.
- **Fiscal Viability:** The Rate Setting Unit will continue to review the fiscal viability of your proposed program at the proposed facility location and will establish an appropriate reimbursement rate for the services to be provided.
- **Legal:** NYSOCFS Counsel's office will confirm that there is current corporate authority in place for your agency. Counsel's Office will confirm that the Regional Office and Rate Setting Unit have completed their reviews and issued written compliance statements. The Office of Children and Family Services then issues the operating certificate.

Time frames for completion of the application process will vary. Also, some of the steps in the processes described above may be completed concurrently.

If you have questions or need additional information, please feel free to contact us . Thank you for your interest.

Sincerely,

Enclosures

I. INTRODUCTION

The purpose and statutory basis of the New York State Office of Children and Family Services' (OCFS) authority for residential care programs for children and adults is in Section 460 of the Social Services Law:

" In order to more effectively protect and assure the life, health, safety, and comfort of adults and children who must be cared for away from their homes, the Office of Children and Family Services acting directly or through social services districts, and with the cooperation of other state agencies, shall have comprehensive responsibility for the development and administration of programs, standards and methods of operation, and all other matters of state policy, with respect to residential care programs for children and adults and all facilities and agencies, whether public or private, which are subject to the provisions of this article."

Private agencies which place out children (arrange for the free care of a child in a family other than that of the child's parent, step-parent, grandparent, brother, sister, uncle, or aunt or legal guardian, for the purpose of adoption or for the purpose of providing care [SSL §371 (12)]), board children (arrange for the care of a child in a family, other than that of the child's parent, step-parent or legal guardian, to whom payment is made or agreed to be made for care and maintenance [SSL §371 (14)]), operate runaway and homeless youth shelters, or provide residential care of children in agency boarding homes, group homes and institutions are subject to State Office of Children and Family Services' supervision, inspection and regulation. Each agency must be incorporated, with OCFS' approval, and each child caring facility must possess a facility specific operating certificate issued by OCFS.

Exceptions to this requirement include such facilities as mental health or developmental centers operating under Articles 31 or 81 of the Mental Hygiene Law, hospitals operating under Article 28 of the Public Health Law and agencies formed by special act of the Legislature.

Agencies engaged only in operating an adoption program and/or foster family care program do not need an operating certificate, but must have a certificate of incorporation that adequately reflects those corporate purposes.

OCFS is empowered to promulgate regulations establishing the procedure for submitting certificates of incorporation for approval and specifying the documentation to be submitted in connection with such approval. (See 18 NYCRR Part 482.)

The purpose of this manual is to explain the statutory and regulatory requirements, and to establish administrative procedures for obtaining OCFS approval of certificates of incorporation and for issuance of operating certificates. **Note that the application for OCFS approval of a certificate of incorporation and the application for an operating certificate are separate and distinct legal processes.** The former seeks authority to function in a broad service area. The latter seeks approval to operate a particular physical facility for the purpose of providing a service

program. To the extent that the information and materials required for each approval are identical, cross-reference or duplicative submittals may be made.

CERTIFICATE OF INCORPORATION
(Amendment, Merger, Consolidation and Restatement)
For Child Caring Agencies

A certificate of incorporation defines the nature, purposes, powers and status of a corporation. In the past, some corporations were created by special acts of the Legislature and, in such cases, the law creating the corporation constitutes the certificate. Generally, child-caring corporations are presently created by the filing of a certificate with the Secretary of State.

The term "certificate of incorporation" technically includes all other certificates that might alter or affect the nature of a corporation. These include:

- certificates of amendment (which revise an existing certificate)
- correction (with regard to a technical error)
- merger (in which one corporation is absorbed into another)
- consolidation (in which two or more corporations join to create a new corporation), and
- restatement (in which multiple certificates are rewritten into a single certificate).

OCFS is vested with the authority, granted by Section 460-a of the Social Services Law and Section 404 (b) of the Not-For-Profit Corporation Law, to **approve** certificates for:

- agencies caring for destitute, delinquent, abandoned, neglected or dependent children¹;
- agencies which place out or board out children;
- agencies which operate shelters for unwed mothers,
- agencies which operate runaway and homeless youth shelters, and²
- agencies which solicit contributions for any of the above child care purposes³.

The format and contents of the various certificates are specified in the Not-For-Profit Corporation Law.

¹ OCFS is also granted with authority under Social Services Law §460-a and Business Corporation Law §405-a to approve certificates for business corporations operating residential institutions for children.

² Runaway and homeless youth shelters can only be operated by an authorized agency (Executive Law §532-a (3)) which must be approved by OCFS under Social Services Law §460-a and Not-For-Profit Corporation Law §404 (b).

³ It should be noted that corporations which are not agencies must also seek OCFS approval under Social Services Law §460-a to solicit contributions for any of the above child care purposes. In addition not for profit corporations under that section must obtain OCFS approval to include the purpose of operating a residential program for victims of domestic violence in the certificate of incorporation

OPERATING CERTIFICATES

Section 460-b of the Social Services Law authorizes OCFS to require an operating certificate for:

- facilities for the care and/or custody of dependent, neglected, abused, maltreated, abandoned or delinquent children,
- homes for unmarried mothers, and
- facilities for residential programs for victims of domestic violence

The authority to **require an operating certificate** is not co-extensive with the authority to **approve certificates of incorporation**. For example, an agency that licenses or certifies or approves foster-family boarding homes must seek approval of OCFS for filing of its certificate of incorporation, but does not need an operating certificate.

II. APPLICATIONS AND APPROVAL PROCEDURES:

A. Certificate of Incorporation – Initial Application

1. Who Must Apply?

Any private agency that wishes to provide the following services in New York State:

- a. Placing out children for free foster family care or adoption;
- b. Boarding out children (paid foster family care);
- c. Residential care of destitute, delinquent, abandoned, neglected, or dependent children in agency boarding homes, group homes, and institutions;
- d. Shelters for unmarried mothers;
- e. Operate a residential program for runaway and homeless youth and

Any not for profit corporation that wishes to provide the following services in New York State:

- a. Residential programs for victims of domestic violence

And whose corporate purposes, if any, do not include the provisions of such services.**

2. Are There Any Exceptions to OCFS Authority Cited Above?

Generally, facilities certified under the Mental Hygiene Law or the Public Health Law do not require OCFS' approval. Also, in rare instances, the New York State Legislature passed legislation that created an agency to care for children. Otherwise, most new agencies for the care of children will be formed by incorporation.

3. What are the Procedures Required for an Agency to Become Incorporated?

The application process usually begins with an inquiry directed to OCFS. The applicant's primary contact is with the appropriate Regional Office where arrangements will be made to discuss specific procedures, forms and information required. (A list of NYS OCFS Regional Offices is included on Page 20 of this booklet.)

Once initial application material is submitted, the person who wishes to incorporate will be directed to an attorney within the New York State Office of Children and Family Services⁴. The applicant will be advised to prepare a draft certificate of incorporation. If the agency will be

** Also includes business and not-for-profit corporation that wishes to solicit contributions for any of the purposes listed in SSL §460-a.

engaged in purposes requiring the approval of OCFS, specific requirements will be explained.

Generally, with a new corporation, the child caring purposes will be limited in duration. Certificates of amendment are subsequently submitted to extend the duration. For additional information, refer to the later section headed "Certificate of Incorporation – Amendments."

Following the initial contact with the Regional Office, the attorney for the applicant will usually work directly with an OCFS attorney on technical preparation of the draft certificate of incorporation. The draft certificate should be forwarded to the appropriate Regional Office. From there, it will be forwarded to OCFS counsel's office for legal review. Depending upon the stated corporate purposes, the counsel's office will determine whether the certificate will require the approval of OCFS. If so, an application for NYS OCFS approval should be submitted to the appropriate Regional Office. (A list of NYS OCFS Regional Offices is found on Page 20 of this booklet.) Concurrent with the legal review, the Regional Office will be completing a comprehensive programmatic review of all necessary documentation. Additionally, the Rate Setting Unit will be completing a comprehensive review of the potential fiscal viability of the proposed corporation. At the completion of its programmatic review, the Regional Office forwards its recommendation concerning approval of the application to the Home Office of Regional Operations. Similarly, the Rate Setting Unit forwards its findings and recommendation concerning fiscal viability. Once both approvals (Programmatic and Fiscal) are in place, and the format of the draft certificate of incorporation is appropriate, counsel's office will proceed with preparation of the approval document.

4. What Kind of Information is Required on the Application?

The information required in the application includes, but is not limited to the following:

- a. the names and addresses of the persons submitting the application;
- b. the name and principal business address of the proposed corporation;
- c. the territory or counties where the proposed corporation will conduct business;
- d. the names and addresses of the proposed members of the board of directors, none of whom may be employed by the corporation in any capacity, and such personal information as may be required in order to determine their character, experience, competency and standing in the community, with reasonable assurance of their ability to conduct the affairs of the corporation in its best interests and in the public interest. There should be a minimum of three directors (OCFS prefers seven), at least one of whom has experience in the area of activity in which the corporation will be engaged;

- e. information and data with reference to the public need for the proposed facilities or programs;
- f. information and documentation about the adequacy of the financial resources and sources of future revenue for the facilities or programs to be operated by the proposed corporation;
- g. information and data required to establish the suitability and adequacy of any facility or program to be operated by the proposed corporation;
- h. information and data required to establish the suitability and adequacy of the personnel to be engaged at the facility or programs;
- i. the policies and procedures to be followed by the proposed corporation in its facilities or programs; and
- j. any other such information as may be required by OCFS.

For additional information, please contact your appropriate NYS OCFS Regional Office.

5. What are the Fiscal Criteria for Foster Care Incorporation?

The Bureau of Rate Setting must review the application materials, report of inquiry and fiscal data to determine the current and future fiscal viability of the agency.

The recommendation issued by Rate Setting relative to fiscal viability should include the reasons for approval or disapproval and any corrective action that must be taken by the agency.

The following criteria will be used to determine the fiscal viability:

a. Existing corporations

- Agency must submit a copy of its most recent audited financial statement. The statement should include the following:
 - Balance sheet
 - Revenue and expense statement
 - Changes in fund balance
- If there is a deficit fund balance, a plan must be submitted to liquidate the deficit
- Submit information required for new programs. (See item c below.)

b. New corporations for the purpose of fund raising

- Submit a budget of projected fund raising expenditures
- Indicate total funds to be raised to establish the proposed corporation
- Demonstrate that the proposed programs will be established within five years

c. **New programs**

1.A Program Narrative Summary submitted by your agency including:

- A general program description
- Staff description
- Description of children to be served
- Description of how children are to be educated
- Description of how the medical needs of children are to be met

2.A current CPA report or a copy of the most recent Federal Tax Return, (IT990)

3.A projected program budget completed on forms obtained from the appropriate Regional Office. The Standards of Payment forms must present a balanced budget of all projected income and expense. It should consider projected care days, and the Standards of Payment ceiling, as advised by Rate Setting.

4.Current letters of support from all relevant local district departments of social services including a statement of need from the district for the specific program to be provided, a commitment that the district will refer children to the program, and a commitment that the district will pay the established rate for the program. If the local department of social services will not pay the maximum State aid rate or if the agency presents a deficit budget, the agency must submit a plan to eliminate the deficit.

5.A compliance statement issued from the appropriate Regional Office stating that the Program Plan as submitted meets all applicable statutes and regulations.

Additionally, if agency will be renting property, it must submit a copy of the lease agreement in accordance with OCFS regulation (18 NYCRR 427.3(b)(1)). Or, if agency is purchasing property, it must indicate the capital cost and the sources of funds used for its purchase.

d. **Applicants will be notified** through their attorneys whether the draft certificate of incorporation is in correct technical form and what other approvals may be necessary. After this notification is received, a final, signed copy of the certificate should then be submitted by the applicant to the appropriate Regional Office.

Rate Setting will make a recommendation regarding fiscal viability. The Regional Office will make a recommendation regarding program compliance. OCFS will subsequently either approve or disapprove the entire package as submitted requesting OCFS approval of the proposed certificate of incorporation.

Approval consists of issuance of a "notice of approval" document attached to the proposed certificate of incorporation. The certificate and approval document are returned to the

incorporating organization by the counsel's office. (If the approval of OCFS is not required, the certificate is returned with a letter to that effect.) In either case, the remaining steps to be performed are identical. All formal notifications are made directly to the applicant by the counsel's office with a copy to the Regional Office and Home Office of Regional Operations.

- e. **When all of the approvals and consents are obtained**, the certificate must be submitted to the Secretary of State, together with the applicable filing fee. The Secretary of State will issue an original filing receipt that should be retained by the agency. A copy of the filing receipt as well as a certified copy of the filed certificate of incorporation must be sent to NYS OCFS Counsel's Office. If the agency will be engaged in any activity for which OCFS approval is necessary, a copy of the filing receipt will be sent from Counsel's Office to the appropriate Regional Office of the OCFS. (Copies of the filing receipt will also be retained at OCFS Counsel's Office and at the Home Office of Regional Operations.) If necessary and appropriate, the agency can then take steps to have an operating certificate issued as explained below.

6. May an Agency Already Incorporated for Another Not-For-Profit Purpose Provide Child Care?

Yes, but the current certificate of incorporation must be amended and the same procedure must be followed as for a new incorporation. The same is true for:

- correcting an error in an existing certificate,
- mergers or consolidations of two existing corporations, and
- the restatement of multiple certificates into one.

7. May an Agency Raise Funds to Provide Child Care Before it is Incorporated for that Purpose?

No. If the sole purpose of incorporation is fund raising, the certificate of incorporation will be limited to five years. Additionally, receipt of approval for fund raising purposes does not mean that authority has been given to operate a program.

8. When May an Agency Begin Operation?

Once an approved certificate of incorporation is filed with the New York State Department of State and a copy of the filing receipt is provided to OCFS, an agency may begin the placing out or boarding out of children into foster boarding homes in accordance with regulations established by OCFS and the approved corporate purposes,(i.e., the corporation must have the authority to place out or board out children in order to engage in those activities.)

However, no residential care facility—agency boarding home, group home, institution, shelter for unmarried mothers, residential program for victims of domestic violence—may be operated without an approved operating certificate issued for that specific purpose at a special location.⁵ Application for an operating certificate, if needed, may be made simultaneously with application for approval of certificate of incorporation, amendment, etc., when feasible.

9. Is OCFS' Approval Necessary for Corporate Dissolution?

Yes, if the purposes of the corporation include those for which OCFS approval would be required for incorporation.

An application for voluntary dissolution of a not-for-profit corporation shall contain information and data with reference to:

- a. the public need for such dissolution;
- b. the proposed disposition of the assets of the corporation; and
- c. such other matters as may be in the public interest.

B. Certificate of Incorporation—Amendments

The process of amending a certificate of incorporation is identical to the initial incorporation process. However, amendments are often minor and therefore efforts are made to simplify the amendment process to the extent that it is legally possible to do so. Corporations planning to amend the certificate of incorporation should consider the following:

1. The initial corporate purposes should be expanded in terms which encompass any anticipated expansion of program activity, while avoiding those which would extend authority to programs beyond the scope of the agency;
2. There should be careful review by the agency of all materials initially submitted as part of the incorporation process. In many instances, the same information, with minor updating, may be used for the amendment process.

The amendment process should begin with a contact and conference with the appropriate OCFS Regional Office.

With respect to agencies providing residential care for children (residential programs):

- A new incorporation, has a five (5) year limit placed upon the duration of corporate authority.
- Near the completion of the initial five (5) years, a corporation must submit a proposed amendment to extend the duration of their corporate authority. Unless there is a reason to approve only a shorter duration, the duration of corporate authority would then be extended for an additional ten (10) years.

- At the completion of the subsequent ten (10) years, a corporation must submit a proposed amendment to extend the duration of their corporate authority. Normally, the duration of corporate authority would then be extended to perpetuity.

With respect to agencies that are authorized to board out or place out children (foster home programs):

- A new incorporation has a two (2) year limit placed upon the duration of corporate authority.
- At the completion of the initial two (2) years, a corporation must submit a proposed amendment to extend the duration of their corporate authority. The duration of corporate authority would then be extended for an additional five (5) year limit and thereafter upon submission of proposed amendments for periods of successive five years.

OCFS has the authority to limit the duration of any extension of corporate authority, if so desired or required. A limitation of duration may be for legal, fiscal or programmatic purposes.

If at any time a corporation allows its corporate authority to lapse either by failing to submit proposed amendments in a timely fashion, or, for any other reason, OCFS will not be able to issue an operating certificate to that corporation until such time as corporate authority is re-established.

Applications for amendment to extend the duration of corporate authority should be submitted at least 90 days prior to the expiration of the existing authority. OCFS does not notify agencies of lapsing authority. It is the responsibility of the agency to maintain current and valid corporate authority.

C. Operating Certificates

1. Who Must Have a Valid Operating Certificate from OCFS?

Under the provisions of Section 460-b of the Social Services Law, any facility subject to the inspection and supervision of OCFS. This includes all charitable, eleemosynary, correctional or reformatory facilities, including those exercising custody of dependent, neglected, abused, maltreated, abandoned or delinquent children, homes for unwed mothers and residential programs for victims of domestic violence.

2. Are There Any Exceptions to the Operating Certificate Requirements?

Yes. There are some types of facilities and operations that do not require an operating certificate from OCFS. These exceptions include:

- a. Any facility operated by a State department or agency (*example*, State correctional facilities);

- b. Any facility which, by law, is licensed or certified to operate by another State department or agency (*example*, schools, camps, hospitals, schools operated for the deaf or the blind);
- c. An authorized agency, under the provisions of Sections 371.10(a), 375 and 376, Social Services Law, may issue certificates to board out children;
- d. An authorized agency, under the provisions of Section 371.21 and 18 NYCRR Part 449 may certify supervised independent living units..

3. When Should a Facility Apply for an Operating Certificate?

As soon as a proposed facility or an agency proposing to operate a facility determines that the facility falls within the criteria described above, it should initiate the application process. If an application for OCFS approval of a certificate of incorporation is being filed for the purpose of operating a facility that requires an operating certificate, such relevant documentation may also be accepted for the application for an operating certificate, with additional or modified information as required.

New facilities must provide, at a minimum, the following information:

- (a) the name of the facility and its location;
- (b) the name and address of the authorized agency, corporation, association, organization, proprietary operator or public agency, who or which operates such facility;
- (c) the type of facility;
- (d) the kind or kinds of care and services to be provided;
- (e) a physical description of the facility, including land, buildings and equipment, and a diagram of the floor plan detailing the location of all fire and smoke detection and alarm devices or systems and sprinkler systems;
- (f) resident capacity;
- (g) a plan for the implementation of the review and evaluation of the background information and references supplied by applicants for employee or volunteer positions as required in the relevant provisions of Title 18 of the New York Codes, Rules and Regulations (Title 18), and the facility's compliance with the provisions of Section 424-a of the Social Services Law and the relevant provisions of Title 18 regarding inquiries to the State Central Register of Child Abuse and Maltreatment concerning employees, volunteers, consultants and individuals supplying or in the employment of individuals, corporations, partnerships or associations supplying goods or services to the facility;
- (h) a plan and description of staff positions, including duties and qualifications;
- (i) if applicant is a corporation, the names, addresses and occupations of the members of the board of directors;
- (j) the ownership or control of the land and premises if other than the operator;

- (k) the financial resources and sources of future revenue of the facility; and
- (l) such other information as may be required. (See 18 NYCRR 477.3.)

It is essential to note that a facility must apply for a revised operating certificate if there occurs any change in items (a) through (f) as listed above!

4. How Does a Facility Obtain an Operating Certificate for Residential Child Care from the OCFS?

The OCFS Regional Offices are the central points of contact to apply for an operating certificate. The Regional Office, in consultation with counsel's office, will ascertain whether a valid certificate of incorporation for the applicant agency is on file and whether it contains the required statement of corporate purposes that includes the proposed activity.

The facility must file an application for an operating certificate with OCFS. Application forms are found at the back of this booklet or may be obtained from the OCFS Regional Office serving the county in which the facility is to be located.

An "Application Cover Sheet for Operating Certificate Request" (OCFS-2981), must be completed. OCFS Regional Office approval of building plans is required if building or remodeling plans are contemplated.

- a. A comprehensive programmatic review will be completed by the appropriate Regional Office.
- b. A comprehensive fiscal viability review will be completed by the office of Rate Setting.
- c. Appropriate physical plant fire and safety standards must be in place.
- d. If the local Department of Social Services will not pay that State aid rate or if the agency presents a deficit budget, the agency must submit a plan to eliminate the deficit.
- e. Submit written confirmation of other than local Department of Social Services sources of income.
- f. If agency is purchasing property, it must indicate that the program can be operated on the existing maximum State aid rate.
- g. If agency is renting property, it must submit a copy of the lease agreement.
- h. Requests for a change in capacity must include the following:
 - reason for capacity change
 - fiscal impact of the change on the program
 - effect on cost allocations
 - plans for hiring or terminating staff
 - for significant changes (20 percent or more), submit a projected budget on forms available from the Rate Setting Unit.

OCFS will review the application and request additional information and documentation as necessary. When it is established that the new facility meets the requirements of all applicable provisions of law and regulations, the application shall be approved and the operating certificate will be sent to the applicant.

5. What if an Application is Denied?

If an application for an operating certificate is denied, the applicant shall be informed in writing of the denial and the reasons. Upon request of the applicant, OCFS must grant a hearing or review of the application. (See 18 NYCRR 343.2 (b).)

6. How May a Facility be Terminated?

The operations of a facility may be terminated voluntarily or involuntarily.

- a. A facility may voluntarily discontinue operations upon at least 90-days' notice to OCFS. Such notice shall include a plan, to be approved by OCFS, for the transfer or discharge of all residents. (See 18 NYCRR 476.2 (d).)
- b. A facility which is not operating in accordance with the terms and conditions of its operating certificate, or is substantially out of compliance with applicable laws or regulations will be subject to enforcement actions by the Commissioner of OCFS. (See SSL §460-d (4).)

D. Operating Certificate—Changes in Terms or Conditions

1. When Changes are Contemplated or Occur in the Operation of a Residential Care Facility for Children, Must the Operating Certificate be Changed?

If the changes involve a change in corporate status, name, facility type, location or capacity, an application for a new operating certificate to reflect those changes must be completed. A new operating certificate must be obtained from OCFS before the changes go into effect. The old certificate becomes invalid and must be returned.

2. Is it Necessary to Repeat the Entire Application Process to Obtain a New Certificate?

Requirements and procedures differ for each change. A facility must send a copy of the original operating certificate, together with an application requesting revisions to the Regional Office. Appropriate documentation justifying and supporting the requested changes will be required. OCFS approval is required prior to the changes taking effect.

The facility must also comply with the corresponding requirements for each of the following changes:

- a. **Name change**—the facility must state the reason for the change in name.
- b. **Facility type**—if the facility is to operate a new program not already included in its current operating certificate, the operator must provide Standards of Payment information as if the application is for a totally new operating certificate, including a description of the population to be served, the services to be provided and the size and qualifications of the staff. The operator must ensure that the new program comes under the existing corporate authority. If necessary, an amendment, to include the proposed program in the certificate of incorporation, must be applied for.
- c. **Capacity Change**—the facility must provide a reason for the change in capacity, information concerning the fiscal impact of the change on the program and its effect on cost allocations, and plans for hiring or terminating staff. If a change is 20 percent or more, a projected budget is required on appropriate forms.
- d. **Change of Location**—if the facility is contemplating a change of location, the new site and the physical plant must be inspected and a new operating certificate issued before any children may be admitted or transferred. This also refers to any new construction on an existing site. Again, OCFS approval is required prior to the implementation of any changes.

3. When Must the Old Operating Certificate be Returned?

As soon as the new operating certificate is received by the facility, the old operating certificate must be returned immediately to the Regional Office. A copy will be retained, and the original sent to the Home Office of Regional Operations. Failure to return the old operating certificate constitutes non-compliance.

OCFS Regional Offices:

Buffalo Region

NYS Office of Children & Family
Services
295 Main St.
Ellicott Square Building Suite 545
Buffalo, NY 14203
Telephone: (716) 847-3145

Allegany, Cattaraugus,
Chautauqua, Erie, Genesee,
Niagara, Orleans and Wyoming
counties

Syracuse Region

NYS Office of Children & Family
Services
100 South Salina Street Suite 350
Syracuse, NY 13202
Telephone: (315) 423-1200

Broome, Cayuga, Chenango,
Cortland, Herkimer, Jefferson,
Lewis, Madison, Oneida,
Onondaga, Oswego, St.
Lawrence, Tioga, and Tompkins
counties

Rochester Region

NYS Office of Children & Family
Services
259 Monroe Avenue
3rd Floor
Rochester, NY 14607
Telephone: (585) 238-8201

Chemung, Livingston, Monroe,
Ontario, Schuyler, Seneca,
Steuben, Wayne and Yates
counties

Albany Region

NYS Office of Children & Family
Services
52 Washington St. 261 West
Rensselaer, NY 12144
Telephone: (518) 486-7078

Albany, Clinton, Columbia,
Delaware, Essex, Franklin,
Fulton, Greene, Hamilton,
Montgomery, Otsego,
Rensselaer, Saratoga,
Schenectady, Schoharie, Warren
and Washington counties

Spring Valley Region

NYS Office of Children & Family
Services
11 Perlman Drive
Spring Valley, NY 10977
Telephone: (845) 708-2498

Nassau, Putnam, Rockland,
Suffolk, Sullivan, Westchester,
Orange, Ulster and Dutchess
counties

New York City Region

NYS Office of Children & Family
Services
80 Maiden Lane, 24th Floor
New York, NY 10038
Telephone: (212) 383-1788

Bronx, Brooklyn, Manhattan,
Queens, Staten Island

VOLUNTARY AGENCY LICENSING
Application for NYS OCFS Approval of Certificate of Incorporation (OCFS-4722)

COVER PAGE

Contact Information For This Application

First Name _____ Last Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Telephone # _____ Fax # _____
 Email Address _____

Corporate Information

Proposed Corporation Name _____
 If Amending, Name of Existing Corporation _____
 Street Address _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Telephone # _____ Fax # _____

Proposed Principal Activity of Corporation

- ☐ Fund Raising
- ☐ Foster Home Recruitment and Certification
- ☐ Residential Child Care

If Residential Child Care, please check type of service:

- ☐ Institution
- ☐ Group Residence
- ☐ Group Home
- ☐ Agency Boarding Home
- ☐ Supervised Independent Living

Location(s) of Principal Activity (List by county.)

The applicant hereby acknowledges that all other information as required and identified on pages 2 through 6 of this application will be provided to support the request for NYS OCFS Approval of Certificate of Incorporation. Such approval must be issued prior to filing the Certificate of Incorporation with the Department of State.

Applicant Name _____ Title _____
 Applicant Signature _____ Date _____

VOLUNTARY AGENCY LICENSING

Application for NYS OCFS Approval of Certificate of Incorporation (OCFS-4722)

APPLICATION REQUIREMENTS FOR NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES APPROVAL OF PROPOSED CERTIFICATE OF INCORPORATION

The following information is required of an applicant seeking New York State Office of Children and Family Services (NYS OCFS) approval of a proposed Certificate of Incorporation or Amendment. Such certificate may be found under Section 404(b) of the Not-For-Profit Corporation Law (excluding day care purposes). Application requirements are identified pursuant to NYS OCFS Regulations, 18 NYCRR Part 482. It is recommended that application materials be accompanied by a cover letter including items #1 through #5, and clearly identifying the intended purpose of the proposed corporation.

1. (Part 482.1(a)(1)) Name(s) of person or persons submitting the application
(Part 482.1(a)(1)) Address(es) of person or persons submitting the application
2. (Part 482.1(a)(2)) Name of proposed corporation
(Part 482.1(a)(2)) Or, if seeking an amendment, name of existing corporation
(Part 482.1(a)(2)) Mailing address of proposed (or existing) corporation
3. (Part 482.1(a)(3)) The territory in which its activities are principally to be conducted
(list counties in New York state):
4. (Part 482.1(a)(4)) With reference to a not-for-profit corporation, provide or attach the following information regarding members of proposed (or existing) board of directors:
 - For each member of the board, list name, address, and such personal information as may be required in order to determine their character, experience, competency and standing in the community, with reasonable assurance of their ability to conduct the affairs of the corporation in its best interests and the public interest.
 - **Note:** Although the Not-For-Profit Corporation Law requires a minimum of three board members, it is the practice of the New York State Office of Children and Family Services to recommend a minimum of seven. Some members of the board should have management or fiscal training or experience (example, attorney, accountant, businessperson, administrator or other organization). Additionally, at least one member should demonstrate expertise in the proposed program area.
5. (Part 482.1(a)(5)) With reference to a business corporation, provide or attach the following information:
 - The names and addresses of the board of directors, officers and stockholders, together with such personal information as may be required in order to determine that they are persons of good moral character who are competent to operate the business.
 - **Note:** The persons submitting this application hereby certify that no member of the board of directors, chief administrative officer, executive director, administrator or an employee of the corporation, or an official of a government agency is in a position to influence contractual, payment or program decisions concerning the corporation.

VOLUNTARY AGENCY LICENSING
Application for NYS OCFS Approval of Certificate of Incorporation (OCFS-4722)

6. (Part 482.1(a)(6)) In order to determine that there is a public need for the facility or program, provide or attach information and data with reference to the public need for the proposed facilities or programs at the time and place and under the circumstances proposed. This information should include, but is not limited, to the following:

- a. Has the organization been in operation as an unincorporated association? ☐ Yes ☐ No

If “yes,” provide or attach the answers to the following questions:

- How long did the association operate?
- Under what name?
- At what location?
- Why was this organization started?
- What have been its major activities?
- What is the program to be conducted now?

If “no,” the organization has not been in operation, provide or attach the answers to the following questions:

- Why is it being started?
- What will be its major activities?
- Where will the program be located?

- b. Provide a comprehensive summary of the program and activities to be carried out by this proposed corporation. This section may also be referred to as the Program Narrative and must include:
- A general program description
 - A staffing description
 - Description of the children to be served
 - Description of how children are to be educated
 - Description of how the medical needs of the children are to be met
- c. Identify and describe any other organizations conducting similar activities in the community you intend to serve.
- d. Provide documentation of public need for the proposed activities. This must include a current letter of support from all relevant local departments of social services including:
- A statement that there is a need for the specific program to be provided
 - A commitment that the district will refer children to the specific program
 - A commitment that the district will pay the established rate for the specific program

VOLUNTARY AGENCY LICENSING
Application for NYS OCFS Approval of Certificate of Incorporation (OCFS-4722)

7. (Part 482.1(a)(7)) In order to determine that there are adequate finances to properly establish and conduct the proposed program activities, provide information and data with reference to the financial resources and sources of future revenue of facilities or programs to be operated by the proposed corporation. This must include but may not be limited to:
 - a. If a new program, submit the following:
 - Program Narrative as described in item 6b. above
 - A Current CPA Report or a Copy of the most recent Federal Tax Return
 - A Projected Program Budget to be completed on forms provided by the NYS OCFS Regional Office
 - Letters of support from all relevant local districts as described in item 6d. above
 - b. If amending an existing corporation, attach financial statements for the last fiscal year, including a statement of actual income, expenditures and balance sheet.
8. (Part 482.1(a)(8)) Provide such data and information as may be required in order to establish the fitness and adequacy of any proposed facility or program to be operated or conducted by the proposed corporation. This must include but may not be limited to all agency policies, procedures and plans demonstrating the agency's ability to operate in compliance with applicable statutes and regulations governing the following:
 - Agency philosophy and mission statement
 - Organizational structure
 - Personnel information including qualifications, safety measures, hiring practices, policy manual
 - Services information including admissions, treatment and discharge criteria, procedures and plans
 - Health services information
 - Educational services information
 - Residential program information including all policies and procedures
 - Nutritional services information
 - Discipline policies including specific references to use of restraint

VOLUNTARY AGENCY LICENSING
Application for NYS OCFS Approval of Certificate of Incorporation (OCFS-4722)

9. (Part 482.1(a)(9)) Provide such data and information as may be required in order to determine the fitness and adequacy of the personnel to be engaged in the facilities or programs. This must include but may not be limited to the following:
 - List all personnel by title, qualifications, daily hours of work, total weekly hours for each staff member
 - Indication of whether volunteers are to be used and, if so, in what capacity?
10. (Part 482.1(a)(10)) Provide the policies to be followed by the proposed corporation in its facilities or programs. This must include but may not be limited to the following:
 - All personnel policies
 - All operational policies
11. (Part 482.1(a)(11)) Any other pertinent information as may be required by the NYS OCFS in order to fully evaluate the request of the proposed agency/corporation
12. (Part 482.1(b)) In the event that one or more of the purposes of the proposed corporation is to solicit contributions for any purpose that requires NYS OCFS approval, the application submission shall also contain such data and information as may be required to determine that it would be successful in raising funds necessary to establish the proposed facility or program within the time period planned but no more than five years from the date of the NYS OCFS approval.
13. (Part 482.1(c)) Accompanying the full program submission, the applicant must submit the original and two copies of the proposed certificate of incorporation.
 - Draft Certificate of Incorporation Document

The following is an example of the Preferred Format for a certificate of incorporation.

VOLUNTARY AGENCY LICENSING
Application for NYS OCFS Approval of Certificate of Incorporation (OCFS-4722)

PREFERRED FORMAT

CERTIFICATE OF INCORPORATION OF

(Name of Corporation)

Under Section 402 of the Not-for-Profit Corporation Law

1. The name of the corporation shall be _____
2. The corporation is a corporation as defined in subparagraph (a)(5) of Section 602 of the Not-For-Profit Corporation Law; the purposes for which it is formed are as follows:

the corporation shall be a Type B corporation.
3. The office of the corporation is to be located in the (city) (town) (incorporated village) of _____, and county of _____.

The activities of the corporation are principally to be conducted in _____

The names and addresses of the initial directors are: (**Note:** minimum legal requirements is for three directors; however, if Office of Children and Family Services' approval is necessary, Office of Children and Family Services policy recommends a minimum of seven directors.)

(If Office of Children and Family Services' approval is necessary, a clause should be included that limits the initial duration of the corporation for a period of five years.)

The Secretary of State is designated as the agent of the corporation for service of process. The post office address to which the Secretary of State shall mail a copy of any notice required by law is:

Prior to delivery to the Department of State for filing, all approvals or consents required by law will be endorsed upon or annexed to the certificate.

(Acknowledgment)

(type name/address of incorporators)

Signature

Approved Corporate Language as of 10/22/12

For Adoption –

To place out destitute, delinquent, abandoned, neglected, abused or dependent children. The corporation's authority to place out such children shall terminate on X. Furthermore, the duration of the corporation's ability to place out children shall not be extended without the prior written approval of the New York State Office of Children and Family Services.

X = A date that will be 1, 2 or 5 years in the future depending on what the approval states. The date selected should be two weeks from the date House Counsel received the approval to allow for processing time. For example, if we get an approval on 11/5/12 and it is for 2 years, the date placed in the certificate should be 11/19/2014.

Perpetual authority is not given to adoption corporations.

For Foster Care –

To board out destitute, delinquent, abandoned, neglected, abused or dependent children. The corporation's authority to board out such children shall terminate on X. Furthermore, the duration of the corporation's ability to board out children shall not be extended without the prior written approval of the New York State Office of Children and Family Services.

X= 1st time, 5 years from date; 2nd time 10 years from date. The date selected should be two weeks from the date House Counsel received the approval to allow for processing time. For example, if we get an approval on 11/5/12 and it is for 5 years, the date placed in the certificate should be 11/19/2017.

Perpetual authority (3rd time) should now read as follows –

To board out destitute, delinquent, abandoned, neglected, abused or dependent children in perpetuity.

For Residential Care –

To care for destitute, delinquent, abandoned, neglected, abused or dependent children. The corporation's authority to care for such children shall terminate on X. Furthermore, the duration of the corporation's ability to care for children shall not be extended without the prior written approval of the New York State Office of Children and Family Services.

X= 1st time, 5 years from date; 2nd time 10 years from date. The date selected should be two weeks from the date House Counsel received the approval to allow for processing time. For example, if we get an approval on 11/5/12 and it is for 5 years, the date placed in the certificate should be 11/19/2017.

Perpetual authority (3rd time) should now read as follows –

To care for destitute, delinquent, abandoned, neglected, abused or dependent children in perpetuity.

For Domestic Violence –

To establish, operate and maintain residential programs for victims of domestic violence, as defined in section 459-a of the Social Services Law. *The corporation's authority to operate and maintain residential programs for victims of domestic violence shall terminate on X. Furthermore, the duration of the corporation's ability to operate and maintain residential programs for victims of domestic violence shall not be extended without the prior written approval of the New York State Office of Children and Family Services.*

X= 1st time, 5 years from date; 2nd time 10 years from date. The date selected should be two weeks from the date House Counsel received the approval to allow for processing time. For example, if we get an approval on 11/5/12 and it is for 5 years, the date placed in the certificate should be 11/19/2017.

Perpetual authority (3rd time) should now read as follows –

To establish, operate and maintain residential programs for victims of domestic violence, as defined in section 459-a of the Social Services Law, in perpetuity.

APPENDIX 7

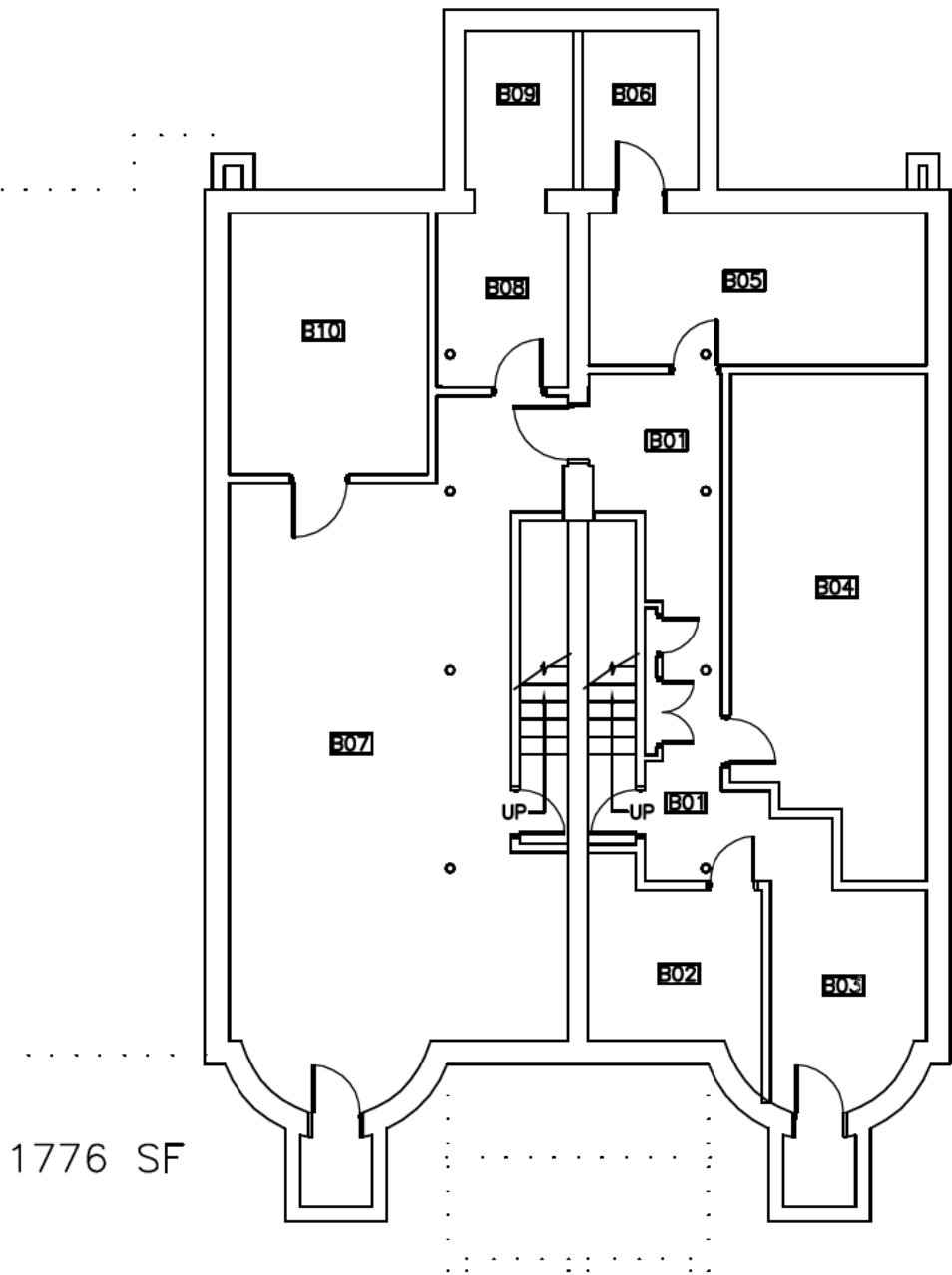
CITY LEASED SITE FLOOR PLANS

ACS recognizes it may be difficult to view these floor plans when printed on letter size paper, they are best viewed on a computer screen where the proposer can zoom in and pan around to get a more detailed view. PDF versions of the floor plans are available on the ACS website, www.nyc.gov/acs with the solicitation. If printed they are best printed on 24 X 36 inch large format paper.

BROOKLYN FLOOR PLANS

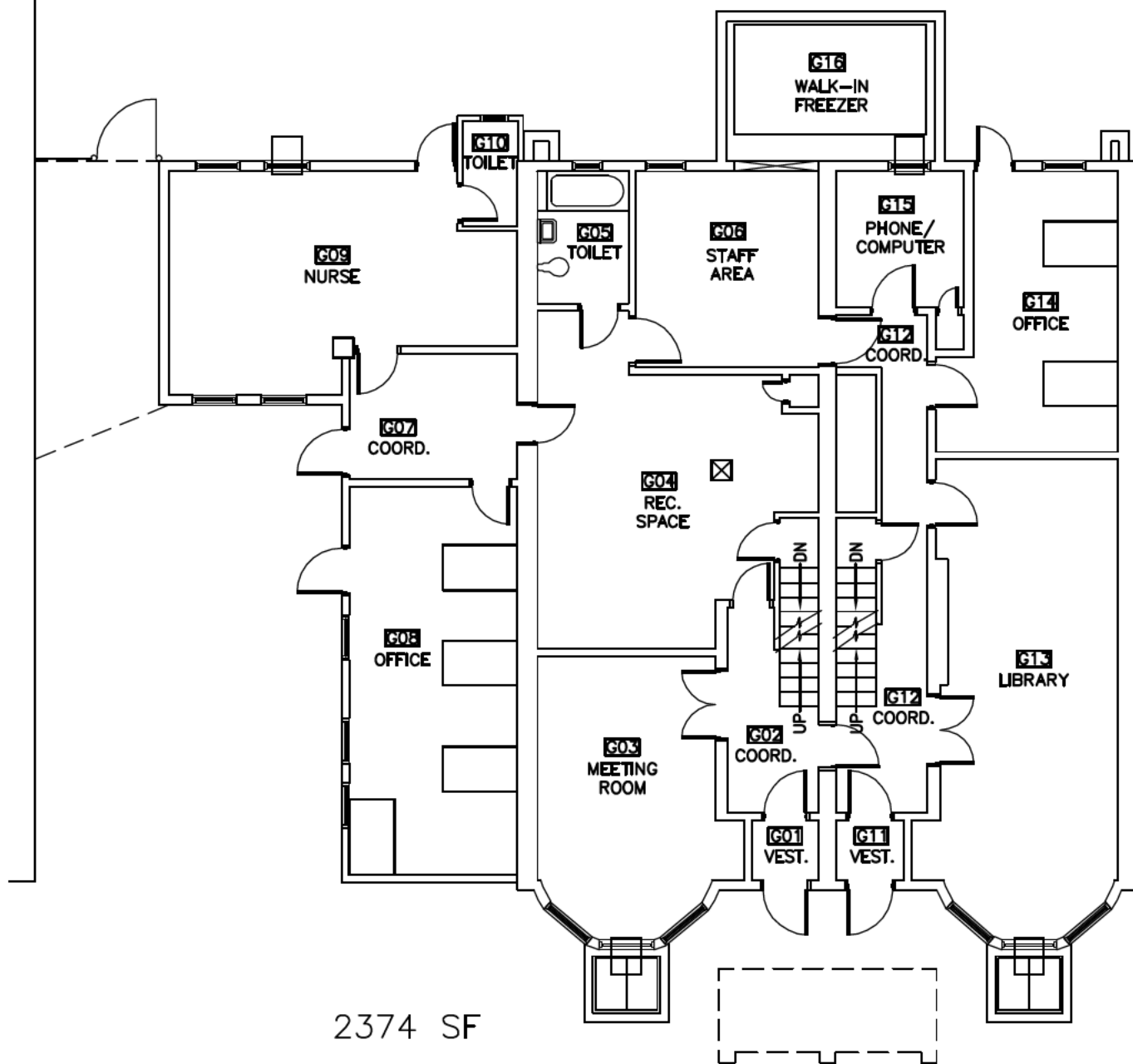
1125 CARROLL STREET
BROOKLYN, NY 11225

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BASEMENT
 1
 A099 SCALE: 3/32"=1'-0" 0 2 4 8 16 FEET

DRAWING NO. A099	DRAWING NAME: BASEMENT ROOM NUMBERS		PROJECT NAME: RENOVATE KITCHEN AND BATHROOMS BROOKLYN for BROOKLYN INITIATIVE	IT IS A VIOLATION OF THE LAW FOR ANY PERSON, UNLESS HE IS ACTING UNDER THE DIRECTION OF A LICENSED PROFESSIONAL ARCHITECT TO ALTER THIS DRAWING IN ANY WAY. ALTERATIONS MUST HAVE THE SEAL APPLIED ALONG WITH A DESCRIPTION OF THE ALTERATION, DATE AND SIGNATURE. COPYRIGHT 2008
XX OF XX	PROJ.# J0656	REVISIONS: XX/XX/XX XX/XX/XX	1125 CARROLL STREET BROOKLYN, NY	
DWG. BY: XXX	DWG. DATE: 07/16/10		New York State Office of Children & Family Services David A. Paterson Governor Glady's Carrion Esq. Commissioner  Capital Services Bureau ph.(518) 473-0487 fax(518) 474-8872 Room 220 North Capital View Office Park 52 Washington Street Rensselaer, N.Y. 12144	
CKD. BY: XXX	PLOT DATE: XXX			
CAD FILENAME: XXX				



GROUND FLOOR

SCALE: 3/32"=1'-0"

0 2 4 8 16 FEET

DRAWING NO.

A100

XX OF XX

DRAWING NAME:

**GROUND FLOOR
ROOM NUMBERS**

PROJ.# J0656

REVISIONS:

DWG. BY: XXX

DWG. DATE: 07/16/10

CKD. BY: XXX

PLOT DATE: XXX

CAD FILENAME: XXX

XX/XX/XX
XX/XX/XX

PROJECT NAME:

**RENOVATE KITCHEN AND BATHROOMS
BROOKLYN RESIDENTIAL CENTER**

1125 CARROLL STREET BROOKLYN, NY

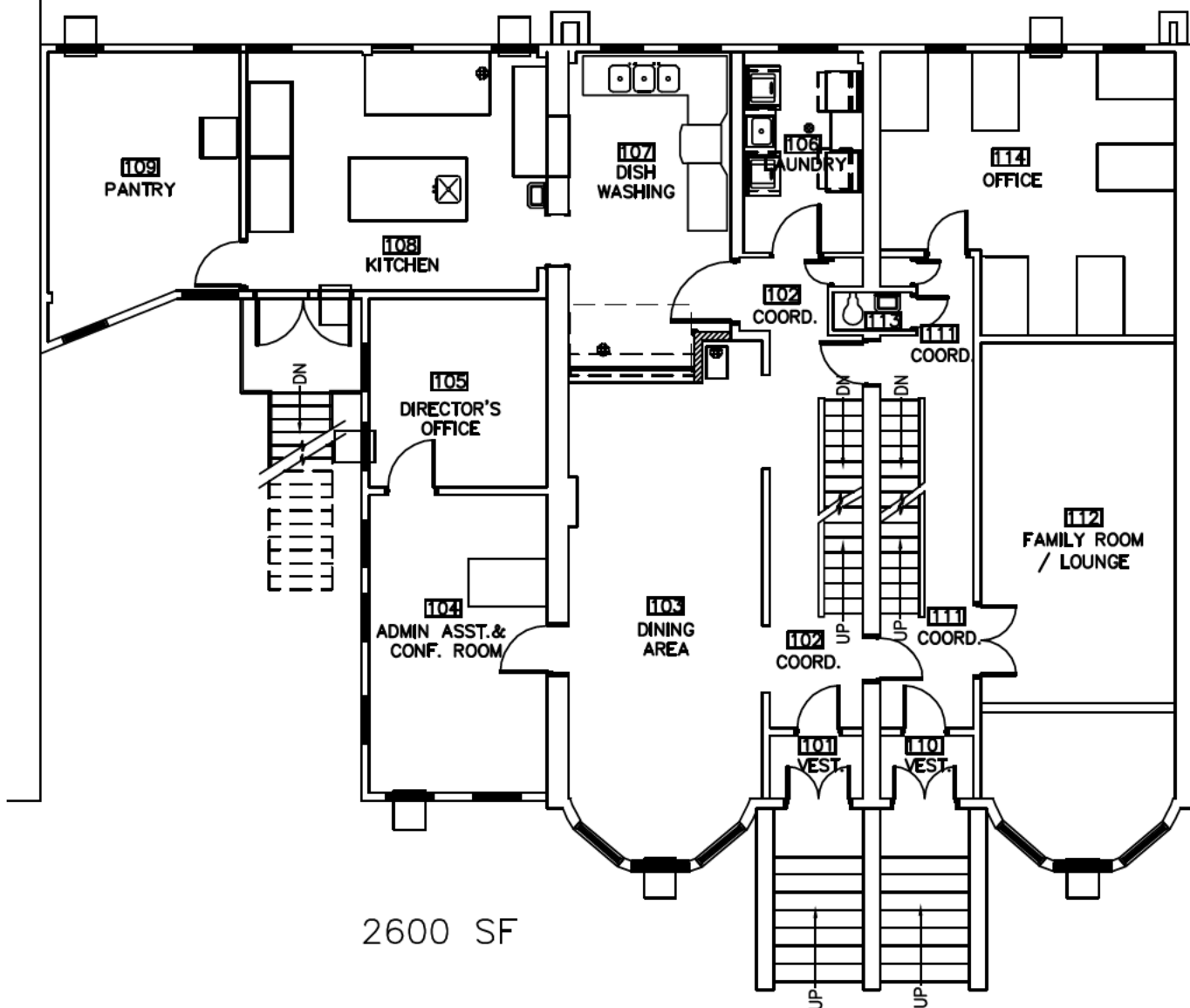
New York State
Office of
Children & Family
Services

David A. Paterson
Governor
Glady's Carrion Esq.
Commissioner



Capital Services Bureau
ph.(518) 473-0487
fax(518) 474-8872
Room 220 North
Capital View Office Park
52 Washington Street
Rensselaer, N.Y. 12144

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WITH A DESCRIPTION OF
THE ALTERATION, DATE
AND SIGNATURE.
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FIRST FLOOR

SCALE: 3/32"=1'-0"

0 2 4 8 16 FEET

DRAWING NO.

A101

XX OF XX

DRAWING NAME:

**FIRST FLOOR
ROOM NUMBERS**

PROJ.# J0656

DWG. DATE: 07/16/10

PLOT DATE: XXX

REVISIONS:

XX/XX/XX

XX/XX/XX

CAD FILENAME: XXX

PROJECT NAME:

**RENOVATE KITCHEN AND BATHROOMS
BROOKLYN RESIDENTIAL CENTER**

1125 CARROLL STREET BROOKLYN, NY

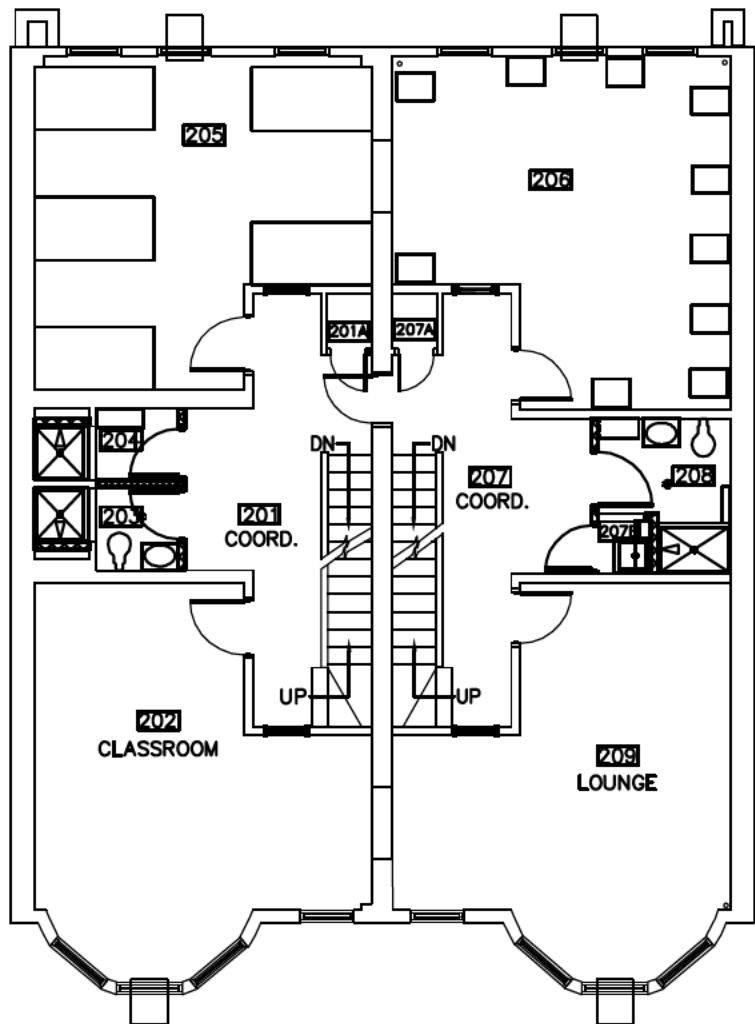
New York State
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David A. Paterson
Governor
Glady's Carrion Esq.
Commissioner



Capital Services Bureau
ph.(518) 473-0487
fax(518) 474-8872
Room 220 North
Capital View Office Park
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Rensselaer, N.Y. 12144

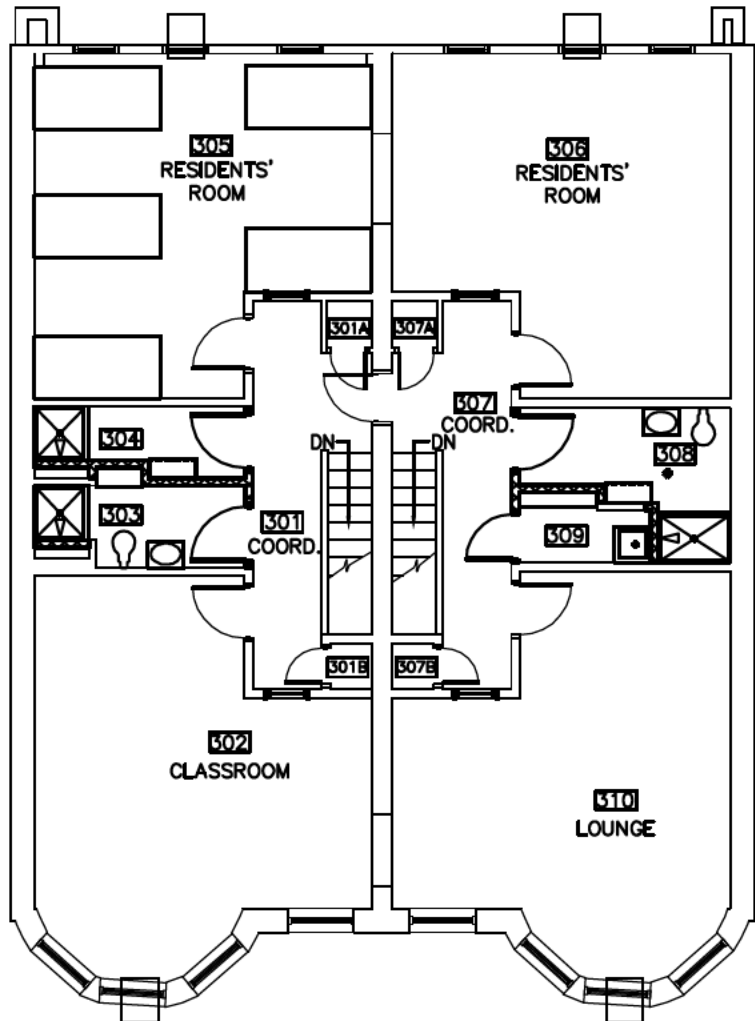
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1655 SF

1
A102 **SECOND FLOOR**
SCALE: 3/32"=1'-0" 0 2 4 8 16 FEET

DRAWING NO. A102 XX OF XX	DRAWING NAME: SECOND FLOOR ROOM NUMBERS	PROJECT NAME: RENOVATE KITCHEN AND BATHROOMS BROOKLYN RESIDENTIAL CENTER 1125 CARROLL STREET BROOKLYN, NY	IT IS A VIOLATION OF THE LAW FOR ANY PERSON, UNLESS HE IS ACTING UNDER THE DIRECTION OF A LICENSED PROFESSIONAL ARCHITECT TO ALTER THIS DRAWING IN ANY WAY. ALTERATIONS MUST HAVE THE SEAL APPLIED ALONG WITH A DESCRIPTION OF THE ALTERATION, DATE AND SIGNATURE. COPYRIGHT 2008
DWG. BY: XXX CKD. BY: XXX	PROJ.# J0656 DWG. DATE: 07/16/10 PLOT DATE: XXX	REVISIONS: XX/XX/XX XX/XX/XX	New York State Office of Children & Family Services David A. Paterson Governor Gladys Carrion Esq. Commissioner
CAD FILENAME: XXX			Capital Services Bureau ph.(518) 473-0487 fax(518) 474-8872 Room 220 North Capital View Office Park 52 Washington Street Rensselaer, N.Y. 12144



1699 SF

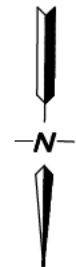
THIRD FLOOR
 SCALE: 3/32"=1'-0"
 0 2 4 8 16 FEET

DRAWING NO. A103 XX OF XX	DRAWING NAME: THIRD FLOOR ROOM NUMBERS	PROJECT NAME: RENOVATE KITCHEN AND BATHROOMS BROOKLYN RESIDENTIAL CENTER 1125 CARROLL STREET BROOKLYN, NY	IT IS A VIOLATION OF THE LAW FOR ANY PERSON, UNLESS HE IS ACTING UNDER THE DIRECTION OF A LICENSED ARCHITECT TO ALTER THIS DRAWING IN ANY WAY. ALTERATIONS MUST HAVE THE SEAL APPLIED ALONG WITH A DESCRIPTION OF THE ALTERATION, DATE AND SIGNATURE. COPYRIGHT 2008
DWG. BY: XXX CKD. BY: XXX	PROJ.# J0656 DWG. DATE: 07/16/10 PLOT DATE: XXX	REVISIONS: XX/XX/XX XX/XX/XX	New York State Office of Children & Family Services David A. Paterson Governor Gladys Carrion Esq. Commissioner
CAD FILENAME: XXX			Capital Services Bureau ph.(518) 473-0487 fax(518) 474-8872 Room 220 North Capital View Office Park 52 Washington Street Rensselaer, N.Y. 12144

BRONX FLOOR PLANS

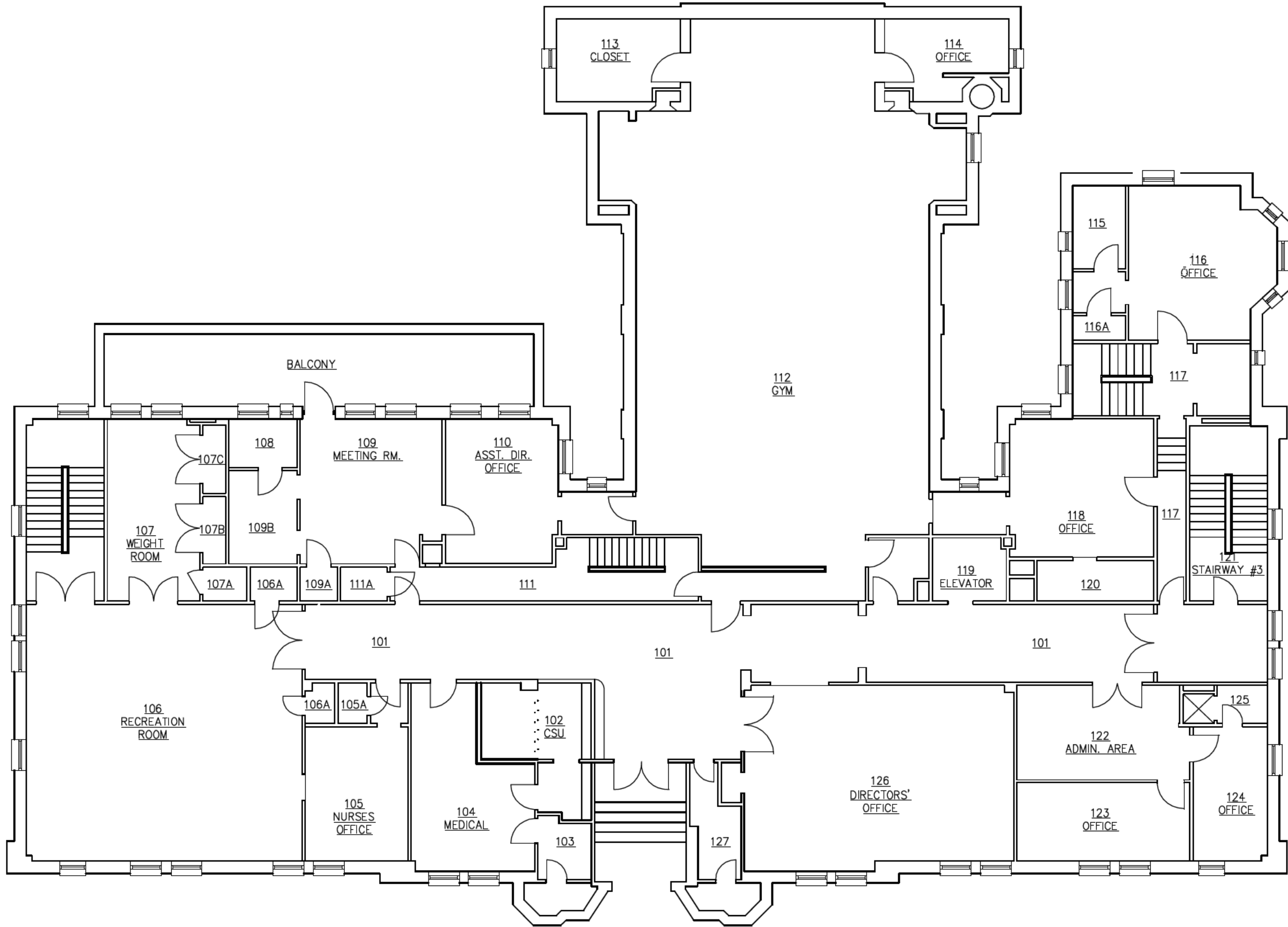
170 EAST 210TH STREET
BRONX, NY 10467

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IT IS A VIOLATION OF THE LAW FOR ANY PERSON, UNLESS HE IS ACTING UNDER THE DIRECTION OF A LICENSED PROFESSIONAL ARCHITECT TO ALTER THIS DRAWING IN ANY WAY. ALTERATIONS MUST HAVE THE SEAL AFFIXED ALONG WITH A DESCRIPTION OF THE ALTERATION, DATE AND SIGNATURE. COPYRIGHT 2008

SEAL:

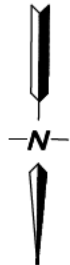


1
A201

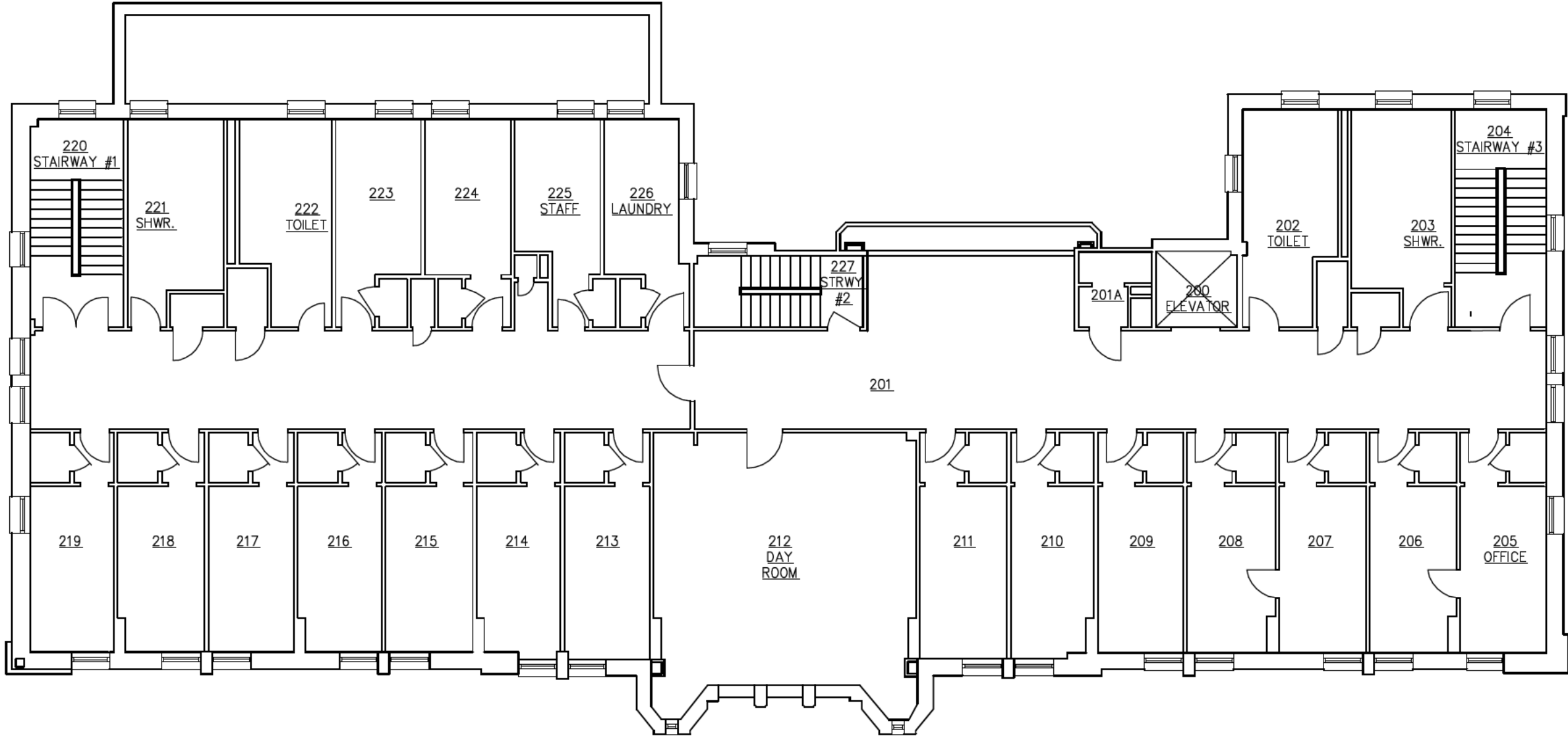
FIRST FLOOR PLAN

SCALE: 3/32"=1'-0"

0 2.67' 10.67' 21.3'



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2 OF 5		PROJ.#		170 East 210th Street New York State Office of Children & Family Services Andrew M. Cuomo Governor Ghadya Carlton Esq. Commissioner		Bronx, NY Capital Services Bureau ph.(518) 473-0487 fax(518) 474-8872 Room 220 North Capital View Office Park 52 Washington Street Rensselaer, N.Y. 12144	
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A202

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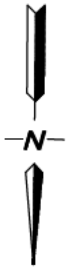
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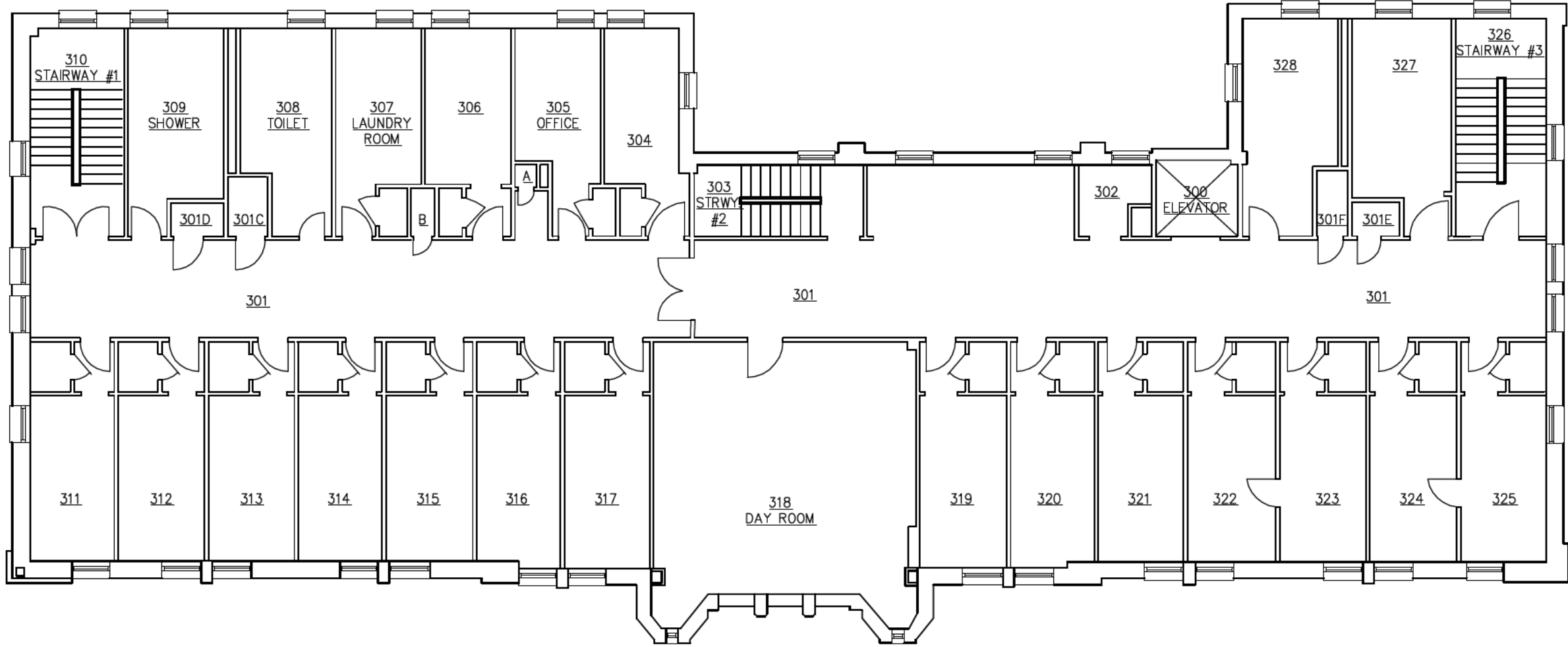
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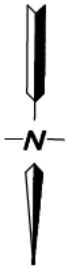
SECOND FLOOR PLAN



DRAWING NO. A202	DRAWING NAME: FLOOR PLAN		PROJECT NAME: SOUTHERN NY RC	170 East 210th Street New York State Office of Children & Family Services Andrew M. Cuomo Governor Gladys Carboni Esq. Commissioner		Bronx, NY Capital Services Bureau ph.(518) 473-0487 fax(518) 474-8872 Room 220 North Capital View Office Park 52 Washington Street Rensselaer, N.Y. 12144	IT IS A VIOLATION OF THE LAW FOR ANY PERSON, UNLESS HE IS ACTING UNDER THE DIRECTION OF A LICENSED PROFESSIONAL ARCHITECT TO ALTER THIS DRAWING IN ANY WAY. ALTERATIONS MUST HAVE THE SEAL AFFIXED ALONG WITH A DESCRIPTION OF THE ALTERATION, DATE AND SIGNATURE. COPYRIGHT 2008
3 OF 5	PROJ.#	REVISIONS:					
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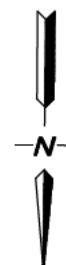


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A203
THIRD FLOOR PLAN
SCALE: 3/32"=1'-0"
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DRAWING NO. A203	DRAWING NAME: FLOOR PLAN	PROJECT NAME: SOUTHERN NY RC 170 East 210th Street New York State Office of Children & Family Services <i>Andrew M. Cuomo Governor</i> <i>Ghadya Camón Esq. Commissioner</i>		 Bronx, NY Capital Services Bureau ph.(518) 473-0487 fax(518) 474-8872 Room 220 North Capital View Office Park 52 Washington Street Rensselaer, N.Y. 12144	IT IS A VIOLATION OF THE LAW FOR ANY PERSON, UNLESS HE IS ACTING AS A LICENSED ARCHITECT OR UNDER THE DIRECTION OF A LICENSED ARCHITECT TO ALTER THIS DRAWING IN ANY WAY. ALTERATIONS MUST HAVE THE SEAL AFFIXED ALONG WITH A DESCRIPTION OF THE ALTERATION, DATE AND SIGNATURE. COPYRIGHT 2008
4 OF 5	REVISIONS:				
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DRAWING NO. A204	DRAWING NAME: FLOOR PLAN		PROJECT NAME: SOUTHERN NY RC 170 East 210th Street Bronx, NY	IT IS A VIOLATION OF THE LAW FOR ANY PERSON, FIRM OR COMPANY TO UNDER THE DIRECTION OF A LICENSED PROFESSIONAL ARCHITECT TO ALTER THIS DRAWING IN ANY WAY. ANY PERSON WHO MUST HAVE THE SEAL AFFIXED ALONG WITH A DESCRIPTION OF MATERIALS, DATE AND SIGNATURE. COPYRIGHT 2006	SEAL:					
	5 OF 5	REVISIONS: <table border="1"> <tr> <td>PROJ.#</td> <td>DWG. DATE:</td> <td>PLOT DATE:</td> </tr> <tr> <td>DWG. BY: OGS</td> <td>12/28/10</td> <td>xxx</td> </tr> <tr> <td>CKD. BY: JB</td> <td></td> <td></td> </tr> </table>				PROJ.#	DWG. DATE:	PLOT DATE:	DWG. BY: OGS	12/28/10
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STATEN ISLAND – FLOOR PLANS

1133 FOREST HILL ROAD
STATEN ISLAND, NY 10314

ACS recognizes it may be difficult to view these floor plans when printed on letter size paper, they are best viewed on a computer screen where the proposer can zoom in and pan around to get a more detailed view. PDF versions of the floor plans are available on the ACS website, www.nyc.gov/acs with the solicitation. If printed they are best printed on 24 X 36 inch large format paper.

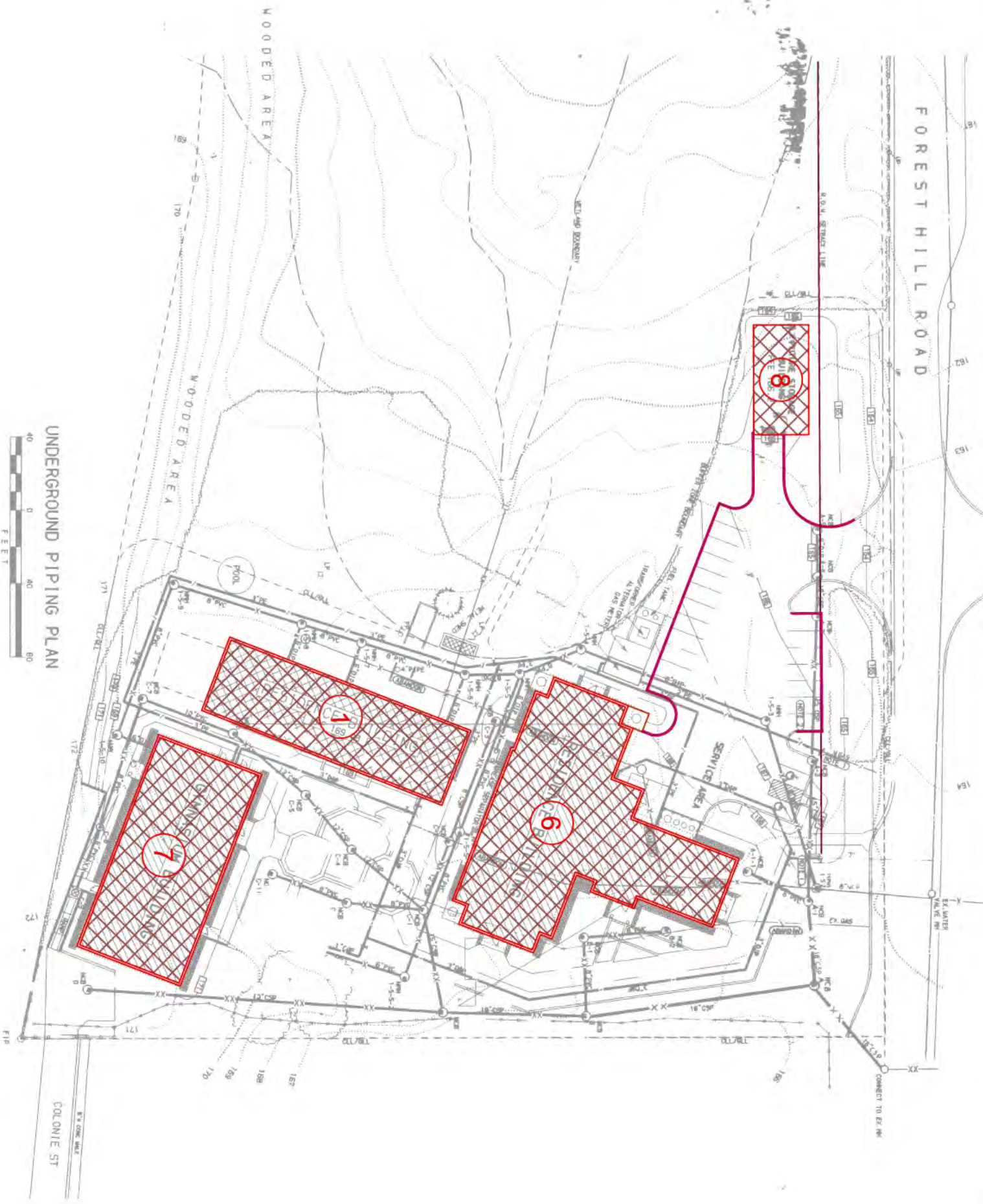


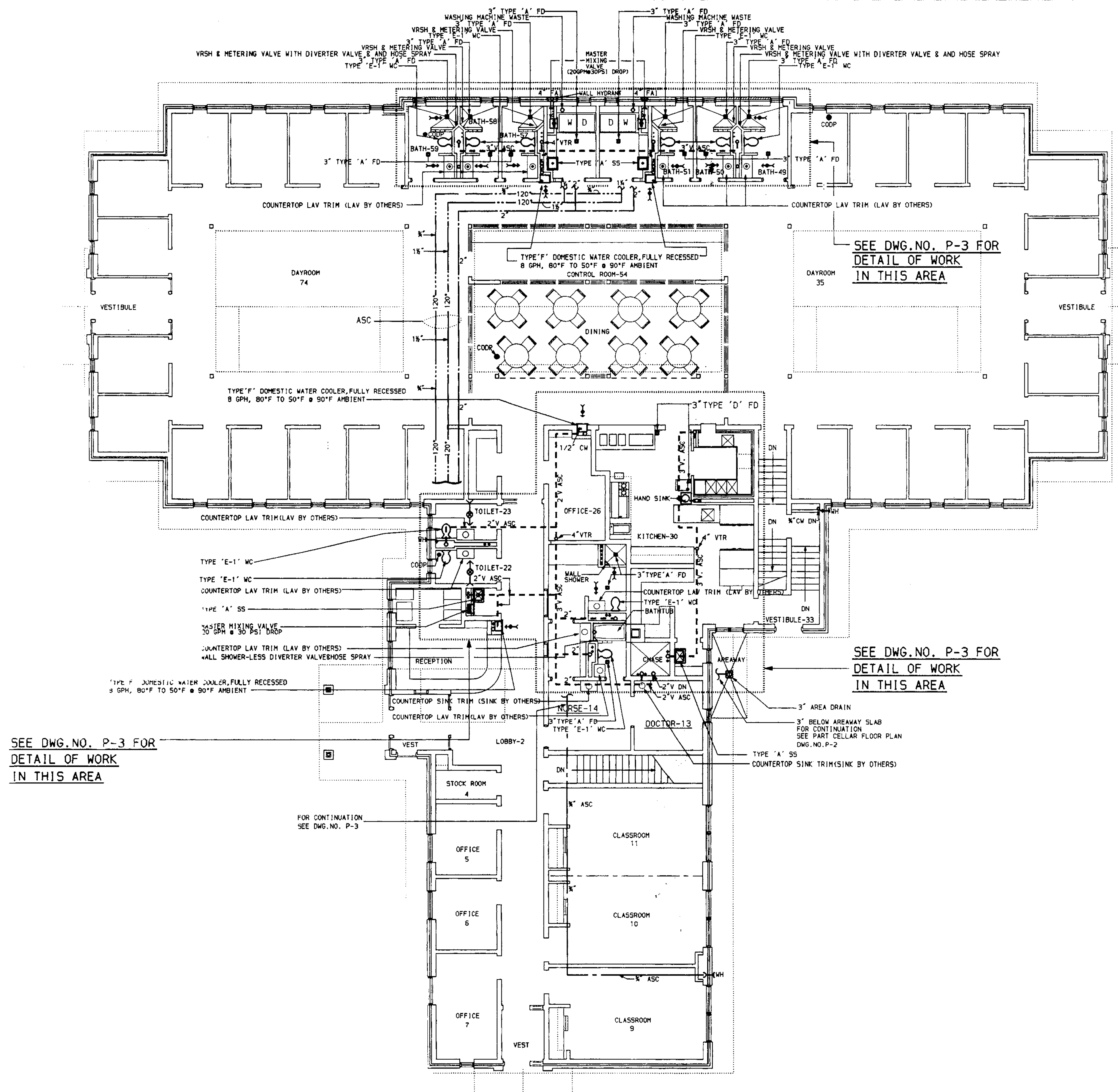
FOREST HILL ROAD

WOODED AREA

WOODED AREA

UNDERGROUND PIPING PLAN





ABBREVIATIONS	
AC	AIR CHAMBER
AF	ABOVE FLOOR
AFF	ABOVE FINISHED FLOOR
ASC	ABOVE SUSPENDED CEILING (ATTIC SPACE)
BF	BELOW FLOOR
CLG, CEIL	CEILING
CO	CLEANOUT
COOP	CLEANOUT DECK PLATE
CONT	CONTINUE, CONTINUATION
COWP	CLEANOUT WALL PLATE
DPV	DUPLEX PROTECTOR VALVE
CW	DOMESTIC COLD WATER
DHW, HW	DOMESTIC HOT WATER
DHWC	DOMESTIC HOT WATER CIRCULATION
DHWH	DOMESTIC HOT WATER HEATER
DWC	DOMESTIC WATER COOLER
DN	DOWN
DWG	DRAWING
ELEV, EL	ELEVATION
FAI	FRESH AIR INLET
FIN	FINISHED
FD	FLOOR DRAIN
FFE	FINISHED FLOOR ELEVATION
HB	HOSE BIBB
HT	HOUSE TRAP
IWF	INDIRECT WASTE FITTING
INV	INVERT
LAV	LAVATORY
MAX	MAXIMUM
SS	SERVICE SINK
MV	MIXING VALVE
NC	NEAR CEILING
NIC	NOT IN CONTRACT
PO	PLUGGED OUTLET
RM	ROOM
VO	VALVED OUTLET
VRSH	VANDAL RESISTANT SHOWER HEAD
VTR	VENT THRU ROOF
V	VENT
WC	WATER CLOSET
W	WASTE
CTFSE	CONNECT TO FOOD SERVICE EQUIPMENT BY OTHERS

SYMBOLS	
---	DOMESTIC COLD WATER PIPING
----	DOMESTIC HOT WATER PIPING
----	DOMESTIC HOT WATER PIPING
----	DOMESTIC HOT WATER PIPING
----	DOMESTIC HOT WATER PIPING
----	DOMESTIC HOT WATER CIRCULATION PIPING
----	VENT PIPING
----	WASTE PIPING - SANITARY
----	UNION
○	WASTE OR VENT STACK
●	WATER RISER
●	STOP VALVE
○	CLEANOUT DECK PLATE
○	MIXING VALVE & STOP VALVES
○	VANDAL RESISTANT SHOWER HEAD
○	SHOWER METERING VALVE
○	STRAINER WITH BLOWOFF VALVE
○	AIR CHAMBER
○	GATE VALVE
○	'P' TRAP
○	CLEAN OUT
○	FLOOR DRAIN
○	FLUSH VALVE WITH STOP VALVE
○	WATER CLOSET
○	LAVATORY
○	SERVICE SINK
○	DOMESTIC WATER COOLER
○	CLEANOUT WALL PLATE
○	FRESH AIR INLET
○	WALL HYDRANT W.H.
○	HANDICAPPED FIXTURE
○	FOOD SERVICE EQUIPMENT BY OTHERS SEE DWG. NO. P-3
○	WASHER (BY OTHERS)
○	DRYER (BY OTHERS)

WARNING
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John J. Fausel

PLUMBING
PROVIDE 25 BED YOUTH FACILITY
STATEN ISLAND RESIDENTIAL FACILITY
1133 FOREST HILL RD., S.I.S., NY
BUILDING No. 4
FIRST FLOOR PLAN

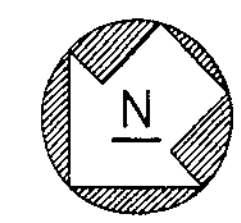
STATE OF NEW YORK EXECUTIVE DEPARTMENT
OFFICE OF GENERAL SERVICES
COMMISSIONER
ROBERT B. ADAMS
DESIGN AND CONSTRUCTION
EXECUTIVE DIRECTOR
RAYMOND W. CASEY
DIVISION OF DESIGN
DIRECTOR
WILLIAM F. O'CONNOR, R.A.

DESIGNED BY	DATE	SCALE	APPROVED
BCF	1-13-94	AS NOTED	<i>BCF</i>
DRAWN BY	CHECKED BY	STRUCTURAL CHECK	FIELD CHECK
JEM	<i>FAUSEL</i>		

APPROVED BY NEW YORK STATE DIVISION FOR YOUTH
DATED 1-13-94 LETTER NO. 031049

PROJECT NO.	DRAWING NO.
39255-P	P-1
PLAN FILE NO.	92/3001

FIRST FLOOR PLAN
SCALE: 1/8" = 1'-0"
FIN. FLOOR ELEV. 169.0'





Division of Administration
Office of Procurement
150 William Street - 9th Floor
New York, NY 10038

RONALD E. RICHTER
Commissioner

DONALD BROSEN
Deputy Commissioner

PATRICIA CHABLA
Assistant Commissioner
Agency Chief Contracting Officer

April 2, 2013

Addendum # 1

Limited Secure Placement Negotiated Acquisition, PIN: 06813N0004

Dear Prospective Proposer:

The Administration for Children's Services is issuing Addendum #1 to the Limited Secure Placement Negotiated Acquisition, PIN: 06813N0004.

Addendum Items:

- A. **Page, 29, Section III – SCOPE OF SERVICES, G. 18. d.** is amended to include the following language:
- i. Contractors providing LSP Program services in City-Leased sites must allow and accommodate Contractors providing LSP Program services in non-City-Leased sites the appropriate and necessary access to the dental service room so youth from non-City-Leased sites may receive dental services at the City-Leased sites.
 - ii. To help facilitate on-site dental services Contractors providing LSP Program services in non-City-Leased sites will be required to transport portable dental equipment from the City-Leased sites to the Contractor's LSP Program site for use by the dentist. Additionally, the Contractor must return the portable dental equipment upon completion of dental services. Portable dental equipment is designed to be easily packaged and transported. Portable dental equipment may include but is not limited to, chair, light, compressor, suction, and water supply.
- B. **Page, 51, SECTION IV- FORMAT AND CONTENT OF THE PROPOSAL,** is amended to include the following section and language:

f. Financial Reporting/Audits

- a. Proposals must include a copy of the Proposer's latest CPA certified financial statements and OMB Circular A133 Audit report. If not in receipt of federal funds, an A133 report is not required. If such statements are not available, the Proposer must explain why. Contractors' financial statements and audit must demonstrate responsible fiscal performance, and specifically must meet the following standards:
 - i. Financial statements, management letters, and audits must cover the Contractor's most recently completed fiscal year or calendar year in accordance with federal, state and city requirements.



- ii. The audit must report an unqualified opinion on financial statements compliance and internal controls, if appropriate. The audit must not contain material weaknesses, unaddressed prior year findings, or excess liabilities.
 - iii. The Contractor's net assets and liquidity must demonstrate minimum financial risk.
- C. **Page, 52, SECTION IV- FORMAT AND CONTENT OF THE PROPOSAL, B. 1. g.** is amended to read:
- g. Copy of the Proposer's latest CPA certified financial statements and OMB Circular A133 Audit report. If not in receipt of federal funds, an A133 report is not required. (submit as Attachment G)

Thank you,

Patricia Chabla

Patricia Chabla



Division of Administration
Office of Procurement
150 William Street - 9th Floor
New York, NY 10038

RONALD E. RICHTER
Commissioner

DONALD BROSEN
Deputy Commissioner

PATRICIA CHABLA
Assistant Commissioner
Agency Chief Contracting Officer

April 18, 2013

Addendum # 2

Limited Secure Placement Negotiated Acquisition, PIN: 06813N0004

Dear Prospective Proposer:

The Administration for Children's Services is issuing Addendum #2 to the Limited Secure Placement Negotiated Acquisition, PIN: 06813N0004.

I. Addendum Items:

A. Page 23, SECTION III – SCOPE OF SERVICES, G. 1. j. has been added:

- j. Contractors may be required to purchase, maintain and secure mechanical restraint hardware on site in the LSP Program site.

B. Page 47, SECTION IV – FORMAT AND CONTENT OF THE PROPOSAL, A. 3. A. iv. The following language has been removed:

- iv. Attach letters of support for the proposal from at least two (2) relevant references. The letters must include the name of the reference entity a brief statement describing the relationship between the Proposer and the reference entity and the name, title, and telephone number of a contact person at the reference entity for the proposer.

C. Page 51, Section IV – FORMAT AND CONTENT OF THE PROPOSAL, d. i. has been amended to read:

- i. If proposing to provide services in one of the City-Leased sites listed in Section II (D) (10), Proposer must have visited the program site prior to proposal submission. ACS will maintain a log of all proposers who have performed site visits.

The following language has been removed: Please provide a signed attestation from ACS which includes the date and time of the visit.

D. Page 52, SECTION IV- FORMAT AND CONTENT OF THE PROPOSAL, B. 1. e. has been amended to read:

- e. Letter of Support from the residential model / approach developer being proposed (Submit as Attachment E).

E. Page 52, SECTION IV- FORMAT AND CONTENT OF THE PROPOSAL, B. 1. k. has been added:

- k. Letter of Support from the aftercare model developer being proposed (Submit as Attachment M).



F. Page 55, SECTION V – PROPOSAL EVALUATION AND CONTRACT AWARD PROCEDURES, C. 3. b. ii. (c) has been amended to read:

(c) In the event that there still remain an insufficient number of technically viable proposals for General LSP programs, ACS may consider, in its sole discretion, offering awards to those proposing acceptable sites up to twenty-five (25) miles outside of New York City. Proposers proposing LSP Program sites outside of New York City must submit a plan to move to a site within the five (5) boroughs of New York City within twenty-four (24) months of the approval date of the Close to Home LSP Plan for New York City.

G. Page 55, SECTION V – PROPOSAL EVALUATION AND CONTRACT AWARD PROCEDURES, C. 3. c. iii. has been amended to read:

iii. In the event that there still remain an insufficient number of technically viable proposals within a service option, ACS may consider, in its sole discretion, offering awards to those proposing acceptable sites up to twenty-five (25) miles outside of New York City. Proposers proposing LSP Program sites outside of New York City must submit a plan to move to a site within the five (5) boroughs of New York City within twenty-four (24) months of the approval date of the Close to Home LSP Plan for New York City. For Specialized LSP Programs, ACS will evaluate the necessity and/or feasibility of this proposed relocation during contract negotiations.

II. Clarifications, Questions and Answers from Pre-Proposal Conference:

Q: If District 79 approves the educational plan can we run our school as a DOE satellite?

A: Yes. District 79 will embed services into residences once a partnership agreement between District 79 and the partner agency is signed.

Q: How do you define a direct care worker? Would a unit manager who is not on shift count towards the ratio?

A: A direct care worker is defined as someone who is in the facility to specifically supervise the youth and who fills the minimum staff to youth ratio requirement. A unit manager may act in this function if he/she is not on duty to provide staff supervision during that time and is there to provide direct supervision to the youth.

Q: Must an Evidence Based Model (EBM) or an Adaptation of an Evidence Based Model (AEBM) be used for residential care? How is the Missouri Model viewed?

A: For residential services, an EBM model is not required. Residential services must include the items listed in Section III Scope of Services E in the RFP. The Missouri Model would be considered one such approach. EBM/AEBMs are only required for aftercare services.

Q: What clinicians are required on site?

A: For every twelve (12) kids the following staff is required, at a minimum, at each LSP Program site: clinical director 24/7 coverage (includes phone and minimum on-site coverage of 8 hours per week), supervisory clinician 24/7 coverage (includes phone, and minimum on-site coverage of 20 hours across the 7 days of the week), one (1) full time on-site family worker for 40 hours a week, one (1) full time on-site mental health clinician for 40 hours a week, and a care coordinator (a portion of the case worker's time can be devoted to care coordination). Full time substance abuse services are required on-site to be

provided by a qualified substance abuse clinician; a portion of the mental health clinician's time can be devoted to substance abuse counseling.

Q: What kinds of crimes will the youth held in LSP be charged with? What is the profile of the youth who will be referred to LSP?

A: Youth referred to Limited Secure may be there on the full range of charges. New York City Family Court Judges make the decision to place youth and it often depends on the nature of the offense and particular circumstances. Charges may be felonies, violent felonies or misdemeanors. ACS is predicting that many of the LSP youth will be there because of assaults and robberies.

Q: Can you clarify violent felony?

A: Violent felonies are defined in Sec 70.02 of the Penal Law, and include, for example, some counts of rape, assault, robbery, burglary and arson.

Q: For City-Leased sites, would maintenance and operation costs be covered by the contracted providers?

A: Yes, however the initial work will be covered by ACS and can be discussed with ACS during the walk through.

Q: Will preparation of the facility be done by ACS?

A: Yes, ACS will prepare the City-Leased Sites for use by the Contractor.

Q: If a provider is using a particular model, would ACS be fitting the facilities to suit them? Will there be an opportunity for the provider to give input into the design of the facility?

A: Due to time constraints, ACS will begin work as soon as we have our lease in place with the State; however, the current structure should be compatible with many approaches such as the Missouri approach. The Brooklyn Site has dormitory style sleeping arrangements, while the Bronx and Staten Island Sites have individual bedrooms.

Q: If you have a community advisory committee for NSP can it be combined with LSP?

A: Yes, provided it is in the same borough.

Q: Aftercare models are being funded at approximately half of what ACS has offered for previous RFPs. Why?

A: They are being funded at the same rate; however, it is just written differently in this RFP.

Q: Will ACS psychiatrists have supervision over contractor mental health clinicians?

A: No, ACS contracted psychiatry staff will not have supervision of LSP Contractor mental health clinicians, however, LSP Contractors must provide Care Coordination services and these staff must work with ACS contracted psychiatry staff in a collaborative manner.

Q: The negotiated acquisition lists one (1) teacher provided by DOE and one (1) by a provider. This sets up a union vs. non-unionized teacher dynamic. What rationale drove the decision to do this?

A: The DOE approach will embed a teacher based on the number of youth; one (1) DOE teacher for every twelve (12) youth. The LSP Contractor will supplement the DOE teachers to lower the student to teacher ratio in the classroom. The Proposer should propose a certain number of teachers based on the ratios outlined in the Negotiated Acquisition – Section II (H) (6). The DOE will work with each Proposer

to ensure that the plan is viable. The DOE will support in hiring and supporting any agency-employed teacher.

Q: If there is a program with twelve (12) youth then can the agency request two (2) additional DOE teachers?

A: No, the Proposer must use the Teacher Ratio Add-On and provide one (1) supplemental teacher in addition to the one (1) teacher DOE would provide for twelve (12) youth. The DOE will work with each Proposer to ensure that the plan is viable.

Q: Is there is a regulation that prevents DOE teachers from teaching at facilities outside of the city?

A: No, there is not a regulation that prohibits it, but for several reasons we believe that the agency should explore options with the appropriate Boards of Cooperative Educational Services (BOCES). D79 is happy to talk through any specific cases in more detail.

Q: Can a Proposer propose certain age ranges?

A: ACS will designate the age range of each LSP Program site based on system needs. However, there is a place on the NA cover page for the Proposer to list their preferred age ranges.

Q: Can agencies subcontract to substance abuse contractors to meet the around the clock substance abuse provider requirement?

A: Yes, as long as the services occur on site, meets the OASAS and CASAC requirements in the NA, and the sub-contractor must be approved by ACS.

Q: Can Contractors access the ACS assessment tool?

A: Contractors will be given the assessment tool prior to start up. The youth specific intake form will be provided to Contractors around the time youth are placed in the facility.

Q: Can ACS recommend reassessment tools?

A: ACS will not recommend specific assessment and reassessment tool at this time.

Q: If there is a site within one hundred (100) feet NYC but not in NYC, will ACS consider not having to relocate the site within the next 2 years?

A: ACS is not authorized to allow General LSP Program sites to operate outside of New York City beyond twenty-four (24) months after the approval of the Close to Home LSP Plan. However, for Specialized LSP Programs, ACS will evaluate the necessity and/or feasibility of relocating within the City during contract negotiations.

Q: ACS has one hundred seventeen (117) as the actual census listed but the negotiated acquisition list one hundred fifty-eight (158) slots. How should Proposers budget for vacancy?

A: ACS is assuming close to full capacity.

Q: Can the base rate be applied to some transitional work for Aftercare?

A: Yes, as long as all the residential LSP requirements are met. This must be indicated on the budget template.

Q: What's the ratio of male to female youth that ACS is expecting for the one hundred eight (108) general beds to be used in LSP?

A: We are anticipating a ratio of approximately 80% males and 20% females.

Q: Who will be doing the coaching with the agencies?

A: Coaching will be done by the model or approach developers (or those authorized by the model or approach developers) working with Contractor staff on site.

Q: Does the coaching need to be done by the developer or a colleague?

A: The developer or an entity certified/authorized by the developer may provide the coaching.

Q: What are ACS's expectations around youth returning to their home schools? There have been ongoing problems in the past regarding youth who are returning to the community and them being denied placement in their community schools.

A: DOE is working through this and expects that this will be resolved soon.

Q: For a twenty (20) child site, how many teachers are needed?

A: There will be two (2) DOE teachers.

Q: If an agency provides an educational plan has been signed off by District 79, will it be part of the evaluation of the proposal?

A: Yes.

Q: What letters are required at the time of submission? Can linkages be provided at the time of service delivery?

A: Developer support letters for both residential LSP and Aftercare are needed at the time of submission and linkage agreements must be provided prior to the program start date. Additionally, ACS will not require letters of support for the proposal as originally indicated at the Bidders Conference. The section requiring these letters has been removed from the NA (see above I. Addendum Items (B)).

Q: Does the site need to be approved by OASAS to fulfill the requirements of this NA?

A: Prior to the program start date, the site will need to be a Certified OASAS site or an OASAS satellite site.

Q: Can you define what you mean by EBM business process?

A: We are looking for how the model works, i.e., how the model sets goals, is home-based, the philosophy, how behavior is changed and how cases are closed.

Q: Can you clarify the population for the intensive site?

A: The Intensive Support LSP Program site operates as a short term crisis intervention program. Youth who are in crisis or who need an intensive supportive intervention will be moved to this site at the discretion of ACS.

Q: Addendum regarding dental services sounded like if you provide dental services in a City-Leased site you need to provide access to the equipment for other clients.

A: Yes, the Contractor(s) operating LSP Programs at the City-Leased sites will need to provide access to both the equipment (for transport to non-City Leased sites) and the dental room for services to youth from other non-City-Leased LSP Programs. This option needs to be available to ensure that all dental care can be provided to all youth in the system.

Q: What instances would allow residents to be outside of the facilities (for recreation) and what type of supervision would that require?

A: ACS will be developing policies that outline the specific requirements for outside recreation, such as staffing and supervision requirements. Additionally, as part of the transition process back to the community, youth will be permitted to attend school in their community school.

Thank you,

Patricia Chabla

Patricia Chabla