Preventive Services Quality Assurance Standards and Indicators

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Ronald E. Richter, Commissioner

As needed ACS will issue and update this document and circulate it to all Providers.

Preventive Services Quality Assurance Standards and Indicators
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.PART I

MISSION STATEMENT - PREVENTIVE SERVICES

The New York City Administration for Children's Services ("ACS" or "Children's Services") was formed in 1996 with the mission of ensuring the safety and well-being of New York City's approximately two million children who live in the five boroughs of the City. To fulfill this mission, Children's Services operates the New York City's child welfare, juvenile justice, child care, and Head Start systems. Children's Services' child welfare system is made up of three main types of services:

- Protection – Children's Services Division of Child Protection investigates reports of abuse or neglect, assesses child safety and makes decisions about removals of children from their homes and/or delivery of services needed for them and their families.

- Prevention – Children's Services funds preventive services for families in which there is a risk of abuse or neglect to children to help avert the need for foster care placement. These services are provided through a continuum of directly-operated and contracted programs.

- Foster Care – Children's Services operates a family foster care and residential care system, and oversees contracts with non-profit social service organizations which provide services and achieve permanency for these children and their families.

Children's Services has the following commitments:

- All children coming into contact with the child welfare system will be protected from abuse and neglect.
- 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 Providers 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.

The overarching goals of Preventive Services are to:

- prevent child abuse and neglect and promote the safety of children;
- serve children and their families in their neighborhoods of origin;
- ensure that children are safe, healthy, and well cared for;

- strengthen families;
- reduce the likelihood of placements into foster care for children receiving Preventive Services;
- reduce the likelihood that children receiving Preventive Services will be the subject of subsequent abuse and neglect reports; and
- work with Family Foster Care and Residential Care contractors to promote permanency for children in foster care, and reduce their risk of re-entry into foster care after discharge.

Children's Services provides preventive services directly and through community-based Providers to families with children at risk of foster care placement. These community-based services promote the safety of children, strengthen the family, and promote permanency for children exiting foster care. Children's Services is committed to providing preventive services that are child centered and family-focused, community-based, and culturally competent. This means that services must address the individual needs of the child and the needs of the family members residing with the child, while recognizing the socio-economic realities which impact their daily lives. Children's Services believes that preventive services provided in such a manner protect children and reduce the need for foster care placement by creating a community of care. Children's Services expects Providers to deliver preventive services in accordance with federal, State, and city regulations, and with policies, procedures, and standards promulgated by Children's Services.

Creating a community of care requires active coordination among preventive service Providers, foster care Providers and local neighborhood resources. In order to create a cohesive and comprehensive system responsive to families, Providers must be prepared to identify, assess and address health or clinical issues such as mental health, substance use disorder/use, domestic violence, elder abuse, sexual abuse and other serious issues that place children at risk for abuse or neglect. This will ensure the seamless provision of services, support, and monitoring to a child at risk for foster care placement, and to her/his family. Preventive services support children and their families in a holistic manner that enables them to lead physically and emotionally stable lives and to pursue healthy and productive futures.

ACRONYMS/GLOSSARY

ADVPO	Advocate Preventive Only Case
AHRC	Association for Help of Retarded Children
AOD	Alcohol and Other Drug
APA	Agency Program Assistance
ARP	Accountability Review Panel
B2H	Bridges to Health (New York State)
CASAC	Credentialed Alcohol and Substance Abuse Counselor
CCR	Comprehensive Case Record
CCRS	Child Care Review Service (New York State)
CDT	Clinical Diagnostic Team
CDTP	Chemical Dependency Treatment Provider
CID	Case Initiation Date
CNNX	CONNECTIONS (New York State)
CODA	Children of Deaf Adults
COS	Court Ordered Supervision (NYC Children's Service)
CPSE	Committee on Pre-school Special Education
CRD	Case Responsibility Date
CSC	Child Safety Conference
CSE	Committee on Special Education
CSS	Commission of Social Services (NYC Children Services)
CWS	Child Welfare Services
DCJS	Division of Criminal Justice Service (New York State)
DD	Developmental Disability
DCP	Division of Child Protection (NYC Children's Services)
DFSS	Division of Family Support Services (NYC Children's Services)
DHMH	Department of Health and Mental Hygiene (New York City)
DHS	Department of Homeless Services (New York City)
DOE	Department of Education (New York City)
DSDD	OPWDD Developmental Disability Services Office (New York State)
ERC	Elevated Risk Conference
FAP	Family Assessment Program
FASP	Family Assessment and Service Plan
FCLS	Family Court Legal Services (New York City Children's Services)
FEGS	Federation Employment and Guidance Service
FPP	Family Preservation Program (New York City Children's Services)
FPS	Division of Family Permanency Services (New York City Children's Services)
FSI	Family Services Intake
FSS	Family Services Stage
FSU	Family Service Unit (New York City Children's Services)
FTC	Family Team Conference
HRA	Human Resources Administration (New York City)
IEP	Individual Education Plan

IFSP	Individual and Family Service Plan
ISP	Individual Service Plan
IT	Interdisciplinary Team
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning youth
NYCHA	New York City Housing Authority (New York City)
OASAS	Office of Alcoholism and Substance Abuse Services (New York State)
OCA	Office of Court Administration (New York State)
OCFS	Office of Children and Family Services (New York State)
OMH	Office of Mental Health (New York State)
OPD	Office of Program Development
OPWDD	Office for People with Developmental Disabilities (New York State)
OPTA	Office of Preventive Technical Assistance (New York City Children's Services)
OTDA	Office of Temporary and Disability Assistance (New York City)
PAMS	Provider Agency Measurement System (New York City Children's Services)
PINS/DAS	Persons in Need of Supervision/Designated Assessment Service
POP	Program Operating Plan
PPRS	Purchased Preventive Services
PROMIS	Preventive Organization Management Information System (New York City Children's Services)
PPC	Preventive Planning Conference
QIC	Quality Intervention Conference
SCR	New York State Central Register of Child Abuse and Maltreatment
SRT	Shared Response Team (New York City Children's Services)
SSO	Systems Support Office (New York City Children's Services)
STC	Service Termination Conference
TASH	The Association for the Severely Handicapped
VESID	Vocational Educational Services for Individuals with Disabilities (NYS)
WMS	Welfare Management System (New York State)
YAI	Young Adults Institute

APPROACH TO SERVICES

NEIGHBORHOOD BASED SERVICE PROVISION

General Preventive Services and Specialized Preventive Services should be provided to children and families within their own neighborhood or as close to their own neighborhood as possible. Children and families shall receive risk and needs assessments, concrete services, supportive counseling, and individual, family, and group therapy within their own neighborhood or as close to their own neighborhood as possible, when appropriate and consistent with the presenting needs of the children and their families.

The Provider shall develop a strategy for accessing (either directly or through subcontracts or linkages with other community-based Providers, coalitions, and networks), a continuum of community-based care to meet the range of needs of the children and families being served. These linkage agreements and collaborations should include provisions for information-sharing and collaborative service planning.

SERVICE DELIVERY MODEL

Caseload/Supervisory Ratios

New York State Office of Children and Family Services (NYS OCFS) regulations require that a preventive services Provider shall assign a family to no more than one case planner at a time. Individual caseloads significantly higher than twelve (12) are not recommended because of the level of services families require. The recommended Supervisory span of responsibility is five (5) case planners with a total of sixty (60) families.

Parent Aides

The Provider is encouraged to employ parent aides to assist in initial outreach and engagement efforts, provide in-home parent assistance, teach/demonstrate homemaking skills, advocate for parents and families, escort parents to service sites, and model appropriate behaviors in various situations. Parent aides can be linked with existing parent support and parent advocacy programs, such as those that are available through the mental health system, for the purposes of training and linking clients with services. This position may provide transitional employment opportunities for program participants/graduates.

Social Work Services and Advocacy

Children's Services requires priority attention by Providers to assess the safety of children in the household and take all necessary and appropriate measures to ensure their ongoing protection and safety including, but not limited to, all actions required of Mandated Reporters*.

Case Planners identify, focus on and provide those specific services that address issues and behaviors that place a child at risk of foster care placement or delay or impede successful family reunification. They promote maximum safety, supervision and support for children and their families and this perspective underlies FASPs, service plans, special assessments and referrals to

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* *See Part II, Section D, CASE PRACTICE.*

appropriate service Providers, and Supervisory guidance. Case Planners are aware of and utilize the full range of in-house and community-based services available to ensure the child(ren)'s safety, reduce/remove identified risks, and strengthen the family unit, and facilitate successful discharge and reunification.

Case Planning and Caseworker Responsibilities

In the spring of 2009, Children's Services received approval from New York State's Office of Children and Family Services and Division of Budget for Phase II of Improved Outcomes for Children (IOC). IOC brought a new level of case management authority and responsibility to Providers of preventive services. The following summarizes casework and Family Team Conference Model functions that are delegated to Provider agencies:

Intake/Case Opening for Advocate Cases;

Family Assessment Service Plans (FASP) Approval:

- Initial FASPs (Advocate Cases only),
- Comprehensive FASPs,
- Reassessment FASPs, and
- Plan Amendments;

Transfer of Preventive Service Cases;

Preventive Case Closing; AND

Modification of Program of Program Choice

<u>Family Team Conference Model</u>

The Family Team Conference Model is designed to engage families and community members in critical child welfare decisions. Decisions are made, and service plans developed, by a group (including the family, their supports, community supports and service Providers) rather than individually.

Objectives:

1. To improve critical decision making regarding a child's safety, well-being, and permanency by including people important to the family's life, key community supports, and Providers with whom the family is involved.
2. To comprehensively asses service needs of children and families, and plan and coordinate service delivery by evaluating the need for ongoing services, reassessing the service needs of the family, ensuring the case is progressing toward stability and ensuring that the family goals are being achieved.

Children Services oversees case specific decision-making through participation in the Family Team Conference model. Family Team Conferences are used to promote practice that reflects Children's Services core principles and outcomes, thus enhancing children's safety and well being.

BASIC CONCEPTS AND SERVICES [1]

Advocate Preventive Only (ADVPO) or Advocate Cases: Any preventive service client case which at any point during the active life of such case doesn't meet one or more of the following criteria: (1) a Preventive Services recipient is involved in an indicated child protective case; (2) the children of Preventive Services recipient family are in or have siblings in foster care; or (3) the children of a Preventive Services recipient family are subsequently referred for placement in foster care. The ADVPO type is used exclusively for Family Service Stages in New York City when Children's Services is the Case manager for preventive cases and the Voluntary agency that will be directly providing only preventive services to the family is exempt from the responsibility of recording the FASP and Progress Notes online, in accordance with the conditions of the Advocates Preventive lawsuit settlement.

Case Planner: Refers to the individual who has primary responsibility for assessing, providing, arranging for, coordinating and evaluating the provision of preventive services and other community based services (e.g., health, mental heath, substance use disorder/use prevention, treatment and aftercare, domestic violence, etc.) needed by the family to prevent foster care placement or help a child in foster care to return home sooner. The Case Planner is also responsible for documenting information in the case record.

Case Planning: Refers to the comprehensive activities of the case planner.

Case Record: The physical and/or electronic preventive services record maintained for a family and all its contents, including but not limited to the LE-DSS2921 'Application for Services'; intake and referral forms and any Provider-required assessments (risk, needs, psychosocial, etc.); signed consents for release of information; OCFS required Family Assessments and Service Plans, progress notes, and correspondence; reports from other service Providers; and referral forms for other services, including Day Care and Preventive Housing Subsidy is known as the Case Record. The electronic record should include a summary of the information learned during the assessment and the nature of services that will be provided.

Casework Contacts: Individual, family or group face-to-face counseling sessions with the child(ren) or family for the purpose of guiding the child(ren) and/or the child(ren)'s parents or guardians towards a course of action for achieving the goals identified jointly by the family and Case Planner in the family's service plan, and agreed to by the child(ren) and/or the child(ren)'s parents or guardians as the best method of resolving problems or needs of a social, emotional, developmental or economic nature or attaining personal objectives relative to these same needs and goals are known as Casework Contacts. Casework Contacts are 45 minutes to one hour in duration. Providers shall adhere to OCFS regulations and all promulgated Children's Services

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[1]Children's Services Providers using evidence-based models may be expected to adhere to the additional standards and documentation requirements set forth by those program. Providers offering Specialized Preventive Services must adhere to the standards outlined in Parts I, II and III.

Guidelines for this provision.

Fatality and Critical Incident Reports: Timely reporting of all child fatalities or critical incidents in an open preventive services case must be reported immediately to Office of Children and Family Services (OCFS) and Children's Services.

Family: The child(ren) at risk of foster care, the parents, legal guardians, or other caretakers and siblings are referred to as the family.

Family Assessment and Service Plan: Contains the electronic documentation of assessments and service planning for the case and formally refers to the family's entire case record; often used to refer to the Initial, Comprehensive, and Reassessment Service Plan Review forms.

Mandated Preventive Services: Services designed to **avert imminent foster care placement or replacement,** or to enable a child to return home earlier than anticipated, or to facilitate a timely discharge when specific conditions exist; OR, youth who are from age eighteen (18) up to age twenty-one (21) for whom aftercare services are sought in preparation for and subsequent to a discharge from foster care, or who are foster care youth who were previously placed in the care and custody or custody and guardianship of Children's Services, where it is reasonable to believe that by providing such services the former foster care youth will avoid a return to foster care.

Non-Mandated Preventive Services: Services designed to **prevent possible future placement** in foster care or services which may enable a child to return home earlier than anticipated when specific conditions exist.

Mandated Reporter: NYS OCFS and Children's Services recognizes certain professionals as holding the important role of Mandated Reporters (MR) of child abuse or maltreatment. Those professionals can be held liable both by the civil and the criminal legal system for intentionally failing to make a report. Mandated Reporters are required to report instances of suspected child abuse or maltreatment only when they are presented with reasonable cause to suspect child abuse or maltreatment in their professional roles. Professionals include, but are not limited to the following: Case Planners/Social Workers/Case Workers; Licensed Creative Arts Therapists; Licensed Marriage and Family Therapists; Licensed Mental Health Counselors; Licensed Psychoanalysts; Physicians; Registered Nurse/Licensed Practical Nurse/Nurse Practitioner; Psychiatrists; Psychologist; other Mental Health Professional; Substance Abuse Counselor/Alcoholism Counselor/CASAC; Teacher; School Official and Support Staff; Social Service Worker; any volunteer in a residential care program for youth, or any other Child Care or Foster Care Worker; Day Care Center Worker; and, Provider of Family or Group Family Day Care. Please see NYS Regulations *Title 18 NYCRR, Section 413* for a more comprehensive listing.

'Permitted Services': Refers to the provision of identified preventive services in accordance with NYS Regulations Title *18 NYCRR, Sections 423, 430.9, 430.10 (b), 435, and Appendices A through C.* Preventive Services Providers shall provide or make referrals for those services within their Provider agency or through community partnerships. These may not be primary services in the family service plan, and the Provider can explore and use other available

resources instead of Mandated Preventive Services for those families. 'Permitted Services' are desirable for preventive families, and shall be offered by the Provider if available.

Program Operating Plans (POP): This is a document that Children's Services requests from each Provider, including current information about the Provider's administrative and managerial structure,. (this includes the Board of Directors); the Provider's main business location, telephone numbers; program types, names, and location of each program site contracted with Children's Services; services that are being provided at each site; overarching goals and policies and procedures of the Provider and each program; staff training and understanding of those goals; and quality improvements techniques and strategies; etc.

Progress Notes: Progress notes document the activities of casework staff and the information acquired during these activities. They also capture the decision-making and actions taken by workers and other staff or service Providers to ensure the safety, permanency and well-being of children. Progress notes must include all contacts and attempted contacts. Each progress note must include the date of the event and the author of the note. For cases that are known to DCP, called Child Welfare Cases (CWS), those notes must be entered in CONNECTIONS (CNNX), which is the New York State child welfare services electronic system of record; and therefore all casework activities and progress notes must be documented in CNNX in a timely manner. For cases not known to DCP, such as those families who simply request services, or some families referred by FAP or other NYC services agencies, the progress notes must be entered into a hard copy format called The Advocates Template (ADVPO), which is to be filed in the case record which the Provider maintains, and must be made available for Children's Services or OCFS review when requested. Please see NYS Regulations Title *18 NYCRR, Section 428.5.*

By Referral Only: Where services are marked "(By referral only)", the primary service can only be supplied in the context of a licensed or other appropriately recognized/trained facility. The preventive services program provides supplementary assistance/support in accordance with assessed need and the family service plan, including (as appropriate and not limited to): assessing need; counseling; arranging/ referring/ advocating for the family to receive the service; and following up to assure provision of the service, referred family member's continued involvement with the service or treatment Provider, and/or level of such participation.

'**Required Services':** Refers to the provision of identified preventive services in accordance with NYS Regulations Title *18 NYCRR, Sections 423, 430.9, 430.10 (b), 435, and Appendices A through C.* Preventive Services Providers shall provide or make referral directly in a formal manner for those services; (some of these are considered "Core" services which should be *readily available f*rom all Providers). Should a 'Required Service' be needed, and is not readily available and accessible, the Provider must take the necessary steps to develop such a service and make it available to Mandated Preventive Services clients when necessary. Without exception, 'Required Services' shall be provided to all preventive families as needed.

* *Formerly DSS (New York State Department of Social Services*).

PART II -- PREVENTIVE SERVICES - REQUIRED SERVICES

**This section identifies those Mandated Preventive Services which, without exception, all Providers shall make available to all eligible families based on need.*

SIMULTANEOUS PROVISION OF PREVENTIVE & FOSTER CARE SERVICES

Standard:

Community-based services can be offered, in a preventive or aftercare capacity, to children and their families during a child's foster care placement and/or after discharge. These services can help to: a) prepare for the child permanency (reunification, adoption or other family-based permanency outcomes); and b) continue to offer help to families with or close to their communities when children return home from care and/or for the siblings of children in care.

Providers coordinate the transfer of children from foster care placement to discharge from foster care and jointly plan with the foster care Provider for the anticipated provision of services to children and their families upon discharge and reunification. The Provider also coordinates with the foster care Provider to facilitate the transfer of children from preventive services to foster care placement.

- When preventive services and foster care services are being provided at the same time, the preventive and foster care Case Planners coordinates services, discharge and after-care planning.

- When possible, families should continue receiving services from other involved service Providers. When necessary/appropriate, the preventive Provider facilitates the linkage to a primary care medical Provider and/or mental health treatment Provider in the neighborhood of family reunification and promotes the transfer of medical records between Providers. The Provider will work with the substance use disorder treatment Provider, if one exists, and communicate about ongoing aftercare services for the parent and prevention services for the child(ren).

Preventive services can supplement foster care and help expedite a child's safe discharge to permanency .There are several categories of cases that may be provided with simultaneous services:

1. When all of a family's children have left foster care and are in a final discharge status;
2. When a family has at least one child who is still in foster care in a trial discharge status;
3. When a family has at least one child who is still in foster care and is anticipated to be trial discharged within ninety (90) days;
4. When a group of siblings in foster care is freed for adoption but there are other siblings at home who are at risk of placement;
5. When the preventive services to be provided are either housing subsidy services or homemaker services;
6. When siblings of children in foster care are themselves at risk of placement and are still

residing either at home with the foster child's previous caretakers or with other caretakers; and

7. When a family was initially engaged with a preventive service Provider, all children have since been placed in foster care, and the continuation of preventive services to the parent/caretakers is expected to help shorten the length of stay for children in care.

Indicators: The Provider delivers such services in accordance with:

- Court Orders;
- Referrals from foster care Providers;
- Referrals from Children's Services via an approved Plan Amendment; OR
- An approved Plan Amendment, when the child(ren) is placed in foster care while the family is in receipt of preventive services from the Provider.

For additional information please refer to *Appendix B* to the Children's Services Reinvestment Plan, November 2005; the memorandum entitled, "*Provision of Preventive and Aftercare Services in Conjunction with Foster Care Services*" dated 4/5/2006; and Procedure # 2010/01: "*Provision of Preventive Services in Conjunction with Foster Care Services: Revised Procedure*" dated 2/2/2010/

Documentation: Plan Amendments; court orders; Connections (CNNX) and Advocate (ADVPO) progress notes; Family Assessments and Service Plans (FASPs); correspondence; PROMIS;CCRS; Notice to CNNX mailbox; assigned CNNX "Case Worker" role.

REQUIRED SERVICES

CHEMICAL DEPENDENCY TREATMENT

Standard:

The Provider shall provide or arrange for chemical dependency/use education, prevention, counseling, licensed treatment, aftercare and recovery services necessary to address the needs of the person presenting with chemical dependency/use issues and his/her family. When the Provider lacks the licensing and capacity to provide chemical dependency education, prevention or treatment services, it shall establish formal referral arrangements and coordinate service delivery with a variety of New York State Office of Alcoholism and Substance Abuse Services (OASAS)-licensed community-based programs that address the range of child and family chemical dependency education, counseling, prevention and treatment needs. For persons with opioid dependency issues, similar referral agreements shall be in place with methadone-to-abstinence or methadone maintenance treatment programs. These referral agreements shall include provisions for information-sharing, collaborative service and discharge planning between the Preventive Services Provider and the Prevention or Treatment Provider. The Preventive Services Provider shall obtain appropriate consent and release forms for the release of confidential information and maintain frequent communication with the chemical dependency prevention or treatment Provider in order to effectively coordinate services to the family.

The Provider also refers the chemically dependent person's family members to appropriate chemical dependency prevention, treatment and self-help groups; and encourages and facilitates the participation of the client families in such services.

Indicators: The Provider provides the above services either directly or through referral to all families, requiring families to meet family goals as outlined in the family service plan. There is evidence in the case record of communication with other service Providers and family members about treatment, and coordination of services.

Documentation: Case Records; 'Program Manual of Standards, Policies and Procedures'; signed 'Consents for the Release of Confidential Information'; letters of linkage that include provisions for information-sharing and collaborative service planning; PROMIS.

REQUIRED SERVICES

CHILD CARE

Standard:

As needed / requested by parents the Provider will provide or arrange for the provision of care for a child age six (6) weeks to fourteen (14) years outside her/his own home for less than twenty four (24) hours per day in a licensed facility that offers a safe, social, learning, nurturing, nutritionally and physically appropriate, and stimulating environment. If a referred service, the Provider shall obtain appropriate consent and release forms for the release of confidential information and maintain frequent communication with the child care service Provider, in order to effectively coordinate services to the family. (By referral only)*

Indicators:

i. Assessment of family's child care needs and attention to child's ongoing growth and developmental needs.
ii. Child care services will help maximize family stability and enable the parent to participate in services and programs, such as parenting support and education, individual counseling, and support group activities.
iii. Parents attend scheduled activities and keep referral appointments.
iv. There is evidence in the record of communication and coordination of services.

Documentation:

- Direct provision: visual inspection; child care workers' schedules and time sheets; CNNX or ADVPO progress notes; FASPs; PROMIS.

- Provision through advocacy with/referral to other Providers: CNNX or ADVPO progress notes; correspondence, completed referral forms; signed 'Consents for the Release of Confidential Information'; FASPs; PROMIS.

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* *This is a New York State required Core Service as outlined in the Title 18 NYCRR, Section 423.*

REQUIRED SERVICES

CHILD SAFETYASSESSMENT

Standard:

Safety and Risk Assessments (please see *Part II, Section F for 'Safety and Risk Assessments'*) must occur on a regular basis. The Provider is required to give priority attention to assessing the safety of all children in the household, regardless of relation to the parents or caregivers and taking all necessary and appropriate measures to ensure their ongoing protection and safety including, but not limited to, all actions required of Mandated Reporters (see *Part II, Section D* for *'Mandated Reporting'*). Direct services staff is required to see all of the children within a household at least once per month for both Child Welfare Services (CWS) and Advocate (ADVPO) cases (see *Part II, Section D* for *'Casework Contacts'*) to ensure their continued safety and well-being.

The purpose of a Safety and Risk Assessment is to ascertain whether there are any safety factors currently present and to determine if any children are likely to be in immediate danger of serious harm. Based on the information gathered, it is then determined what interventions and safety plans, if any, need to be initiated or maintained to provide appropriate protection for the child(ren). The safety assessment should reflect the identification of any safety factors present or impending in the child/family behaviors and/or circumstances. Safety factors should be viewed as "red flag alerts" due to present identified circumstances, conditions or behaviors.

Safety assessments are made in both Child Welfare Services (CWS) and Advocate (ADVPO) Cases. In CWS cases, safety refers to the health and well-being of a minor child living in the home of a family who is caring for that child. In CWS cases, the Provider should review the CPS Investigation Stage in (CNNX) and/or request from the Division of Child Protection (DCP) information on the safety decisions that have been made and the safety factors which Child Protective Services (CPS) has identified. In ADVPO cases, safety means that there are no children, parents or caretakers, family members, or community members (that the Provider is aware of) who are in immediate danger of serious harm or will likely face a serious threat to their emotional, physical or developmental well being.

Indicators:

i. Provider conducts s safety and risk assessments for all children in the household; and there is evidence in the case record of the outcomes of those assessments.
ii. Provider uses FTCs for meaningful discussions of safety and risk.
iii. Provider reviews any subsequent SCR reports through CNNX.
iv. Provider maintains adequate casework contacts with the family based on assessed need, and uses each casework contact to assess for safety and risk issues.
v. Supervisory case reviews and guidance documented in progress notes. (See Revised Supervisory Standards for Preventive Services Providers.)

Documentation: FASPs; CNNX or ADVPO progress notes; Supervisory logs/notes.

REQUIRED SERVICES

CRISIS RESPITE

Standard:

The Provider will provide or arrange for the provision of brief and temporary twenty four (24) hours a day care and supervision of children for up to twenty one (21) consecutive days .Where a parent is participating in a substance abuse detoxification treatment program, Crisis Respite may be provided for up to a maximum of thirty (30) consecutive days at a time. The purpose of Crisis Respite is to relieve parents of the care of children at a time of need for support or when there has been a loss of capacity to maintain an adequate level of care and supervision due to an unexpected demand upon the family or deterioration of family relationships such that the family needs immediate assistance in order to maintain or restore family functioning or where a parent, legal guardian, caretaker or child has critical illness, requires emergency hospitalization or in-patient drug treatment services, and/or the family is mandated to receive preventive services under the parent service need or child service need sections of the FASPs. The Provider shall obtain appropriate consent and releases for the release of confidential information and maintain frequent communication with the respite service Provider (where applicable), in order to effectively coordinate services to the family. (By referral only)*

Indicators: The Provider shall provide the above services through referral to all families that require them for the protection of the children and to meet family goals. There is evidence in the record of communication and coordination of services.

Documentation: FASPs; CNNX or ADVPO progress notes; PROMIS.

* *This is a New York State required Core Service as outlined in the Title 18 NYCRR, Section 423. .*

REQUIRED SERVICES

DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES

Standard:

Providers will assist parents with having children screened for developmental delays and disabilities. Providers must be familiar with and be able to link and refer youth with necessary supports and services. Such referrals will include but not be limited to: NYC DOH/MH Providers of Early Intervention Services for Children Birth – 3 years old, NYC DOE Committee on Preschool Special Education for Children 3-5 Years old, NYC DOE Committee on Special Education for Children 5-21 Years old, NYS Office for People with Developmental Disabilities (NYSOPWDD). Providers must be familiar with New York State Law and Guidelines pertaining to eligibility for New York State Services offered through NYS OPWDD, accessing necessary clinical assessments (Psychological evaluation, Psychosocial History and Annual Physical) and counseling through Article 16, and Article 28 clinics, OPWDD's Home and Community Based Services Waiver (HCBS), available supports and services under the waiver as well as other non-waiver family support services. The Provider shall guide the family through the eligibility determination process for OPWDD services. The Provider will refer and link the family and youth to necessary supports and services. The Provider shall obtain appropriate consent and releases for the release of confidential information and maintain frequent communication with the service Provider, in order to effectively coordinate services to the family. The Provider will obtain reports to include, but not be limited to the following: School Reports, Individualized Education Plan (IEP) from school for Preschool and School Aged Students, as appropriate, Individual and Family Service Plan (IFSP) from Early Intervention Program, as appropriate, Individual Service Plan (ISP) from OPWDD Provider Agency, as appropriate, as well as Psychological Evaluation, Psychosocial History and Annual Physical.

Indicators: The Provider shall provide service directly or through referral to an appropriate service Provider. This must be completed for all families with a child/family member whose disability may rise to the level of eligibility for New York State services. There is evidence in the Case Record of communication and coordination of services.

Documentation: FASPs; CNNX or ADVPO progress notes; CNNX- Education/Medical tabs/screens; clinical reports; referral and treatment arrangement(s); signed 'Consents for the Release of Confidential Information'; correspondence; PROMIS.

- **REQUIRED SERVICES**

DOMESTIC VIOLENCE

Standard:

The Provider will universally screen for domestic violence regardless of the presenting issues in the case, using the Children's Services Domestic Violence Screening Tool-Form CM-737. Suspected abusive partners and caregivers should always be interviewed separately. Family Team Conferences should always be held separately for the survivor and the abusive partner when domestic violence is suspected or identified.

Screening for domestic violence using the Domestic Violence Screening Tool – Form CM – 737 (or another comparable tool reviewed and approved by ACS) must occur:

- during the initial assessment of the family;
- any time the family composition changes;
- whenever any case involving domestic violence allegations is called in to the SCR; and
- whenever the worker suspects the presence of domestic violence

The Domestic Violence Protocol – Form CM -736 (or another comparable tool reviewed and approved by ACS) must be administered in the following situations:

- when the case initially presents with allegations of domestic violence;
- when the caregiver answers affirmatively to any of the Screening Tool questions; or
- when the case planner suspects domestic violence; even though it may be denied by one or both partners.

The Domestic Violence Protocol will assist in making informed assessments of the family situation and the risks to the children and consists of three sections:

- The Survivor's Interview;
- The Suspected Abusive Partner's Interview; and
- Overall Case Assessment.

The Provider will be prepared to assess if a family member is in immediate danger of harm because of domestic violence. The Provider will possess the expertise to create a plan for the safety (safety plan) of a family member and children, utilizing the full spectrum of safety interventions available to families experiencing domestic violence.
At times, it may not be safe for the family to remain together and/or for the survivor and children to receive domestic violence services within the family's immediate community.

The Provider will provide directly and/or establish a formal referral arrangement with a domestic violence advocacy agency or agencies to provide services to Children's Services-referred clients. The services will include:

- ongoing intervention with survivors of domestic violence; and
- services for children who have experienced domestic violence.

The Provider will also establish a formal referral arrangement with at least one batterer intervention/education program to provide services for abusive partners. Anger management programs, mediation and couples counseling do not address abusive partners' violent or coercive tactics and are therefore not appropriate referrals.

The Provider shall obtain appropriate consent and releases for the release of confidential information and maintain frequent communication with the domestic violence service Provider, in order to effectively coordinate services to the family.

Providers should be aware of the Children's Services Domestic Violence Initiative that provides free technical assistance, capacity building and consultation to enable Provider agencies to effectively safety plan and work with families affected by domestic violence. Providers should refer to the *Children Services' Preventive Practice Guidelines: Domestic Violence* for assistance in engagement, assessment, documentation, and intervention regarding domestic violence cases as well as interviewing children. Providers should refer to *Children's Services' Practice Guidelines for Addressing Teen Relationship Abuse in Foster Care Settings. The guideline contains materials that will assist preventive agencies* in engagement, assessment, intervention and documentation regarding teen relationship abuse and exposure to domestic violence in their families of origin.

Indicators: The Provider shall conduct domestic violence screening directly with all families, and provides domestic violence advocacy services directly or through referral to all families when required to meet family goals. There is evidence in the record of communication and coordination of services.

Documentation: FASPs; Case records; CNNX or ADVPO progress notes; referral arrangements; letters of linkage; signed 'Consents for the Release of Confidential Information'; Forms CM-736 and CM-737.

REQUIRED SERVICES

EDUCATION – PARENT INVOLVEMENT

Standard:

The Provider promotes parent/caretaker involvement in their child(ren)'s education through parental and/or joint activities such as: assuring enrollment and monitoring attendance in school; assisting with and monitoring homework; attending parent-teacher meetings, school open houses and parent advocacy groups; and communicating and/or documenting the child(ren)'s educational needs to appropriate school/DOE staff. This includes advocacy for children in need of services from the CPSE and the CSE.

When the assessment of educational needs indicates a need for such coordination (for example, when the family has a history of educational neglect, or a child is at risk of school failure), the Provider shall obtain appropriate consent and releases for the release of confidential information and maintain regular communication with the child(ren)'s school, in order to effectively coordinate services to the family.

Indicators: The Provider shall provide education services to all families requiring them to meet family goals. There is evidence in the record of communication and coordination of such services.

Documentation: FASPs; CNNX or ADVPO progress notes; CNNX- Education tab/screen; group notes; copies of educational/informational material; correspondence; PROMIS.

REQUIRED SERVICES

EDUCATION – TRAINING AND EMPLOYMENT

Standard:

The Provider shall assess the need for and arrange educational counseling and training for parents, caretakers, and other adults or adolescents in the home; assist the adult or adolescent to secure or maintain paid employment, or provide training leading to such employment, which matches her/his skills, experience and/or limitations.

The Provider educates staff and client families about welfare system work requirements and assists them in achieving compliance.

The Provider has established linkages with neighborhood-based employment agencies, vocational training institutions and high school, college and GED programs, including alternative high schools for older youth, LGBTQ youth, and adolescents in substance use disorder/use treatment programs. The Provider also has linkages to Vocational Educational Services for Individuals with Disabilities (VESID) programs[2] and Early Childhood Direction Centers. It provides client families with up-to-date information on and assists them in enrolling in such programs.

NOTE: The key contacts/units at the Department of Education and their respective web links include:

Enrollment Office http://schools.nyc.gov/ChoicesEnrollment/default.htm;
Office of Alternative Instruction
http://schools.nyc.gov/ChoicesEnrollment/AlternativesHS/default.htm;
ACS Education Resources Website: http://www.nyc.gov/html/acs/education/index.html

Indicators: The Provider shall provide education training and employment services either directly or through referral, as appropriate, to all families requiring them to meet family goals.

Documentation: CNNX or ADVPO progress notes; CNNX- Education tab/screen; FASPs; group notes; copies of educational/informational material; correspondence; signed 'Consents for the Release of Confidential Information'; PROMIS.

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[2] VESID information can be accessed at www.Vesid.nysed.gov/

REQUIRED SERVICES

EMERGENCY SERVICE ACCESS

Standard:

The Provider will arrange or provide for emergency services when necessary, including cash or the equivalent thereto, goods, and shelter when a child is at risk of foster care placement and such services may prevent placement. The plan may include the Provider providing an on-call service for families in crisis, coordination with income maintenance staff (previously IM, now called NYC Multiservice centers) staff who regulate benefits for public assistance, food stamps, etc., or identification of service Providers within the community that provide twenty four (24)-hour services. *

Indicators: All families have access to Emergency Service Access services as necessary and appropriate to achieve family goals and maintain the health and safety of children and parents.

Documentation: FASPs; CNNX or ADVPO progress notes; correspondence; written plan ensuring family access to services; 'Program Manual of Standards, Policies, and Procedures'; informational materials distributed to families; PROMIS.

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* *This is a New York State required Core Service as outlined in the Title 18 NYCRR, Section 423.*

REQUIRED SERVICES

HEALTH

Standard:
The Provider will arrange or provide the necessary diagnostic, therapeutic and preventive medical care and treatment, counseling, health management, and follow-up services needed to attain and maintain a favorable condition of health including the following.

1. Education/assistance (group and individual) regarding:
   - the importance of good and consistent primary and specialty care;
   - the importance of health literacy, that is, understanding health information so as to make informed decisions, decrease health risks, and improve quality of life;
   - the importance of recording and maintaining family members' own medical records/ histories, including information on: basic medical history and contacts for all medical Providers, current and chronic illnesses or conditions, medications for chronic conditions, dietary restrictions/allergies, recent exposure to communicable disease, immunization records, current/past Providers, prenatal care, etc.; and
   - access to medical coverage (Medicaid/other public insurance) and medical services in the community (including a list of available resources for primary care).

2. Provision of educational materials on-site and discussion of this material during casework with families. Materials should include, but are not limited to, information on: child and adolescent immunizations; HIV/AIDS prevention; sexual and reproductive health and rights; family planning services; sexual orientation and gender identity; pre and post natal care; developmental and mental health; substance use disorder/use education, prevention, treatment and aftercare services; domestic/family violence prevention (including spousal/family abuse, teen relationship violence, and elder abuse); smoking cessation; proper nutrition; and physical fitness.

3. Assistance for the family in the selection of a community-based primary care physician if the family does not have one and assist the parent with scheduling and attending health care appointments when necessary. Link the family to needed personal health services and assure the provision of healthcare when otherwise unavailable.

4. Review and documentation of service plans and goals so that they include: routine examinations by the selected primary care physician (in accordance with time frames recommended by the American Academy of Pediatrics and the Child/Teen Health Plan Services); screening for developmental delays and mental health issues; any follow-up visits recommended by the physician to ensure child/youth has appropriate specialty and subspecialty referrals, medications and medical equipment; dental, eye, hearing care; and updated immunizations as appropriate and when deemed necessary. The Provider coordinates with the health service Provider to facilitate scheduling of appointments, and follows up with parents to track attendance and outcomes of appointments. The Provider shall obtain appropriate releases of health information and maintain regular communication with health care Providers, in order to

effectively coordinate services to the family.

5. When appropriate and necessary, assistance for families deemed eligible for Medicaid or Child Health Plus/Family Health Plus in obtaining health services coverage. For those families who are not eligible for public insurance, assist with identifying other health care resources (e.g., clinics with sliding scale fees).

Indicators: The program provides health services to all families either directly or through referrals. Children receive well child care in accordance with timeframes recommended by the American Academy of Pediatrics and the Child/Teen Health Plan Services, and receive follow up care related to any special medical needs. There is evidence in the Case Record of communication and coordination of services and follow up care related to any special medical needs. There is evidence in the Case Record of communication and coordination of services.

Documentation: CNNX or ADVPO progress notes; FASP; CNNX- Health tab/screen; group notes; educational/informational materials; correspondence; signed 'Consents for the Release of Confidential Information'; medical reports/records; PROMIS.

REQUIRED SERVICES

HOME ATTENDANT

Standard:

Children Services, in conjunction with the **New York City Human Resources Administration** offers **Home Attendant Service**s to *Medicaid eligible* individuals who are incapacitated and who otherwise might be institutionalized. Home Attendant Services provide personal care to adults and children whose personal care tasks cannot be completely met by family due to medical needs.

The referral process will include making an assessment of the client's need and eligibility for Home Attendant Services, and assisting the client in assembling required documentation in order to complete the referral process. The Provider will **submit required documents** to ACS Preventive Services Home Care Liaison. Original M11Qs must be submitted with the package within 10 days of the date of examination. The Provider shall obtain appropriate consent and releases for the release of confidential information and maintain frequent communication with the Home Attendant Service Provider, in order to effectively coordinate services to the family.

NOTE: Before requesting Home Attendant Services, arrangements must be made to ensure that an adult is available to supervise the home attendant while he or she is on duty. If the incapacitated person is a child or an adult who is not self-directing, then the legal guardian is responsible for arranging for the supervision of the Home Attendants.

Indicators: The program provides Home Attendant Services through referral to Children's Services to all families requiring them to meet family goals. There is evidence in the record of communication and coordination of services.

Documentation: FASPs; CNNX or ADVPO progress notes; physicians' reports; Medical Requests for Services (M11Q); referral forms; signed 'Consents for the Release of Confidential Information'; correspondence; PROMIS.

REQUIRED SERVICES

HOMEMAKER

Standard:

Homemaking Services are used temporarily when stress prevents primary caretakers from contributing to the developmental growth of their minor children or if parents or guardians possess poor parenting skills, are emotionally immature or incapable of coping with the care of their children without exposing these children to neglect or abuse. The homemaker provides services to the entire family

Homemaking Services is a specialized short-term service that complements the casework services of the agency and which is provided to families in their own homes for the purpose of maintaining normal household operation during periods of stress or crisis (medical or environmental), and/or for the purpose of teaching and training child care and home management skills to a parent or guardian in order to strengthen family life. The Provider will refer clients to Children's Services who require homemaker services. The referral process will include making an assessment of the client's need and eligibility for Homemaking Services, and assisting the client in assembling required documentation in order to complete the referral process.* The Provider will **Submit documents** to ACS Preventive Services Home Care Liaison. Original M11Qs must be submitted with the package within 10 days of the date of examination.

The Provider shall obtain appropriate consent and releases of the release of confidential information and maintain frequent communication with the Homemaker service Provider (as appropriate), in order to effectively coordinate services to the family.

Indicators: The program provides Homemaking Services through referral to Children's Services to all families requiring them to meet family goals. There is evidence in the Case Record of communication and coordination of services.

Documentation: FASPs; CNNX or ADVPO progress notes; physicians' reports; Medical Requests for Services (M11Q); referral forms; signed 'Consents for the Release of Confidential Information'; correspondence; PROMIS.

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* *This is a New York State required Core Service as outlined in the Title 18 NYCRR, Section 423.*

REQUIRED SERVICES

HOUSEKEEPING SERVICES

Standard:

The Provider will refer clients to Children's Services who require Housekeeping Services. The referral process will include making an assessment of the client's need and eligibility for Housekeeping Services, and assisting the client in assembling required documentation in order to complete the referral process. Housekeeping Services are provided to *Medicaid eligible* individuals, who have no personal or child care needs and cannot handle their own chore needs.

Housekeepers assist only with chore services. These tasks include cleaning, sweeping, mopping, cooking, laundry, shopping and ironing. The client must be in the home while the housekeeper is on duty. Housekeepers provide services to the approved clients only.

The Provider shall obtain appropriate consent and releases of the release of confidential information and maintain frequent communication with the Housekeeping Service Provider, in order to effectively coordinate services to the family.* The Provider will **submit documents** to ACS Preventive Services Home Care Liaison. Original M11Qs must be submitted with the package within 10 days of the date of examination.

Indicators: The program provides such services through referral to Children's Services to all families requiring them to meet family goals. There is evidence in the record of communication and coordination of services.

Documentation: FASPs; CNNX or ADVPO progress notes; physicians' reports; Medical Requests for Services (M11Q); referral forms; signed 'Consents for the Release of Confidential Information'; correspondence; PROMIS.

3131

* *This is a New York State required Core Service as outlined in the Title 18 NYCRR, Section 423.*

REQUIRED SERVICES

HOUSING

Standard:

The Provider will provide Housing Services by assessing 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 Providers that regulate housing, including arrangement for legal services when necessary.*

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 need and eligibility for the Preventive Services 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 (1) preventive service in addition to housing assistance at the time of referral. Eligible families must have an open active ACS case and meet all necessary financial requirements for this assistance. The Provider promotes and monitors its staff's appropriate use of housing subsidy services. * The Provider will **submit documents** to Children's Services Housing Support Unit. The package includes Form CM-622; Form CM-621-A; CM-621B (Proof of Income); W-9 (Vendor ID); a copy of lease and a copy of deed (for private homes with 3 apartments or less); Memorandum of Attestation. (All housing forms can be obtained from the Housing Support Unit or the ACS Intranet, through Docushare)

Indicators: The program provides Housing Services either directly or through referral to all families requiring them to meet family goals.

Documentation: FASPs; CNNX or ADVPO progress notes; correspondence; 'Program Manual of Standards, Policies, and Procedures'; copies of completed applications for the Preventive Services Housing Subsidy; controls used to monitor staff use of the subsidy; PROMIS.

3232

* *This is a New York State required Core Service as outlined in the Title 18 NYCRR, Section 423.*

REQUIRED SERVICES

MENTAL HEALTH

Standard:

The Provider will provide or arrange mental health assessment, diagnosis, testing, psychotherapy, and specialized therapies and interventions to families who require them. These services are provided by a person who is a licensed social worker, a licensed psychologist, a licensed psychiatrist, or other recognized therapist in human services.

The Provider shall recognize indicators of mental health issues and provide necessary screening, evaluation and treatment. If the Provider lacks capacity to provide such services, the Provider shall establish a formal referral and treatment arrangement with at least one neighborhood-based children's mental health Provider and one adult mental health provider, to the extent that local Providers exist or exist in nearby neighborhoods in the same borough. The Provider shall seek to establish referral agreements with mental health providers having specific expertise in the treatment of Post-Traumatic Stress Disorder, and other conditions relevant to the child welfare population.

The Provider shall develop relationships with parent and family support programs and parent advocacy programs available through the mental health system. 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 (programs run either by OMH or DOHMH for children and adults with mental disorders); and OMH Home and Community-Based Services Waiver programs for children with serious emotional disturbance.

The Provider shall also provide parents with basic information about children's mental health, including but not limited to: trauma and the emotional impact of abuse/neglect on children; the range of behaviors traumatized children may express, what these behaviors 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. Parents shall also receive education about parent mental health (including maternal depression) and its impact on children. As needed, parents should 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 consent and release forms for the release of confidential information and maintain frequent communication with the mental health service Provider, in order to effectively coordinate services to the family.

The Provider shall monitor and record all children's prescribed psychotropic medication. The following information is required 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.

The Contractor shall work with the Parent/Caretaker to ensure that psychiatrists prescribing psychotropic medication communicate regularly with child and family. The Parent/Caretaker and Contractor shall ensure that 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. The Parent/Caretaker and Contractor shall ensure that 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 all children receiving psychotropic medication at least once a month, and report the observations and thereafter recorded in the case record by the designated PPRS staff. The Parent/Caretaker and Contractor shall ensure that all children on psychotropic medication shall be given a physical examination and appropriate lab tests at a minimum of every six (6) months or based on the frequency required by accepted New York State health standards. The Parent/Caretaker and Contractor shall 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 Parent/Caretaker and Contractor shall ensure that all Youth prescribed psychotropic medication are required to receive concurrent non-medical mental health treatment, unless indicated by the child's condition or treatment needs.

Indicators: The program provides Mental Health Services either directly or through referral to all families requiring them to meet family goals. There is evidence in the case record of communication and coordination of services.

- Evidence of an assessment for each child in the family was completed with regards to their emotional, physical, developmental, and social well being.
- The program may also serve as a co-located OMH Clinic Plus site.

Documentation: FASPs; CNNX or ADVPO progress notes; 'Program Manual of Standards, Policies and Procedures'; signed 'Consents for the Release of Confidential Information'; letters of linkage agreements that include provisions for information-sharing and collaborative service planning; PROMIS.

REQUIRED SERVICES

PARENT-CHILD INTERACTIONS

Standard:

The Provider will promote, provide, support and observe frequent and positive parent-child interactions through a variety of strategies, such as family counseling, parent-child homework groups, infant-parent interaction training, educational, recreational and socialization activities including interactions during home visits and other settings.

Indicators: The program promotes parent-child interaction directly with families in the office or home. The home may be a more familiar setting to observe this critical interaction and assess for safety and risk issues specific to dyad, along with, assessing the parenting and discipline style. When such services are specifically required to facilitate the family's achievement of its service plan goals, this is documented in the progress notes and the FASP. There is evidence that program completed an assessment of parent-child interactions and as appropriate, incorporated dyadic work into ongoing service intervention.

Documentation: FASPs; CNNX or ADVPO progress notes; group notes; attendance sheets; copies of publicity for events and activities; PROMIS.

REQUIRED SERVICES

SEXUAL HEALTH AND PRE/POST-NATAL CARE

Standard:
Providers shall make available sexual and reproductive health information for parents and youth. Topics will include but not be limited to pregnancy prevention, birth spacing, unplanned pregnancy options, Human Immunodeficiency Virus / Sexually Transmitted Disease(s) (HIV/STDs), safe sex practices and contraception methods, issues of genito-urinary health, education about community resources and the accessibility of services for youth, adolescents' rights, specific information for young men, general health information, gender identity and sexual preference, and availability of family planning and sexual health resources.

Case planners or a designated staff person will link a youth and/or family to local community organizations that provide comprehensive sexual and reproductive health and family planning information and services. Providers should identify and develop standing relationships with community Providers to obtain sexual health information and make referrals for sexual and reproductive health services. As part of an initial assessment and intake process, designated Provider staff will assess if a youth is sexually active. The goal is to create a respectful, safe, non-judgmental, and youth-friendly atmosphere which allows the adolescent the opportunity and permission to talk about sexuality and ask questions, while in full compliance with laws and regulations regarding confidentiality.

Providers shall assist pre-natal and recently post-natal family members with obtaining quality, community-based pre-natal and post-natal counseling and services, termination of pregnancy and/or adoption counseling and services consistent with the family's preferences. The Provider must have established linkages with primary prevention home visiting programs, such as the Nurse-Family Partnership Program (discussed below)* and Healthy Families New York (discussed below)**.

Providers shall see to it that pregnant youth receive pre-natal counseling, pre-natal healthcare as appropriate and assistance in planning for the impending birth as appropriate. If the Provider does not offer these services, community resources must be sought immediately to ensure the youth receives the support they need to access these services.

After delivery, post-natal care must be offered to the youth and infants to promote continued health of mother and baby. Additionally, mothers should receive counseling and screening for depression. Men should be linked with fathers' programs and should be informed about their rights and responsibilities, as appropriate. If the Provider is unable to provide these services, services must be sought from other resources.

It shall be understood that the Provider will make all reasonable efforts so that services rendered by Providers other than themselves further the goals of: informed decision-making from youth and their families regarding sexual and reproductive health services; providing pre/post natal services, and advising youths and families of the most recent family planning and sexual health information.

Where appropriate, the Provider shall obtain releases of information and maintain frequent communication with the health care Provider, in order to effectively coordinate services to the family.

Indicators: The Provider provides sexual and reproductive health and pre/post natal care services either directly or through referral to all families requiring them to meet family goals.

Documentation: FASPs; CNNX or ADVPO progress notes; correspondence; signed 'Consents for the Release of Confidential Information'; medical reports; PROMIS; CNNX Health tab/screens.

NOTE:
*The New York City Department of Health and Mental Hygiene is the lead City agency (DOHMH) Nurse Family Partnership contact # is 646-672-2880; web link @ http://www.nyc.gov/html/doh/html/ms/ms-nfp.shtml; Providers are citywide.

**Healthy Families New York: Provider agencies are citywide. Agency contact information can be found @ www.healthyfamiliesnewyork.org.

REQUIRED SERVICES

TRANSPORTATION

Standard:

The Provider will provide or arrange for transportation of the child and/or his family to and/or from services arranged as part of the service plan except transportation may not be provided as a preventive service for visitation of children in foster care with their parents; and may only be provided if such transportation cannot be arranged or provided by the child's family.*

The Provider shall pay particular attention to the needs of families that must travel with several small children, and/or children that are medically fragile and/or physically challenged, where these circumstances represent deterrents/barriers to the family's participation in services.

Indicators:

1. The Provider provides transportation services either directly or through referral to all families requiring them to participate in services and meet family goals.

2. The program has and utilizes standard practices that enable families to overcome travel barriers related to the transportation of small medically fragile, and/or physically challenged children to enable participation in services.

Documentation: FASPs; CNNX or ADVPO progress notes; separately maintained records of cash or MetroCards given; referral arrangements with outside service Providers and records maintained of referrals and service provision; receipts for payments; PROMIS.

3838

* *This is a New York State required Core Service as outlined in the Title 18 NYCRR, Section 423.*

PREVENTIVE SERVICES - PERMITTED SERVICES

**This section identifies those Preventive Services which are desirable, and which Providers shall offer to eligible families if available. Providers shall make a good-faith effort to offer these services directly or through referral, but are not required to develop them if the resources are not present.*
'Permitted Services' are based on NYS OCFS regulations and established Children's Services policy and procedures. When services are provided through referral, documentation in the Case Record must include signed consents for release of information by the Provider. If parents refuse to sign a 'Consent for the Release of Confidential Information' form, a referral to another service Provider should still be made.

Day Services
A program for children offering a combination of services including:

- at a minimum, social services, psychiatric, psychological, substance use/abuse, educational and/or vocational services and health supervision;
- recreational and transportation services, as appropriate,
- for at least three (3) but less than twenty-four (24) hours a day and at least four (4) days per week. (By referral only)

Note: There are also day treatment/mental health services and special education services for this population.

Emergency Shelter
Providing or arranging for shelter when a child and his/her family who are in an emergency or acute problem situation reside in a site other than their own home in order to avert foster care placement. (By referral only)

Entitlements
Monetary (monetary equivalent) benefits which supply basic material or health needs, including but not limited to Income Maintenance, Food Stamps, Medicaid, Family Support Claims, and Social Security. (By referral only)

Home Management
Assessing the need for, arranging for, providing and evaluating the provision of formal or informal instruction and training in management of household budgets, maintenance and care of the home, preparation of food, nutrition, consumer education, child rearing and/or health maintenance and wellness. The formal or informal instruction and training may be provided by: a case planner, trained homemaker, or through referral to appropriate community resources.

Housekeeper/ Housekeeping Support
For families for whom this is identified as a service need, but does not fit the criteria for improvement of living conditions, correction of sub-standard housing, finding suitable and adequate alternative housing, and obtaining needed assistance or relief from public agencies that regulate housing as stipulated under "*Required Services," Part II, Section B - Housekeeping*

Services. This service refers to the provision of light work or household tasks (including such activities as help with shopping, simple household repairs, and errands) which families and individuals in their own homes are unable to perform because of illness, incapacity, or absence of a caretaker relative, and which do not require the services of a trained homemaker. (By referral only)

Youth Development
Services provided for a child, age fourteen (14) or over, which include counseling, education, and training in: career objectives and job seeking skills; health maintenance; and development of housing, transportation and educational resources; and are designed toward successful independent community living as well as identifying and helping to establish or reestablish contacts with significant others in child's past.

Legal
Assistance provided to individuals to help them understand their rights under the law and to help them to secure any necessary legal services. (By referral only)

Parent Education and Support
Parent education and support recognizes and builds on parents' strengths, considers culture, gender and other aspects of identity, recognizes that parents have different needs, builds on parents' common experiences. Services will utilize defined models, maintain clear objectives, and combine experiential and didactic components so that parents may practice what they learn. If possible, programs should involve parents in facilitation and leadership of parent education. Integration into parents' overall service plans is paramount. Providers shall assess parents and determine the most appropriate form of parent education and support for them. Not every parent needs to attend a parenting class. If a group is appropriate, content areas may include education about trauma, the emotional impact of abuse/neglect on child and adult survivors of trauma, and the range of behaviors traumatized children and parents may express what they mean and how to appropriately intervene. Providers are strongly encouraged to utilize a nationally recognized curriculum, which has been evaluated and found effective or at least promising for populations similar to the Provider's client population. If a Provider would like to use an approach that does not meet these criteria, the curriculum must receive prior approval from Children's Services.

Socialization
Services geared toward personality development and the encouragement of interpersonal skills through the participation in sports, camping, arts and crafts, games, outings, or other group or one-to-one programs.

Special Needs Therapy
Structured regimen of treatment directed towards the development of physical or neurological capacities which have been impaired by illness or handicapping conditions, e.g., speech therapy, physical therapy, etc. (By referral only)

Therapeutic After-School Program
A structured program of combined services which include individual/group counseling, tutoring, play therapy, art therapy and/or recreational activities for children and youth experiencing

problems at home, in school, or in the community. (By referral only)

Vocational/Rehabilitation
Specialized educational training or counseling to correct or substantially improve a physical or mental condition which is a barrier to employment. (By referral only)

PREVENTIVE SERVICES - CASE PRACTICE

** The expectations and activities described in this section compose the basic elements of case practice. All preventive programs should include these in their case planning and support services work with families and children.*

FAMILIES' RIGHTS – CONFIDENTIALITY, CONFERENCE AND/OR FAIR HEARINGS

Standard:

The Provider will give written and verbal notice regarding confidentiality and other rights to preventive client families and prospective client families. A family's right to an Agency Conference or State Fair Hearing if services are denied or curtailed is to be explained as well.

Indicators:

1. Family's rights and responsibilities are verbally explained.

2. Family is given written notification of rights and responsibilities.

Regulation(s) governing eligibility for preventive services are set forth in NYS Regulations *19NYCRR part 404 and sections 423.3 and 430.9.*

Documentation: CNNX or ADVPO progress notes describe what confidential information was given to family and how it was explained; copy of Form CS-174, "General Information for all Applicants and Recipients of Preventive Services" or a clearly identified, signed, dated receipt from applicant family member; copy of Form CS-174A, "Notice of Acceptance or Non-Acceptance for Preventive Services" or Provider's equivalent forms, as approved by Children's Services; public display of material; materials available in foreign language versions compatible with the language(s) of the service population; packages of materials readily available in program office; CS-174B Notice of Intent to Reduce or Discontinue Services, 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

REFERRAL & OUTREACH

Standard:

Providers shall implement an outreach plan to engage families in need of preventive services who historically are hard to reach and have issues that place their children at risk of foster care placement or replacement. These services shall be provided to parents, children, adolescents, and all other members of the household. It is expected that approximately sixty five (65) % of the families served by preventive services programs will be referred from Children's Services, and thirty five (35)% will be self-referred or referred from local community or other Providers and professionals organizations. Children's Services approval is not required for non-Children's Services referred families, but Children's Services will monitor programs to ensure that such families meet the criteria for the receipt of preventive services.

Prior to accepting a referral, Providers have a process in place that ensures rapid engagement and acceptance of families into the preventive program. In all cases, this engagement and acceptance process may not exceed thirty (30) calendar days. Initial outreach to the family must occur within no more than two (2) days. There is a common understanding among staff about what they are expected to do; this is fostered through training, supervision and distribution of written policies and procedures.

a. Mandated Services and Rapid Outreach: During the initial ten (10) days of the Provider's receipt of referrals, or the initial twenty (20) day period (if ACS permits an additional ten (10) day extension), the Provider shall not be liable for regulatory or mandated activities and responsibilities required solely of the ACS Division of Child Protection (**"Child Protective Services"**) as set forth in the New York Codes, Rules and Regulations at 18 NYCRR Part 432. However, during such period, the Provider's Intake Worker (if the case is pending) or the Provider's Case Planner (if the case is accepted) shall be responsible for initiating rapid outreach to clients and promptly beginning the service engagement process in accordance with ACS Policies. All pending client cases are included in determining the Provider's program utilization rate and are credited for outreach and initial contact. After the initial contact is made with the client, the Provider must decide whether to accept the case and have the case opened by ACS, or to reject the case.

b. Unsuccessful Client Outreach: If the Provider is unable to contact the clients in person or by phone during the first three (3) days of the initial ten (10) day period following the Provider's receipt of the referral, the Provider shall so notify ACS staff by the fourth (4^{th}) day. ACS may agree to conduct a joint contact, withdraw the referral, or request that the Contractor continue outreach activities, including home visit attempts. If the Provider is still unable to engage clients in services by the end of the initial ten (10) day period, the Provider shall notify the ACS staff by telephone and in the Family Service Stage (**"FSS"**) progress notes in CONNECTIONS that clients are "not accepted for services" and shall state the reason. ACS may, at its discretion, request the Provider to continue outreach activities for up to an additional ten (10) days. If at the

end of such an extended period, the Provider has been unable to engage clients in services, the Provider shall so notify the ACS Preventive Services liaison by telephone and in the FSS progress notes, documenting all outreach activities and contacts with clients. The Provider shall reduce its utilization rate accordingly and such cases shall remain with ACS pending further action.

Indicators:

1. Written procedures describe:
    a) who is responsible for intake;
    b) who is responsible for conducting initial interviews;
    c) how cases are assigned to Case Planners; and
    d) the time frame in which each step is to be carried out to ensure timely outreach to referred families.

As different circumstances may require different time frames, these procedures include time frames for the following:

- any family whose situation is described as an emergency, whether self-referred or from any other referral source;
- referrals from DCP and other high priority referral sources such as:
    - New York City Department of Homeless Services (DHS) shelters
    - foster care Providers
    - Family Assessment Program (FAP)
    - New York City Housing Authority (NYCHA)
- referrals from other organizations when the family has discontinued their involvement with that organization;
- referrals from other organizations where there is continuing involvement; and
- self-referrals.

2. Written procedures are distributed to all intake and Case Planning staff.

3. Potential client families are contacted promptly within the time frames outlined in the 'Program Manual of Standards, Policies and Procedures' and Program Operating Plan (POP).

Documentation: 'Program Manual of Standards, Policies and Procedures'; POP; referral forms/logs; pending/active case records; CNNX or ADVPO progress notes; PROMIS; form CS-842 and equivalent documentation.

NOTE:

i. Regardless of referral source, families which do not meet eligibility requirements for preventive services, such as foster parents, should not be accepted.

ii. If at one hundred percent (100%) or more of utilization of its program capacity and staffing levels do not allow for adequate coverage of additional cases, and the Provider has notified ACS in writing that it chooses to close intake, or has otherwise received permission or a

directive from ACS to close intake, the Provider is not obligated to accept referrals from ACS.

iii. If the Provider is fully staffed and is operating at below one hundred percent (100%) of utilization of its program capacity, the Provider may not reject a client who meets the Preventive Services eligibility requirements.

iv. The Provider may not accept clients from any source if the Provider does not have the specialized skills (such as mental health staff to provide trauma-informed therapy, or licensed staff to perform drug assessment and treatment) to provide the required service to clients. In such instances, the Provider shall refer clients to a more appropriately qualified Provider.

v. If the Provider cannot provide Preventive Services to clients for any of the above reasons, the Contractor shall timely notify the party who originally referred the client to the Contractor.

CASE PRACTICE

REFERRAL PROCESS – FOLLOW-UP FILE

Standard:

The Provider maintains an accurate system for following and documenting activity on each referral. This system ensures that the casework process is begun in a timely way, that appropriate outreach is maintained, and that the disposition of the referral is recorded with all rejections explained.

The Provider shall maintain an accurate system for documenting all activity, including instances where clients cannot be contacted within forty-eight (48) hours of receipt of the referral. Such system shall ensure that the casework process is commenced in a timely manner, that appropriate outreach is maintained, that the disposition of the referral is recorded with all rejections explained, and that data on the number and type of referrals received indicates that priority is given to high priority referrals.

Indicators:

1. The intake record for each referral indicates:
   - the referral source;
   - referral date;
   - date assigned to permanent case planner (if not the intake worker); OR reason a decision was made not to open the case; AND
   - indication that the referral source was informed of disposition in a timely manner.
   - Documentation includes dates and specifics of all outreach attempts, plus all home visit attempts.

2. The supervisor and/or staff member with overall responsibility for intake/engagement maintains a record of the number of families referred/applying for preventive services, maintains controls and monitors intake to ensure that all referrals are processed in a timely manner.

Documentation: Referral file and logs; CNNX or ADVPO progress notes; PROMIS; activity controls.

NOTE: Children's Services requires that programs maintain progress notes in CNNX for all CWS cases.

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CASE PRACTICE

CHILDREN'S SERVICES REFERRALS – PRIORITY

Standard:

Providers shall accept referrals on a priority basis from the following sources: Children's Services, Family Assessment Program (FAP), New York City Department of Homeless Services (DHS) shelters, New York City Housing Authority (NYCHA), and foster care Providers[3].

Indicators:

1. All Children's Services, FAP, DHS shelters, NYCHA, and foster care referrals (high priority referral sources) are assigned to intake/engagement worker or Case Planner in a timely manner.

2. No referrals from other sources are assigned to Intake/Engagement Worker or Case Planner prior to Children's Services and other high priority referral sources except in the case of an emergency.

Documentation: PROMIS; written records of notification of vacancies to the appropriate DCP PPRS Liaison, FAP, DHS shelters, NYCHA and foster care Providers; copies of Form CS-842s - 'Disposition of ACS Referral For Purchased Preventive Services'; active/pending case records; interviews with staff; 'Program Manual of Standards, Policies, and Procedures'; POP.

NOTE: FASP, Plan Amendments and CNNX progress notes should reflect regular contacts and coordination with the foster care Provider.

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3 High priority cases that are transferred to another preventive Provider will be considered to have high priority referral status.

CASE PRACTICE

NYCHA REFERRALS – PRIORITY

Standard:

Providers shall accept referrals directly from NYCHA. In addition, clients who go to the Provider's site with a NYCHA introduction letter or a NYCHA "no engagement letter" (a letter given to NYCHA clients who decline NYCHA services) shall be counted as a NYCHA client referral. After NYCHA client referrals are assigned to either the Contractor's Intake Worker or a Case Planner, the Intake Worker or Case Planner shall make contact with the NYCHA social worker(s) to discuss the clients' Preventive Service needs.

NYCHA Client Referral Documentation: For each NYCHA client referral, the Provider shall receive a fax from NYCHA social work staff addressed to the Provider's Intake Worker which consists of the following documents: (1) a NYCHA case referral and case assessment form; and (2) a release of confidential information form signed by the client. The Provider's Intake Worker(s) shall confirm receipt of the above referral forms and signed client confidentiality release forms through phone contact with the referring NYCHA social worker(s).

Acceptance or Rejection of NYCHA Client Referrals: When NYCHA client referrals are accepted, the Provider shall take the necessary steps to have ACS open a Preventive Services client case by following ACS Policies for case opening. If the NYCHA client referral is rejected, the Case Planner or Intake Worker shall refer the case to another Preventive Service Provider and consult with the referring NYCHA social worker regarding alternative service options for the client. After the Contractor has made the determination either to accept or reject the NYCHA client referrals, the Provider's Case Planner shall then email or fax to the NYCHA social worker a disposition form with the Case Planner's decision to accept or reject the case. The Case Planner shall email the case disposition form to the Office of Preventive Technical Assistance (OPTA) NYCHA mailbox at prevnycha@dfa.state.ny.us or fax it to NYCHA at 718-488-5343.

Indicators:

1. All NYCHA referrals (high priority referral sources) are assigned to intake/engagement worker or Case Planner in a timely manner.

2. No referrals from other sources are assigned to Intake Worker or Case Planner prior to Children's Services and other high priority referral sources except in the case of an emergency.

Documentation: PROMIS; written records of notification of vacancies to the appropriate DCP PPRS Liaison, FAP,DHS shelters, NYCHA and foster care Providers; copies of Form CS-842s - 'Disposition of ACS Referral For Purchased Preventive Services'; active/pending case records; interviews with staff; 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

WAITING LISTS

Standard:

No family referred for preventive services is ever placed on a waiting list.

Indicators:

1. All accepted referrals are acted on in a timely manner in accordance with Children's Services' requirements and the program's written procedures and POP.

2. There is a common understanding among all staff that waiting lists are prohibited.

Documentation: PROMIS; referral logs; intake records; pending/active case records (CNNX or ADVPO progress notes); 'Program Manual of Standards, Policies, and Procedures'; POP; promotional materials; inquiries to staff.

NOTE: If there are **staff vacancies** and the Provider cannot ensure appropriate case coverage, or if the Provider is at maximum capacity, the referral should not be accepted and must be referred to another community resource.

CASE PRACTICE

INTAKE AND ENGAGEMENT

Standard:

The Provider's intake and engagement process ensures that families are offered services in a timely manner. It includes a range of engagement strategies designed to attract and retain families.

Indicators:

1. Available data on the number and type of referrals indicate that priority is given to cases in each of the following categories: Children's Services; FAP: NYCHA: foster care Providers; DHS shelters.

2. The decision to accept/not accept is made in a timely manner appropriate to the type of referral: Children's Services; FAP; NYCHA; foster care Providers; DHS shelters. The Provider shall immediately classify all clients cases referred to the Provider and not yet accepted or rejected for services as "pending". During the initial ten (10) days of the Provider's receipt of referrals, or the initial twenty (20) day period (if ACS permits an additional ten (10) day extension), the client cases shall be pending until officially opened or rejected. The Provider shall inform ACS of the outcome of the attempted contacts the Provider has made with clients during such initial ten (10) day period. If the Provider has made two (2) attempts to contact clients, but has not yet contacted the clients, ACS may grant an additional ten (10) day extension for the Provider to make contact with the clients. Once the referral is accepted, the Provider has made the decision within thirty (30) calendar days, to open or reject the case in the PROMIS system.

3. If the family cannot be engaged, supportive documentation indicates that appropriate outreach and engagement strategies, including home visits and phone calls are used. It is expected that, for Children's Services referrals, such outreach strategies should include at least two (2) attempted home visits, conducted at different times of the day. Outreach efforts should be documented in referral logs, PROMIS, CS-842s, and CNNX progress notes.

4. Documentation shows that once the referral is received, outreach to the family is made promptly, within forty eight (48 hours), to begin the engagement process, either by an intake worker or by the case planner if the family has been assigned. The Provider is expected to participate in a face-to-face transition meeting with the DCP Child Protection worker for all referred families to preventive services as a result of an indicated child abuse or maltreatment report.

5. The case is assigned to a Case Planner, and services are initiated promptly upon acceptance of the referral.

6. Services are routinely maintained during periods of staff vacation, sick leave, and/or vacancy.

Documentation: Referral logs; intake records; analysis of the duration of cases in pending status; CNNX or ADVPO progress notes; PROMIS; any methods of documentation used for Supervisory case review.

NOTE: During intake and throughout the life of the case Providers are expected to reinforce with families the value of Family Team Conferencing, specifically the importance of parent and youth participation in the decisions that affect them.

CASE PRACTICE

CHILDREN'S SERVICES REFERRALS – NOTIFICATION AND FACE-TO-FACE TRANSITION MEETING

Standard:

After receiving a referral of a family from the Children's Services DCP Protective Services Office (Borough Office Liaison), the Provider submits written notification of the disposition of the referral via Form CS-842 to the DCP PPRS Consultant/Liaison. The Provider submits such notification within thirty (30) calendar days of the PROMIS referral.

The Provider is expected to participate in a face-to-face transition meeting for all referred families to preventive services as a result of an indicated child abuse or maltreatment report. The transition meeting can be in one of the following formats:

- A joint home visit
- A family team conference
- A family meeting

An effective face-to-face transition meeting bridges the investigation phase to the services phase of a case. The meeting has the following purposes:

- Introduce the preventive worker/Provider to the family while discussing the reason for the referral.
- Describe to the family what Preventive Services is, and what the Provider can offer the family.
- Share the Child Protective Specialist's assessment of safety and risk, behaviors or circumstances that threatened the child(ren)'s safety, or place the child(ren) at risk for repeat maltreatment with the family.
- Discuss with the family their assessment of the situation and what services they feel they need to best care for their children and keep the children safe.
- Discuss how the family and the preventive service Provider will address these safety and risk concerns.
- Discuss the possible consequences to the family of not participating in preventive services.

A face-to-face transition meeting should occur within the first seven days following the referral to the Provider. Concurrently, the Provider shall initiate outreach to the family within forty eight (48) hours. Should the meeting not occur within the first seven (7) days, the Provider shall continue the engagement process independently, while working with the Child Protective Specialist to schedule the transition meeting.

NOTE: For families referred to preventive services following an unfounded child abuse or maltreatment report, or during an active investigation for which a determination has not yet been

made, the child protective and preventive services staff involved with the case should determine together on a case by case basis whether a face-to-face transition meeting is necessary. Should there be no transition meeting, there must be a substantive documented phone conference between the Child Protective Specialist and the Provider.

When a decision is made not to accept planning responsibility, the Provider documents the reason(s) in the PROMIS system.

If the family fails to keep appointments/engage in services, the Provider attempts at least one transition meeting prior to making the final disposition. The transition meeting must be an effort to engage the family; failure to keep the most recent office appointment is not considered a rejection of services.

Indicators:

1. A transition meeting in office or home is always attempted before the decision is made not to accept a case.

2. Provider notifies DCP immediately by sending a Form CS-842. Engagement with the family occurs within thirty (30) calendar days of the referral.

3. If the decision is not to open the case, the explanation on the Form CS-842 includes dates and specifics of all outreach attempts.

Documentation: Referral files/logs; PROMIS; copies of Form CS-842s; CNNX or ADVPO progress notes.

CASE PRACTICE

ELIGIBILITY

Standard:

The Provider establishes a family's eligibility for preventive services at the time of intake, in accordance with NYS OCFS regulations, without regard to race, color, creed, national origin, sex, age, disability, marital status or sexual orientation. The Provider reassesses eligibility when completing and approving each FASP Assessment/Reassessment.

The Provider does not reject referrals as ineligible, nor close the cases of families already engaged in services, solely because the families do not live in the contracted catchment area.

The Provider takes into account: ease or difficulty of travel for the family to the program site and the current availability of more conveniently located services that can meet the family's needs. With respect to a family currently engaged in services, the Provider and the family discusses the family's feelings and concerns about the impact of a change in service Providers on the family's ability to progress towards goal achievement.

Indicators:

A. Mandated Preventive Services

Initial determination of eligibility – The FASP clearly and specifically documents, on the first (Re) Assessment and Service Plan Review form due after preventive services begins, that the parent is not a foster parent. (For ADVPO cases, prior to documentation in the FASP, the program completes an FSI Standardized Intake Template and the form LE-DSS2921, Application for Preventive Services).

OR

Youth who are from age eighteen (18) up to age twenty-one (21) for whom aftercare services are sought in preparation for and subsequent to a discharge from foster care, or who are foster care youth who were previously placed in the care and custody or custody and guardianship of ACS where it is reasonable to believe that by providing such services the former foster care youth will avoid a return to foster care."

1. AND:
    a. The parent/caretaker is parent or caretaker of at least one child under eighteen (18) years of age who is at imminent risk of placement AND the FASP clearly and specifically documents the circumstances that demonstrate imminent risk of placement resulting from:
        i. 'Child Health and Safety, an "Indicated" SCR Report for possible abuse or maltreatment which occurred within the twelve (12) months prior to the application for preventive services. ACS uses the term 'Indicated' to mean that there was a "substantiated" finding in the SCR report of abuse and

maltreatment);
ii. 'Parental Refusal' (to maintain child in the home);
iii. 'Parent Unavailability';
iv. 'Parent Service Need'(emotional, mental, physical or financial condition seriously impairs parental ability to care for child);
v. 'Child Service Need' (child has special supervision/service needs the parents cannot meet);
vi. 'Family Court Contact' (risk of replacement when a child has been subject to, or judged at risk of being subject to, a Juvenile Delinquent (JD) or PINS petition;
vii. 'Unplanned Discharge' (unplanned discharge from foster care at least three (3) months prior to planned date of discharge);
viii. 'Recurrence of Reason for Placement'; OR

b. clearly and specifically documents that discharge from placement is anticipated within six (6) months and mandated preventive services would alleviate the service needs requiring placement more rapidly than foster care services alone; OR
c. clearly and specifically documents the applying family member is a pregnant woman of any age unable to provide adequate care for the unborn/infant child); OR
d. a court orders preventive services directly or the court has stayed or reversed an order for placement; OR
e. clearly and specifically documents that services will help prevent placement or replacement into foster care.

2. Reassessment of Eligibility
The Reassessment and Service Plan Review (FASP) clearly and specifically documents that:
a) not all service plan goals which are related to the reason establishing the initial mandate for Preventive Services and which are currently being pursued have been achieved; OR
b) removal of services at the present time would lead to a deterioration in the progress made; OR
c) children would be considered unsafe at home without controlling interventions in place.

B. Non-Mandated Preventive Services
1. The (Re)assessment and Service Plan Review (FASP) documents that there is some long term risk of foster care placement that could be alleviated by preventive services.

C. All Cases, Geographical Criteria – Families Living Out of Catchment Area
1. For a newly referred family, the Provider accepts the referral unless it determines that there is a more appropriate, more conveniently located Provider which can accept the family, and makes the referral with the agreement of the family.

2. For a currently engaged family, the Provider continues services unless there is an

appropriate and more conveniently located preventive services Provider that can accept the family, the family and the Provider agree that this would be appropriate, and the Provider refers the family, convenes a face-to-face transfer meeting with all parties, prepares a progress note describing the need for the transfer of the family's case to the receiving program, and coordinates with that program so that there is no break in service delivery during the transition period.

Documentation: FASP; PROMIS; LE-DSS2921; CNNX-FSI (CWS and ADVPO template).

Note: 'Housing Subsidy Only' Preventive Services Cases – cases must be coded in WMS as 25 "Mandated Preventive" in order to be eligible for preventive housing. In "Housing Subsidy Only" cases , in accordance with state regulations, the case is considered Mandated if the most recent assessment and service plan required by the uniform case record indicates that termination of housing subsidy would result in the family's in ability to maintain or secure adequate housing.

CASE PRACTICE

SAFETY AND RISK ASSESSMENT

Standard:
The Provider shall monitor safety and risk throughout the life of a case for all children and families they service. For all cases, including those initiated as a result of an open substantiated SCR report of abuse or maltreatment, the following activities shall occur:

- At intake, the Provider must review the investigation that led to the services referral, consult with child protective services staff, and incorporate the results of that investigation into their ongoing assessment of safety and risk, and their ongoing case planning for the child and family. Throughout the life of the case, the Provider is responsible for maintaining adequate casework contacts with the family, as required by *Children's Services' Guidance - Casework Contact Requirements for General Preventive Service Providers' revised 8/23/10* and NYS OCFS Regulations, *Title 18 NYCRR, Sections 423.4, 430.12, and 441. 21* and using those casework contacts to assess child safety and risk.
- The case planner is expected to see **all** the children in the household for both CWS and ADVPO cases at least once per month. These contacts are to be used to assess the safety of the child, discuss child's progress and to address any personal concerns of the child. When a child has not been seen within these timeframes, the Provider must use alternative mechanisms to assess the child's safety, such as collateral contacts with a school or child care Provider. Diligent efforts to meet this expectation should be clearly documented throughout the life of the case.
- Throughout the life of the case, the Case Planning Supervisor is responsible for providing supervision to the Case Planner, to monitor and support the case planner's ongoing assessment of safety and risk through contacts with the family, and with collateral contacts.
- Case Planners, Supervisors, and Family Team Conference (FTC) Facilitators are expected to identify unresolved safety and risk concerns and seek a satisfactory resolution through a FTC, or through supervision and discussion. If safety and risk issues remain unresolved, they *must* raise the issue to a higher level within the Provider's agency or through Children's Services' oversight channels; and, given seriousness, consider calling SCR. Throughout the life of the case, Provider agency case planners and Supervisors are responsible for reviewing any subsequent under investigation or indicated SCR reports through CNNX.
- In reviewing each FASP, the Case Planning Supervisor must consider the following questions:
    - Has a safety plan been initiated or maintained when necessary?
    - Does that safety plan protect the child from immediate or impending danger of serious harm?
    - Are the services planned and/or provided likely to reduce the identified risk(s) to children? If the services have not yet begun, is the family willing to participate?
    - Are service plans modified when progress has been insufficient?
    - Are the needs of all the children in the household taken into consideration?
    - Do the best interests of the child require Family Court or Criminal Court action?

When a major change in the service plan is considered, the Provider staff must carefully review the case to determine whether the planned action is consistent with the assessment of child safety and risk. Major changes include:

- Considering the return home of a child;
- Considering placing a child in foster care;
- Termination of mandated preventive services;
- Removing the protective program choice on an active service case; and
- Consideration of a court petition for removal of a child from a home where there are allegations of abuse/neglect or maltreatment and taking that child into protective custody under Article 10, or recommending a significant change in court disposition.

It will be the responsibility of the Case Planner, the Case Planning Supervisor, and the FTC Facilitator to initiate a thorough discussion of safety and risk factors in the family, leading to a decision that is consistent with child safety and well-being.

- Prior to closing a case, Provider staff are expected to:
  - Conduct a thorough review of the Case Record;
  - Review all available FASP and service plan assessments of the family, with a focus on the overall risk rating/profile;
  - Review the family's progress towards service plan goals, particularly those goals that most closely relate to the identified risks to children;
  - Discuss with the family or other Providers the family's response to the termination of services;
  - Consider the following questions:
    - Are all children assessed to be safe?
    - Has the risk of future abuse or neglect decreased sufficiently?
    - Can progress be sustained without the Preventive Provider's involvement?
    - Is there a need to pursue Family Court intervention?
    - Is such an intervention in the best interest of the child?
  - Prepare the family for termination of services;
  - Refer to other services as needed; and
  - Notify others who have been actively involved in the case, i.e. school personnel, other services Providers of the plans for closing.
- The Provider is notified of subsequent SCR reports through CNNX; it is the Provider's responsibility to review and incorporate the results of such reports, including any changes in the assessment of safety and of future risk of abuse or maltreatment, into the family's services plan.

Documentation: CNNX and ADVPO progress notes; FASP; correspondence; Safety and Risk Desk Aid for Preventive Providers.

NOTE 'Housing Subsidy Only' Preventive Service Cases: families must continue to receive ongoing assessments for safety and risk factors in the household. This must include an assessment of the safety and well being of each child in the family. There should be ongoing attention to safety issues so that the case can be returned to a full preventive service if need be

(including reestablishing protective program choice in CNNX if appropriate). For additional guidance see Children's Services Policy #2010/05 Subject: "*Casework Requirements for 'Housing Subsidy Only' Preventive Service Case"* dated July 1, 2010*).*

CASE PRACTICE

CASEWORK CONTACTS

Standard:

All Family members are seen individually or together as frequently as necessary to meet the goals of the service plan. At minimum, the Provider performs at least twelve (12) casework contacts within each (6) six-month period of preventive services with children and/or their families, however, frequency of casework contact is based on the family members' assessed needs; refer to NYS OCFS Regulations, *Title 18 NYCRR, Sections 423.4, 430.12, and 441.21*, and Children's Services '*Preventive Services Casework Contacts Requirements' Guidance*, revised 8*/23/10* as discussed below. A group contact includes members of more than one of the families being served by the program, such as a parenting training or an adolescent socialization group. *

- General Preventive cases with **NO** history of CPS Indication
    - A minimum of twelve (12) casework contacts per six (6)-month FASP cycle; at least two (2) casework contacts must be made per month:
        - A minimum of six (6) casework contacts must be made by the Case Planner:
            - Four (4) casework contacts must be individual (with child/and or family);
            - One (1) home visit must be made every three (3) months; and
            - **All the children in the home must be seen by the case planner at least once each month.**
            -
        - No more than six (6) of the twelve (12) required casework contacts may be conducted by Provider-employed specialized rehabilitative service staff (e.g. CASAC or MSW); and no more than two (2) of the six (6) contacts may be conducted by Provider-employed supportive service staff (e.g. Case Aides and Parent Aides). All contacts by specialized rehabilitative or supportive service staff may be group or individual casework contacts.

In all situations in which the specialized or supportive staff does not make the maximum number of casework contacts permissible, the case planner is ultimately responsible for all required casework contacts.

- General Preventive cases ***WITH*** a history of CPS Indication (per six (6)-month FASP cycle),
    - A minimum of twelve (12) casework contacts per six (6)-month FASP cycle; at least two (2) casework contacts must be made per month:
        - A minimum of six (6) casework contacts must be made by the Case

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*OCFS Preventive Services Program Manual and CASE PRACTICE, Services Consistent with Needs.

Planner:

- Four (4) casework contacts must be individual (with child/and or family);
- One (1) home visit must be made per month; and
- **All the children in the home must be seen by the case planner at least once each month.**

- No more than six (6) of the twelve (12) required casework contacts may be conducted by Provider-employed specialized rehabilitative service staff (including CASAC and MSW); and no more than two (2) of the six (6) contacts may be conducted by Provider-employed supportive service staff, (including Case Aides and Parent Aides). All contacts by specialized rehabilitative or supportive service staff may be group or individual casework contacts.

- General Preventive Cases With a History of CPS indication and **Newborn Present**

  - A minimum of two (2) home visits a month <u>for the first six (6) months when a newborn is present in the family:</u>
    - A minimum of one (1) home visit per month must be made by the Case Planner;
    - No more than one (1) required home visit per month may be made by either an Provider-employed specialized rehabilitative service staff (including CASAC or nurse) or Provider-employed supportive service staff (including Case Aides and Parent Aides); and
    - **All the children in the home must be seen by the case planner at least once each month.**

In all situations in which the specialized or supportive staff does not make the maximum number of casework contacts permissible, the Case Planner is ultimately responsible for all required casework contacts.

- Housing Subsidy Only cases

Families for which housing subsidy is the only remaining family/child service need generally require a reduce level of casework as compared to other preventive service cases. Case planners and Supervisors assess the family's ongoing need for a housing subsidy as well as safety and risk factors for a family prior to designating a case as "Housing Subsidy Only". Preventive service Providers are responsible for the assessment that a family's case could be closed were it not for the ongoing need for housing subsidy, and this assessment must be approved by the Program Director. If a case has a program choice of protective, all protective issues must be resolved and the protective choice must be end dated via Plan Amendment or FASP prior to designating the case "Housing Subsidy Only".

A minimum of one home visit per quarter (every 3 months). Due to the reduced level of contacts required on these cases, and to ensure continuity of services, all contacts should be made by the assigned case planner. Additionally a home visit is required to take place no more

than 30 days prior to termination of the housing subsidy and or the preventive case. The case planner is expected to see every child in the family at least once per quarter and assess the physical condition of the home to ensure there are no obvious health and safety hazards present also assess whether the family circumstances and other needs have changed. There should be ongoing attention to safety issues so that the case can be returned to a full preventive case if need be. If families do not make themselves available for needed casework contacts, the housing subsidy may end prematurely. Ongoing casework contacts should focus on helping the family plan for permanent and affordable housing either by accessing other housing supports or by increasing the family's income so the rent can be managed without housing subsidy.

Note: Specialized preventive services will not have the option to designate a case as "Housing Subsidy Only". Children's services recommends that when families in specialized preventive programs achieve their goals such that housing subsidy is there only remaining service need, the cases should be transferred to a General Preventive program. General Preventive should accept theses families as a full case and then convert them to the Housing Subsidy Only status when families are ready.

Refer to policy #2010/05 Subject: *"Casework Requirements for Housing Subsidy Only Preventive Services Cases"* dated July 1, 2010, and revised *"Foster care and Preventive Housing Subsidy Application and Approval Process"*, dated November 18, 2008.

For indicated Child Welfare Cases (CWS) cases that step-down to the status of Housing Subsidy Only", Children's Services higher standard of home based contacts articulated in the Commissioner's memorandum of April 7, 2000, *Family Casework Requirements and Safety Assessment for Families with Histories of CPS Indicated Cases Receiving Services from Protective, Preventive and Foster Care Providers* will not apply.

For questions access the ACS Housing Support and Services Unit mailbox at: acs.sm.housing.preventive@dfa.state.ny.us.

Indicators:

1. The program uses assessed need as the basis for scheduling and providing casework contacts/home-based casework contacts to participating families.
2. During initial stages of participation, and during any subsequent periods of crisis, the program schedules and provides frequent, regular casework contacts including extensive home-based casework contact.
3. The Provider staff had a minimum of twelve (12) face-to-face casework contacts with children and/or their family, within each six (6)-month time period the family is in receipt of preventive services (as defined by NYS OCFS Regulations, Title 18 NYCRR, Sections 423.4, 430.12, and 441.21, and *Children's Services' Guidance - Casework Contact Requirements for General Preventive Service, revised 8/23/10.*)
4. At least two (2) of the contacts were in the child(ren)'s home.
5. At least four (4) of the contacts were individual contacts with the child(ren) and/or their family.
6. The progress notes for each casework contact document that the contact had at least forty

five (45) minutes to an hour's duration as well as substantive content in accordance with NYS OCFS regulations.

Documentation: CNNX or ADVPO progress notes; FASP; FASP Contact Grid (that part of the FASP document where the case planning staff lists their contacts with the family during the service plan review period); Provider-required assessments such as intake assessments and psychosocial reports from other service Providers; PROMIS.

NOTE: NYS OCFS preventive services regulations are as follows: "The first six-month time period commences at the case initiation date or at the date of case responsibility; subsequent six-month periods will be calculated from the service plan due date."

NOTE: To be counted as a casework contact in home, office, or field, the progress notes must substantiate that there was casework content, i.e. counseling or other activity (as specified in the service plan) such as play therapy or a socialization or parenting group. A progress note entry such as "Mrs. Jones was not home so I asked Johnny how he was doing in school and to have Mrs. Jones call me to make a new appointment" does not substantiate that a casework contact took place in the home.

CASE PRACTICE

FAMILY TEAM CONFERENCE MODEL

Standard:
The Provider shall facilitate (as appropriate) and participate in the Family Team Conference (FTC) model. The Children's Services FTC model is designed to engage families and community members in critical child welfare decisions related to safety, risk, well-being and service planning. Decisions are made and service plans developed by a group, including the family, their supports, community supports and service Providers, rather than individually. FTCs will be used to promote practice that reflects Children's Services core principles, thus enhancing children's safety and well-being.

The FTC model in Preventive Services includes the following conference types:

Child Safety Conference (CSC)
Child Safety Conferences are held at the point and time in which the CPS has made a preliminary assessment that there is imminent / impending danger to the child's life and health, prior to or following an emergency removal or when legal intervention is deemed necessary. 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. A Follow- up Child Safety Conferences is held within 20 days of the Initial Child Safety Conference for a review of the action plan developed at the initial conference and for the development of a comprehensive service plan. *A CSC can only occur as the result of a DCP investigation.* DCP will utilize the conference when the case is determined to need some level of Family Court Intervention, to develop a safety plan that lowers the level of imminent risk or safety concern.

Family Team Meeting
While a CSC must be held prior to finalizing any safety plan that involves removal or legal intervention to ensure all alternatives are explored, a Family Team Meeting is convened by the CPS team to develop a service plan to address identified risk elements when they do not present immediate or impending danger of serious harm to the child(ren) and court intervention is not being considered.

Preventive Planning Conference (PPC)
For all cases referred to preventive services, the Provider shall convene and facilitate a Preventive Planning Conference every six (6) months, two (2) to four (4) weeks prior to the FASP due date in order to develop and refine the service plan with the family, address any concerns regarding safety or risk, reach agreement on strategies to reduce risk, assess progress toward achieving service plan goals and examine the need for ongoing preventive services. Children's Services' FTC Conferencing Specialists will attend the first six (6) month conference. On a case-by-case basis, Children's Services may attend subsequent conferences. In ADVPO cases, should the parent strongly object to Children's Services attendance at the conference, Children's Services will not attend that conference.

Elevated Risk Conference (ERC)

Preventive Services Providers can request this conference when there is an indication of heightened risk to the child(ren) and/or there is a need to re-engage the family in services. The Elevated Risk Conference is available for all Preventive Case types, including advocates cases and cases involved with DCP, as well as foster care cases where Preventive Services are used to: a) prepare for the child's permanency (reunification, adoption or other family-based permanency outcomes); and b) continue to offer help to families within or close to their communities when children return home from care and/or for the siblings of children in care; and can be requested at any given time during the life of the case. The ERC is available in circumstances not requiring a call to SCR, but when risk to the family's children is increasing. ERC can be requested when DCP is conducting an investigation (during the investigative stage following an SCR report) or when DCP hold case management responsibility, while the case is in the Family Service Unit (FSU) and the family is also receiving Preventive Services.

Specifically, the Elevated Risk Conference is designed to:
a) Bring together Providers and others who are involved with a family, to prevent potential harm to children when the family's situation poses an increased risk to their safety.
b) Inform the development of interventions needed to stabilize the family,
c) Facilitate safety planning decisions at a critical point in the life of a case.

In those circumstances when such steps cannot be agreed on, and if an indicated CPS case was the cause of the Preventive case, a SCR or additional information report should be made asking for consideration of court-ordered supervision or placement for the children at risk.

FTC Facilitators from the Division of Family Support Services (FSS) will facilitate ERCs in partnership with preventive services Providers.

Examples of case situations that call for an Elevated Risk Conference

- A family has disengaged from services without sufficiently addressing the issues placing the children at risk of maltreatment.
- Children and youth have not been seen, or preventive workers are not given access to observe and interview a child/youth.
- A family consistently misses appointments, refuses to come to the office or is not available for home visits.
- Family members are not willing to share information that will help you understand what is going on in the family.
- Case planner is unsure if the family can protect the child and want to consult with ACS about the facts and situation that lead them to that conclusion.
- The service model chosen for the child/youth does not meet the level of care that the child, youth or family needs.
- Additional issues/conditions have surfaced that create an increased risk of maltreatment to the children and the family is not working with the agency to address them. For example:
- Not following through on services, i.e. drug treatment when in an FRP program; mental health service, when there are young or multiple children in the home.
- A parent or child tests positive for drugs.
- Child or youth are not attending school.

- A child/youth has an untreated or under-treated medical condition.

By partnering together in an Elevated Risk Conference, the Preventive Provider, ACS, the family and its supports can develop realistic steps to re-engage the family in the needed efforts, identify actions to reduce risk of maltreatment to children and reinforce safety assessments, analyses and decision making.

Refer to Child Safety Alert #32 entitled *"Responding to Heightened Safety Concerns in Preventive Service Cases"* dated March 30, 2011.

Service Termination Conference (STC)

Providers are encouraged- but not required- to arrange and facilitate a conference with the family and potential community based supports prior to service termination. At the request of the Provider, Children's Services may attend such a conference as a participant.

Quality Intervention Conference (QIC)

The Quality Intervention Conference may be considered by the following parties and for the following reasons:

- Children's Services staff may identify a particular case requiring special attention during the course of their ongoing monitoring and/or evaluation of agencies. Children's Services may then ask the Provider to schedule a Family Team Conference, which Children's Services will facilitate.
- A family in receipt of services may identify the need to schedule a Quality Intervention Conference. The family may seek the assistance of NYC Children's Services Office of Advocacy in assessing the need for and coordinating a QIC.
- NYC Children's Services Office of Safety First through its work with Provider agency staff may identify a particular case that would benefit from a QIC.

Family Team Conferencing when Domestic Violence is Present: In cases where a history of domestic violence has been identified, or when there is a full or limited order of protection, separate family team conferences should be held for the abusive partner and the survivor and the children. A domestic violence consultant or service Provider shall attend the conference whenever possible. If there is a "no contact" order of protection in effect, separate case conferences **must** be held for each parent. Conferences should be scheduled in such a way as to reduce the likelihood of contact between the partners, and an "exit" strategy should be developed beforehand with the survivor in the event that the abusive partner appears at the conference or the partners accidentally meet.

If the family has reconciled or has a temporary order of protection that permits contact between them, the partners should still be interviewed/met with separately to ensure safety and provide a safe space in which to assess for new incidents of domestic violence. In the rare circumstance where holding a conference together is insisted upon by the survivor, it is important to ask the survivor beforehand if s/he wants to discuss the domestic violence at the conference, and whether conferencing will place anyone in jeopardy.

Housing Subsidy Only Cases: Providers are not required to hold six month planning conferences during the period of time that a case is designated as "Housing Subsidy Only". However Children's Services will be available to facilitate Elevated Risk Conferences as needed and encourages the use of Service Termination Conferences prior to the termination of the preventive case and/or the housing subsidy.

Refer to policy #2010/05 Subject: *"Casework Requirements for Housing Subsidy Only Preventive Services Cases"* dated July 1, 2010.

Indicators: Trained staff from Preventive Services Programs will be expected to facilitate PPCs every six (6) months, approximately two (2) to four (4) weeks prior to the FASP due date. Children's Services will attend these conferences at the first six (6) month juncture; however, Children's Services will not attend when the parent in an ADVPO case strongly objects to Children's Services participation and/or attendance.

Preventive Services Provider staff will also be responsible for requesting ERCs when there is an indication of heightened risk to the child(ren) or when there is a need to re-engage the family in services. Children's Services FTC Facilitators will facilitate ERCs in partnership with Preventive Services Providers; the Preventive Services Providers will be responsible for ensuring that the appropriate people attend the conference.

Documentation: CNNX or ADVPO progress notes; PROMIS.

CASE PRACTICE

CASE PLANNER/CASEWORKER FUNCTIONS

Standard:

Every child welfare services case in CONNECTIONS must have a single "Case Planner" identified for the family. The Case Planner is responsible for the coordination of the work with the family and is the author of the FASP (i.e., the Case Planner is responsible for the entirety of its contents and the timeliness of its submission for approval).

Only the identified Case Manager may initially assign the role of Case Planner to a staff member in an agency/program (via its "Assign Unit") in accordance with the rules below. In all cases, the role of Case Planner can only be assigned to a worker in an agency/ program that is designated as a *planning* agency/program. If the agency/program is designated as a *non-planning* agency/program then it may only be assigned the role of Case Worker.

If the roles of Case Planner and Caseworker are not entered into the CONNECTIONS system, the worker(s) will not be able to document their assigned tasks. The Case Manager must therefore assign these roles in CONNECTIONS (which will be to an agency's/division's "Assign Unit") as soon after the event as possible. However, once assigned, Case Planners/ Caseworkers can assign additional persons or reassign these roles within the same agency. Only the ACS Case Manager can reassign a role to a different agency.

CONNECTIONS will provide "alerts" to all workers with a role in the case whenever a role has been assigned or un-assigned.

General Rules Applicable to **All** Programs

1. Whenever there is only one *planning* agency/program serving a family, that agency/program (i.e., a staff member) will **always** be assigned the role of Case Planner.

2. Whenever there is a designated *non-planning* foster care agency serving a family, and:
   (a) the child was referred there by the ACS/Division of Child Protection (DCP), and there is no other planning agency serving the family, then DCP is assigned the role of Case Manager (which incorporates the functional role of Case Planner). The *non-planning* foster care agency must **always** be assigned the role of Case Worker.
   (b) the child had been cared for by a foster care *planning* agency prior to transfer, then the "sending" agency retains its role as Case Planner (or Case Worker). The *non-planning* foster care agency must **always** be assigned the role of Case Worker.

3. Whenever there is a designated *non-planning* preventive services program serving a family, and:
   (a) the family was referred to them for *Homemaking Services* by DCP and there is no other planning agency serving the family, then DCP is assigned the role of Case Planner.

(b) the family was referred to them for *Homemaking Services* by a preventive or foster care *planning* agency/program, then the referring agency/ program retains the role of Case Planner.

At this time, a Homemaking Services agency will **never** be assigned the role of either Case Planner or Caseworker, as Homemaker programs do not provide any casework services and are not CONNECTIONS users.

(c) the family was referred to them for *Respite Care and Services* and no foster care or preventive case planning agency is already assigned to the family, the Respite Care and Services program will assume planning responsibility and will be assigned the role of Case Planner.

(d) the family was referred to them for *Respite Care and Services* by a preventive or foster care planning agency/program, the referring agency/program retains the role of Case Planner. In this instance, the Respite Care and Services program will be assigned the role of Case Worker.

4. To help insure continuity for the family to the extent possible whenever another Program Choice (protective, preventive or placement) is added to an already assigned Program Choice (preventive or placement), the program that was initially assigned the role of Case Planner (even if this is another agency within that program) will retain the role of Case Planner.

   Note: When both foster care and preventive agencies are working simultaneously with the same family, both programs must maintain at least each program's minimal casework contacts with the family, but the assessment/service responsibilities of each agency must be clear so that services are not duplicated and that the family is not overwhelmed with caseworkers performing the same tasks or are working towards conflicting goals. - if preventive program is already serving a family (i.e., a planning worker has already been assigned to the family) and one or more children are placed in a foster care *non-planning* agency directly from the community, the existing preventive planning program will retain the role of Case Planner.

5. Whenever a preventive services *planning* program is serving a family along with protective services (but with no foster care agency involvement), the preventive services program will **always** be assigned the role of Case Planner. (When the preventive services are being provided by a *non-planning* preventive Provider, then the protective services worker retains the role of Case Planner.)

6. Whenever preventive services are being provided to a family by a preventive services *planning* program, there may be no other preventive services *planning* program serving the family. However, there may be *non-planning* preventive services programs also serving the family.

7. Whenever Housing Subsidy Services are being provided to a family (must be authorized as a mandated preventive service only), the responsibility for determining/redetermining programmatic and financial eligibility and casework services relating to housing subsidy services (regardless of CONNECTIONS role) is based on the following:

(a) if Housing Subsidy Services are initiated by a foster care agency as a means of expediting discharge from foster care, the foster care agency (or *a* foster care agency) is **always** responsible. The (a) foster care agency remains responsible for housing subsidy services during the period of trial discharge.

(i) if any siblings remain in foster care, a foster care agency will continue to be responsible for housing subsidy services (even if there is a preventive services program serving the family.)

(ii) if there is a preventive services program serving the family also, at any time prior to final discharge of the child from foster care *and there are no other siblings in foster care*, the preventive service program will assume all housing subsidy services responsibilities.

(b) if Housing Subsidy Services are initiated by a preventive services program as a means of preventing placement/replacement, the preventive program is **always** assigned the role of Case Planner *if there are no siblings in foster care.*

These assignments are a continuation of existing policy as stated in ACS Procedure No. 82/Bulletin No 90-2, Provision of Mandated Preventive Housing Subsidy Services dated 4/5/90, Children's Services Memorandum entitled *Revised Foster Care and Preventive Housing Subsidy Application and Approval Process,* dated 11/18/08 and Children's Services Policy entitled *'Casework Requirements for "Housing Subsidy Only" Preventive Services cases,* dated 7/1/10.

Indicators:

1. Preventive Services Providers maintain documentation of their case management functions, regarding approval of FASPs and Plan Amendments, case openings/intake on ADVPO cases, transfers of preventive services cases, changes in program choice, and case closings.

2. The program has a system for Supervisory review of individual cases and FASPs.

Documentation: CNNX and ADVPO progress notes; FASPs; Supervisory approval; Supervisory Case Review; Provider Self Evaluation Plan 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

FAMILY ASSESSMENT and SERVICE PLAN (FASP)

Standard:

Preventive Provider staff will assess family service needs, periodically reassess those needs, and develop and revise, as necessary, individually tailored service plans for all family members, known as the FASP, which include the active participation of the family. Supervisors or Program Directors will approve FASPs after review of service goals and family progress. The PPC (discussed in *Part II Section D 'Family Team Conference'*), shall inform service plan development.

Initial FASPs consider child and family history information available from individuals significantly involved in the child's life, including but not limited to the child's parents, extended family members, teachers, friends, and recreational personnel. The Provider facilitates the incorporation of such individuals into the child's and family's support network to the extent this has been assessed as appropriate. These supports will be invited to FTCs as appropriate.

CWS Cases:
Preventive Provider staff will complete the various FASPs (including Comprehensive and Reassessments) for CWS cases and must follow the timelines as indicated here:

- The Comprehensive Assessment FASP is the CID plus **ninety** (**90) days**; and
- The Reassessment FASP is CID plus two hundred and ten (210) days (**or seven** (**7) months**).
- A Second Reassessment (is the case remains open) is due **six** (**6) months** after the first Reassessment.

The Initial (30-day) FASP will be completed and approved by DCP. Once the FASP is approved, the Provider's role will be changed from case worker to a case planner in CNNX.

Advocates Cases:
Preventive Provider staff will complete the various FASPs (including Initial, Comprehensive and Reassessments), ADVPO cases, and must follow the timelines as indicated here:

- The Initial Assessment FASP begins with the Case Initiation Date (CID) plus **thirty** (**30) days**;
- The Comprehensive Assessment FASP is the CID plus **ninety** (**90) days**; and
- The Reassessment FASP is CID plus two hundred and ten (210) days (**or seven** (**7) months**).
- A Second Reassessment (is the case remains open) is due **six** (**6) months** after the first Reassessment.

Program Choice

When opening a case and prior to the launch of any FASP the Program Choice should be checked for accuracy and updated as needed. For further guidance, please see NYS Regulation *18 NYCRR section 428.2(g)* and/or Children's Services Procedure, *Centralization of Data Entry Responsibilities into Legacy Systems (CCRS and WMS), January 2011*.

Indicators: FASPs are available for review in accordance with the above schedule.

1. The FASPs and service plan includes:
    a. Detailed, case-specific documentation of risk of placement and continued eligibility and need for preventive services;

    b. Current family functioning and any changes if applicable;

    c. Assessment of the service needs of all children and caregivers in the family;

    d. The most significant service priorities; and

    e. The family's ability to benefit from services.

2. The FASP focuses on the Permanency Planning Goal(s) and includes:
    a. For Comprehensive and Reassessment FASPs, specific, objective, measurable, achievable goals written in behavioral terms;

    b. For Comprehensive and Reassessment FASPs, target dates for new or retained goals;

    c. For Reassessment FASPs, each goal that was included in the previous FASPs appears as a retained or discontinued goal;

    d. For Reassessment FASPs, explanations for all discontinued goals; and

    e. For Reassessment FASPs, discussion of level of goal achievement for retained goals;

3. Service "Plan Development" documents: Family Team Conferencing

    a. How parent(s)/caretaker(s) and each child ten (10) years of age and over have participated; OR

    b. Why any parent(s)/caretaker(s) and child(ren) ten (10) years of age and over have not participated; AND

    c. Concurrence, non-concurrence of family members with any aspect of the service plan.

    The Provider conducts appropriate outreach to engage non-custodial and/or incarcerated

parents to the extent necessary and required by NYS OCFS regulations to develop and successfully implement the child's and family's approved service plan.

4. All relevant sections of each Assessment/Reassessment and Service Plan are completed, and it is been signed by both the case planner and supervisor.*

5. When an Assessment/Reassessment and Service Plan cross-references the progress notes, the content of the progress note entry corresponds to the cross-reference.

6. Preventive Services Providers maintain documentation of their IOC-delegated case management functions, regarding approval of FASPs and Plan Amendments, case openings/intake on ADVPO cases, transfers of preventive services cases, changes in program choice, and case closings.

7. Housing Subsidy only cases – prior to submission of each 6-month FASP, case planners are required to conduct a home visit and assess whether the family remains eligible for subsidy as described in the Children's Services memorandum entitled "*Revised Foster Care and Preventive Housing Subsidy Application and Approval Process"*, dated November 18, 2008.

   Changes in circumstances that would effect the family financial eligibility (including but not limited to increased income, addition of new, income generating household members; or the foster care placement or movements of one or more children to another household) must be brought to the attention of Children's Services Office of Housing Support and Services immediately and not solely at the time of the six month reassessment. If the family no longer needs the housing subsidy or if the family moves this too, must be bought to the immediate attention of Children's Services Office of Housing Support and Services. Eligible families may apply to have subsidy transferred to a new apartment through Office of Housing Support and Services.

   For questions regarding housing subsidy send questions to the ACS Housing Support and Services Unit mailbox at: acs.sm.housing.preventive@dfa.state.ny.us.

Documentation: CNNX and ADVPO progress notes; PROMIS; FASPs.

CASE PRACTICE

COMPLETE ASSESSMENTS

Standard:

Preventive Provider staff completes the following specialized assessments for each family and reassesses each family for each area in accordance with the FASP Assessment/Reassessment and Service Plan completion schedule:

Within thirty (30) days of service initiation:

- (Whenever appropriate and necessary) the family's financial status for Medicaid eligibility, or for Child Health Plus eligibility for the children; and
- Domestic/Family Violence.

In accordance with the timelines for the Comprehensive Family Assessment and Service Plan:

- A full medical history review, including any psychiatric history and mental health issues, for each child and other family member residing in the household. This includes obtaining immunization history, and information from health services Providers involved with the family.

As necessary and appropriate and including but not limited to the following:

- Intergenerational neglect and the parents' own history of neglect/abuse, including placement in foster care;
- Alleged or known abuse/neglect in the home;
- Relative or non-relative adults residing in or frequenting the home;
- Young mother or mother was young at time of the first child's birth;
- Larger number of children;
- Literacy and comprehension and writing skills of the children and families to be served;
- Health status of the children and family members, and need for immunizations, preventive health visits, referrals to specialists, etc.;
- Child and parent mental health and developmental issues;
- Substance use disorder/use issues affecting children and their resident family members;

- Domestic violence issues affecting children and their resident family members;
- Parental need for parenting skills education; such assessments distinguish between indicators suggesting the presence of mental health issues and indicators suggesting a lack of basic parenting knowledge and skills;
- Disciplinary practices, supervision of children, children's response to caregiver, caregiver's response to children, etc.;
- Chronic tardiness and absenteeism from school by child;
- Extreme poverty;
- Unemployment, inadequate education and lack of marketable job skills;
- Homelessness/unsuitable housing; and
- Social isolation or lack of relationships due to a lack of family and social supports.

Indicators: All required and appropriate assessments are completed in a timely manner.

Documentation: FASPs; CNNX or ADVPO progress notes; reports from other service Providers; Provider's own intake and assessment forms; correspondence; completed referral forms for other Providers where appropriate; 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

ADDRESSING REASONS FOR INDICATION

Standard:

Preventive Provider staff shall assess and reassess families for abuse or neglect. When there is an open "Indicated" case in DCP which is being tracked and monitored by the SCR, the FASP Assessment/Reassessment summarizes the family's progress in dealing with the problem or situation which gave rise to the report of abuse or neglect, including an evaluation of risk to the child if s/he remains in/returns to the home.

In discussing risk to the child, the assessment/reassessment considers:

1. the family's potential to harm the child;
2. the family's ability to protect the child or prevent future harm; and
3. the family's capacity to care for the child.

Indicators:

1. There has been a discussion of how and to what extent the problems resulting in indication have been addressed.

2. There is an evaluation of the risk to the child if s/he remains in the home.

3. The Assessment/Reassessment addresses points 1, 2, and 3 in the above 'Standard'.

Documentation: CNNX or ADVPO progress notes; group notes; reports from other service Providers; correspondence; PROMIS; FASPs; any other relevant material.

CASE PRACTICE

SERVICES CONSISTENT WITH NEEDS

Standard:

The Comprehensive Case Record (CCR) – which includes the entire case record and FASPs demonstrates consistency among: the service and treatment needs identified as contributing to the child's risk of placement; the agreed upon goals; treatment and services planned to meet these needs; and the treatment and services that are actively provided to the child, members of the child's family and/or other significant resource persons consistent with the presenting problems. Where multiple needs exist, the Provider works with the family to set appropriate priorities, taking the parents and children's views into account. As the families' needs and circumstances change, the Provider adjusts the delivery of services where appropriate.

Indicator:

1. The FASP and Service Plan shows a clear link between the specific risks to children in the family and the services utilized to reduce those risks and strengthen family functioning. In addition, the plan must demonstrate a match between services provided and the family's needs and abilities.
2. The progress notes document that:
   a) services are being provided consistent with the child/family treatment and service needs identified on the FASP and Service Plan, subsequently submitted Plan Amendments, or current child/family circumstances; OR
   b) there are substantive reasons (such as family refusal or interruption by a sudden emergency) for not providing these services.
3. The Provider staff appropriately identifies the family's service needs in accordance with *Title 18 NYCRR, Section 441* and Children's Services' policy and procedures.
4. The Provider staff only requests information from other service Providers with written consent of the referenced family member(s).

Documentation: CNNX or ADVPO progress notes; FASPs; Plan Amendments; signed 'Consents for Release of Confidential Information'; medical, mental health, substance use disorder/use treatment and school records; any other appropriate documentation in the CCR.

NOTE: 1) "Preventive Services" and "Casework Counseling" are not service needs/priorities, they are the basic requirements. The terms "casework counseling" may be used relative to a specific area of service need, as in the phrase: "casework counseling on appropriate discipline for early adolescents."

2) When the most recent Assessment/Reassessment and service plan was written by another Provider, services should be provided consistent with that service plan. If the program's assessment is different, the program carefully documents this in the progress notes. If the family has a foster care case, services are coordinated and provided consistent with the foster care Provider's approved service plan.

3) The service environment shall be accepting and supportive of lesbian, gay,

bisexual, transgender, and questioning youth.

4) The Provider shall refer pregnant/parenting youth to appropriate Providers of family centered services, including Children's Services Teen Age Services Act (TASA) programs and other Preventive Services Providers to obtain the appropriate services. For example, supervised child care services may be needed to enable the youth to participate in services and programs, such as parenting education and skills training, individual counseling, and support group activities.

CASE PRACTICE

ABILITY TO BENEFIT FROM SERVICES

Standard:

The Provider ensures that the health, mental health, domestic violence, substance use disorder/use treatment and other services that are being provided are those that will address those behaviors, conditions or situations which gave rise to the need for preventive services. When there is a question about a parent's or family member's ability to meaningfully engage and participate in services, intellectual and cognitive assessments and referrals for appropriate services, as indicated, shall be made.

Indicators:

1. The FASP and service plan identifies the strengths, assets and resources available to the family that enable them to benefit from the services to be provided.

2. The FASP and service plan shows why the services to be provided will accomplish the preservation and/or restoration of family functioning.

Documentation: CNNX and ADVPO progress notes; FASPs; group notes; reports from other service Providers; correspondence; PROMIS.

NOTE: It is not appropriate to say that "the family can benefit because they need preventive services"… service need and the ability to make use of the service to meet the need are not the same. The case record must document that the family can reasonably be expected to use the services provided to alleviate those conditions that place the child(ren) at risk of placement.

CASE PRACTICE

CASEWORK COUNSELING INTERVENTIONS

Standard:

The Preventive Provider staff will provide casework counseling and other individual or group interventions to the families being served. The frequency of casework counseling and the specific type of intervention are both consistent with minimum standards (see *Part II, Section D* "Casework Contacts") established by Children's Services, and based on an assessment of need documented in FASP.

Indicators:

1. The preventive Provider staff provides casework counseling and other individual or group interventions to the families being served based on assessment of need.

2. The Provider provides services directly as identified in the POP.

Documentation: FASPs; Case records, including CNNX or ADVPO progress notes; PROMIS reports; other documentation maintained by the Provider, including but not limited to group work notes, documentation of appropriate referrals, psychiatric and psychological evaluations, and records of clinical services provided by Provider staff other than the case planner; POP; 'Program Manual of Standards, Policies, and Procedures'.

CASE PRACTICE

ADVOCACY AND REFERRAL

Standard:

Children's Services and Providers refer children and their families to necessary services in the community and outside (when preferred, or not provided by the Provider or not conveniently available) and advocate for families with the Providers of services to which the Provider has referred them, as well as with those Providers with which families have an independent involvement.

The Provider's services include, but are not limited to assisting children and their families in navigating public and private sector bureaucracies to the extent needed to successfully meet the families'/family members' needs. The Provider accesses specialized services outside of the community in instances where the child's or family's needs cannot be addressed by Providers within the community.

The Provider has established linkages or referral protocols which specifically address services to be provided under the contract with Children's Services. Providers shall also establish linkages with advocacy organizations that work with families affected by specific health conditions, mental health, domestic violence, etc.

Advocacy and referral services include: coordinating service delivery with Providers, monitoring children's and their families' level of participation in services provided through referral, and providing such follow-up services as are necessary to ensure successful outcomes. In domestic violence situations, advocacy may take the form of escorting the victim to court, or help the victim to navigate the Criminal Justice System or the Family Court, and/or other key systems like Children's Services or HRA.

Indicators:

Preventive Provider staff will:

1. Make all referrals necessary to achieve family outcomes and assist children and their families to meet their needs.

2. Advocate for children and their families as necessary to achieve family goals and meet their needs.

3. Coordinate with other service Providers, monitor service delivery/family participation, as well as provide any necessary follow-up services to assist families to achieve family goals and meet their needs.

Documentation: FASPs; Case records (which include referral/advocacy/follow-up controls); CNNX or ADVPO progress notes; correspondence; linkage agreements with community/non-community-based service Providers; referral protocols; completed referral forms where appropriate; reports from service Providers; PROMIS; 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

CASE RECORDS AND CONFIDENTIALITY

Standard:

The Provider will maintain a case record for each family in receipt of preventive services. 'Case Record' refers to physical and/or electronic preventive services record maintained for a family and all its contents. The physical record needs to be legible, every entry is dated, conforms to Children's Services' expectations for CCRs, and to the Provider's own expectations is in an agency-maintained Preventive Services Program Manual.

Documentation must be as contemporaneously as possible with the occurrence of the event or the receipt of information which is to be recorded, so that all documentation is logged as soon as possible to ensure an accurate, timely account of all casework activity and family circumstances.

Case Records are confidential. The contents are made available only to Provider staff and approved Children's Services investigative/monitoring/review units.

Case records are open to the inspection of NYS OCFS, the local social services district, a preventive services Provider or authorized foster care Provider providing services to the family, or with a court order. Information may be provided to other service Providers only with prior informed, written consent by the family member (adult or child-to the degree the child is capable of giving such consent) to reveal specified information.

A family may gain access to records according to the guidelines of needing documentation for a Fair Hearing (see NYS Regulations *Title 18 NYCRR, Section 428.8 and OCFS Form 174 – 'Clients Rights and Responsibilities'.*

In addition to the above confidentiality restrictions, case information pertaining to the following categories of information has additional limitations on the re-disclosure of such information, including the requirement of written consent before re-disclosure of such information, except where otherwise permitted by law:

- health and mental health treatment records;
- substance use disorder/use treatment records;
- educational records;
- domestic violence service records; and
- HIV-related records.

If the family resides in a domestic violence shelter, references in the case record should 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 **should never be documented** in CNNX, PROMIS, or a court report or given to anyone directly or indirectly, particularly the abusive partner or his or her agent (see *Title18 NYCRR Section,*

452.10 for details).

All information pertaining to domestic violence safety planning (i.e. a shelter's business address or any confidential address of a survivor of domestic violence) should be clearly and boldly identified in the case record by preventive staff as "**Confidential Information Due To Domestic Violence, Do Not Share**". This same precaution is required when a survivor of domestic violence is residing in a homeless shelter, substance use disorder treatment program, or other location not known to the abusive partner.

Indicators: The case record is legible; every entry is dated, and contains:

1. PROMIS Case Detail Information (printable from PROMIS) - A face sheet, with identifying information (optional).

2. CNNX or ADVPO progress notes, with concise recorded entries providing a chronological overview of activities and events in the case. These include, but are not limited to:

    a. actions taken by the Case Planner to implement the service plan;

    b. descriptions of contacts with family and collaterals, including missed or cancelled appointments. Key documented elements should include location of contact, participants, focus of the meeting, keys issues that emerges or are discussed, and next steps;

    c. ongoing safety assessments of family circumstances and child safety;

    d. the family's responses to services and referrals;

    e. communications with other service Providers;

    f. legal activities such as results of court hearings, basis and specifics of judges findings, etc. ;

    g. significant events, such as birth, marriage, divorce;

    h. events which facilitate or impede service;

    i. documentation that all service plan goals are being addressed, OR clear, compelling reasons why such goal(s) cannot be addressed;

    j. documentation that service plan tasks are being performed, OR substantive reasons for lack of performance; and

    k. documentation of case specific Supervisory review and guidance, at least once per month.

3. FASP which consists of:

   a) Initial, Comprehensive, AND Reassessment FASPs and Service Plans. (If there are no Initial or Comprehensive FASPs, Provider staff must document diligence to acquire those documents from the Children's Services' manager through progress notes, e-mails, and telephone calls etc.)
   *For ADVPO cases, copies of the FSI should be kept in the case record.

4. Plan Amendments, including a 'Request for Preventive Services' by a preventive program and Case Closings.

5. WMS (Welfare Management System) required form:

   a) LE-DSS2921 (Common Application Form) - Required by OCFS to be maintained in the case record, and used to establish CID date or date of agency intervention if a CID is already established in CNNX.

      For CWS cases that originate in DCP, the CPS worker will have the family sign a LE-DSS2921. Upon referral for preventive services, the Provider will have the family sign a second LE-DSS2921 ONLY to establish the start of preventive service's date with that Provider. That LE-DSS2921 signed by the family should be filed in the CCR that is maintained by the Provider and must be provided for Children's Services' review when requested. For ADVPO cases, the LE-DSS2921 is to be transmitted via email to the Children's Services' System Support Office (SSO) Application Unit, and the CID is established based on the date that the electronic LE-DSS2921 application was received. The original LDSS 2921 should be filed in the CCR that is maintained by the Provider and must be provided for Children's Services' review when requested. Note: A completed LE-DSS2921 and CNNX-FSI (Family Services Intake) must be transmitted on the same day to establish the CID and to stage progress to an FSS. If the electronic forms do not arrive on the same date, and/or the information on the LE-DSS2921 and the FSI don't correspond the LDSS 2921 will be rejected.

      The LE-DSS2921 is also used by other NYS agencies, including Public Assistance and food stamps; Provider staff must be trained and become familiar with which section of this form should be completed for families receiving preventive services: (a family signature should only be on the last page of the Application).

6. Family Service Intake:

   The FSI must be completed and filed in the on-site family record. It is essential that it is accurately completed and matches with the LDSS 2921. The FSI **should not** be submitted without a completed Relationship Matrix. Please refer to Children's Services Procedure, *Centralization of Data Entry Responsibilities into Legacy Systems (CCRS and WMS), January, 2011*.

7. Applicable documentation, obtained with appropriate family member's written consent allowing for the release of confidential information, regarding services from other Providers. Includes, but not limited to current health, mental health, education, substance use disorder/use, and domestic violence services as appropriate.

8. Correspondence to/from family and service Providers.

9. The Provider does not release information to persons/agencies not authorized by law to receive information without having obtained the appropriate family member's written consent.

10. Current consent for release of confidential information. Written consent forms are on file as appropriate. The Provider obtains informed written consents/releases, as appropriate to a given family member, from adults and children who are capable of giving informed consent, as necessary to obtain information from and/or release it to service Providers including but not limited to schools, medical and mental health Providers, and substance use disorder/use prevention, treatment and aftercare programs.

NOTE: The relevant State Regulation is 18 N.Y.C.R.R. 428.5.

Documentation: Case records, including CNNX or ADVPO progress notes; PROMIS reports; other documentation maintained by the Provider, including, but not limited to group work notes, documentation of appropriate referrals, psychiatric and psychological evaluations, and records of clinical services provided by Provider staff other than the case planner; other CNNX documentation; 'Program Manual of Standards, Policies, and Procedures'; POP, staff written affirmation of receipt and understanding of those policies; case records.

CASE PRACTICE

TRANSFER OF CASES BETWEEN PREVENTIVE PROGRAMS

Standard:

Families whose cases are transferring between preventive services programs must be assured of service continuity for the parents and children.

If and when a decision is made to refer the family to another preventive program, the referring program must identify an appropriate program for the family, if one has not already been identified. Once a new program has been identified, the referring program case planner must initiate the process for transferring the case by convening a meeting between the client and the new program to discuss the request for the transfer, the service plan and desired outcomes.

The meeting should include the following persons:

- the client and his/her family member and any resources agreeable to the client, and
- the case planner, supervisor or intake worker from the new program.

At minimum the meeting should address:

- Reason the family is receiving preventive services;
- Reason for the transfer request;
- What goals have been reached to date;
- Safety and risk factors that may exist;
- Any safety plans or safety responses that need to be maintained or modified;
- Pending actions that need to be taken/addressed;
- Outstanding service planning needs/goals for each member of the family; and
- Expectations of new program or agency.

The referring program retains case planning responsibility, including the responsibility for casework contacts, until the family signs a new application for services/common application (DSS-2921) and the receiving program accepts the case in PROMIS.

Once a case transfer has been approved by the client and receiving program, the referring program will complete the necessary documentation to facilitate the transfer.

When families in specialized preventive service programs achieve their goals such that housing subsidy is their only remaining service needs, their cases should accept these as "full" cases and then convert them to the 'Housing Subsidy Only' when families are ready.

Provider agencies do not have the authority to transfer the following types of cases without prior approval from Children's Services:

- Cases open within the Division of Child Protection (DCP) i.e., Court Ordered Supervision (COS), Family Service Unit (FSU) or active investigation. DCP maintain responsibility for approving transfers under these circumstances.

- Families receiving simultaneous services (preventive and foster care) where the foster care agency holds case planning.

Indicators:

1. Cases are transferred to meet the service needs of the family and not as an agency strategy to reduce length of stay.
2. A transition meeting in office or home is always attempted prior to accepting or rejecting the case.
3. PROMIS and CNNX will indicate the referring and receiving programs appropriate roles in the case.

Documentation: CNNX or ADVPO progress notes; PROMIS; and CS 174B "Notice of Intent to Reduce or Discontinue Service".

NOTE:

- Please find specific instructions in the *Preventive Services Handbook Tools and Resources for Improved Outcomes for Children 2009* in the Transfers Section.
- For additional information about record sharing, please see ACS Guidance #2008/01 titled "Sharing Child Case Record Information between Children's Services, Foster Care and Preventive Provider Agencies."
- Refer to "Ending Preventive Services – Planning" and "Ending Preventive Services – Notification" and "Ending Preventive Services –Casework" for additional guidance.
- For additional information about 'Housing Subsidy Only' please refer to ACS Policy #2010/05 titled "Casework Requirements for 'Housing Subsidy Only' Preventive Services Cases".

CASE PRACTICE

ENDING PREVENTIVE SERVICES – PLANNING

Standard:

The Provider will make a good faith effort to end services for families in a planned and structured manner and after careful and case-by-case review; all decisions to end preventive services will be based on assessed need and approved by the Program Director.

Planning for service termination is expected to start from the beginning of the work with each family. Termination should begin at the first contact with families. Staff should contract with families around the focused, time limited nature and scope of services

When the Provider and family agree that all goals that relate to addressing the need for preventive services have been met, or when the Provider in accordance with Children's Services Improved Outcomes for Children (IOC) Guidance 2009/1 *"Preventive Services Case Closing" Issued 4.30.09* determines that, although all such goals have not been met, the family is no longer able to benefit from services, a staff member at Supervisory level or above will:

- conduct an exit interview with the family (parents/caretakers and children, and other household members as appropriate) to review the reasons for ending preventive services;
- assure the family of continued availability in case of future service need;
- ensure that education, health, mental health, substance use disorder, domestic violence and other service Providers know that the preventive case will be closed, and provide any necessary arrangements and/or referrals for post-ending services; and
- conduct a Service's Termination Conference (STC) (optional).

For all preventive cases Providers must use the Children's Services "Safety and Risk Desk Aid for Preventive Service Providers" when assessing the decision to end preventive services.

The Provider also utilizes the exit interview or STC to help determine the effectiveness of the services that have been provided by the Provider and to learn more about the child(ren)'s and family's experiences. The determination to end preventive servicers will be made after careful and case-by-case review; all decisions to end preventive services will be based on assessed need. After this review and assessment of the appropriateness of the decision to end preventive services, Providers are authorized to approve the closing. All decisions to end preventive services must be approved by the Program Director.

Indicator:

1. The number of planned closings versus unplanned closings.

2. The program has a system for Supervisory review of individual cases.

3. A staff member at Supervisory level or above conducts an exit interview with each family

prior to ending services.

Documentation: Controls maintained by Provider; case records; CNNX and ADVPO progress notes; FASPs; Supervisory progress notes; correspondence to/from family; ending preventive services Plan Amendment; exit interview tool (if applicable); PROMIS; 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

ENDING PREVENTIVE SERVICES – CHILDREN'S SERVICES NOTIFICATION

Standard:

The Provider shall record the family/Supervisory session in progress note in CNNX for CWS cases or in template for ADVPO cases. Document Supervisory approval in the FASP Plan Amendment, record intent to close preventive services in PROMIS, and submit a Family Services Stage (FSS) for closure. The Provider shall submit notification to end services for ADVPO and CWS cases fifteen (15) days prior to each planned ending of preventive services in PROMIS. Children's Services will provide the participating family with written notification of the intent to end preventive services (Children's Services Form CS174b: 'Notice of Intent to Reduce or Discontinue Services') at least fifteen (15) days prior to the planned date of closing. Provider staff shall submit an FSS in CNNX to Children's Services for system closure.

The Plan Amendment to end Preventive Services clearly documents the reasons for ending services in accordance with the progress notes and other pertinent material in the case record, discusses all goals relating to alleviating the need for preventive services, which were not met prior to ending services, and addresses all protective issues for "Indicated" cases.

The process described here for ending preventive services for ADVPO and CWS preventive cases should be used when:

- There will be no ongoing/simultaneous services with a Children's Services contract Provider.

- The client/family and Provider are in agreement to close a case.

Documentation: Closing Plan Amendment; FASPs; previous assessments and services plans; CNNX or ADVPO progress notes; correspondence; PROMIS.

NOTE:
Preventive Providers are responsible for submitting their Family Service Stages (FSS) for system closure. This is the last step in the case closing procedure. Providers should **not** submit the FSS for system closure if the case has an open investigation, needs to remain active with Family Service Unit (FSU/DCP), foster care, B2H, homemaking/housing subsidy, an active Court Ordered Investigation, etc.

Bridges to Health Cases
When preventive Providers receive referrals from foster care Providers and a child in the home is receiving New York State Bridges to Health (B2H) Medicaid Waiver program services, the CNNX case must remain open even after the preventive Provider is no longer working with the family and closes that section of the case record to ensure that the Health Care Integration Agency's and ACS B2H unit can continue to properly track that case.

Coordination with the ACS B2H Unit must be done prior to case closing to ensure that the CNNX case is not improperly closed.

Homemaking Services
For cases receiving both preventive and homemaker services that are approaching the termination stage, Provider agencies are encouraged to invite a caseworker from Children's Services Family Home Care unit to a Preventive Planning or Service Termination Conference to discuss the possibility of arranging for alternative services for the family prior to closing., as required by *Children's Service Memorandum – Preventive Cases with Homemaking Services' issued 9/8/10* and *Title 18 NYCRR Section 460.1*.

Once it has been decided that homemaking services will end, the preventive agency case planner must submit a copy of CM20E (Notice of Intent to Reduce or Terminate Homemaker Services) to Family Home Care with the expected date of termination. The original form must be given to the family no less than fifteen (15) days before the expected last date of homemaker services. State regulations require that clients in receipt of homemaker services be given advance notice of intent to discontinue (or reduce) services and that such notice include their right to request a Fair Hearing. Neither the homemaker service nor the preventive service case closing may be implemented if the client requests a fair hearing within the allowable timeframe or an "aid-to continue" notice from the New York State Department of Social Services is received by the preventive case planner or Family Home Care.

CASE PRACTICE

ENDING PREVENTIVE SERVICES – CASEWORK

Standard:

The Provider will make a good faith effort to end services for families in a planned and structured manner and after careful and case-by-case review; all decisions to end preventive services will be based on assessed need and approved by the Program Director.

Indicators:

1. The number of planned closings versus unplanned closings.

2. The program has a system for Supervisory review of individual cases.

Documentation: Controls maintained by Provider; case records; CNNX, PROMIS; 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

CASE DURATION

Standard:

Children's Services expects agencies to maintain an average length of service of twelve (12) months. At the six month point, each family's needs and progress should be addressed using the Family Team Conference and pending 7-month FASP to help guide the work. At this point in the case, Providers must be able to clearly articulate what needs to be accomplished in order to comfortably terminate services

PROMIS - "Cases Active for 6-12-18 Months or Longer Report." (See *Children's Services Procedures No. 103/Bulletin No. 99-102*).

NOTE: "Housing Subsidy Only" cases will not be counted when tracking length of service or determining the percentage of a program's cases that are open for more than 12 or 18 months for monitoring or program evaluation purposes.

Indicators:

1. Number of cases open more/less than twelve (12) months.

2. No shared cases open over twenty four (24) months.

Documentation: Administrator's sign-off on most recent FASP; case conference notes of biweekly review by supervisor and administrator; and current approval for (re)authorization for shared (foster care/DCP Protective Services Office/other) cases from the Children's Services office having primary case management responsibility; PROMIS - "Cases Active for 6-12-18 Months or Longer Report"; 'Program Manual of Standards, Policies, and Procedures'; POP.

CASE PRACTICE

CASE RECORDS – ACCESSIBILITY

Standard:

The Provider will provide Children's Services with contact persons and telephone numbers to permit access to records on a twenty four (24)-hour basis when cases of alleged child abuse or neglect are reported from the SCR.

Indicators:

i. The Provider will provide the name of a contact person who Children's Services staff should contact in the event of an incident involving a client or fatality.
ii. POP (face sheet)

Documentation: DCP Protective Services Office Reports; POP; 'Program Manual of Standards, Policies and Procedures'.

CASE PRACTICE

MANDATED REPORTING

Standard:

The Provider has a written policy and procedure with regard to **MANDATED** reporting of **SUSPECTED** child abuse/maltreatment to the SCR in accordance with New York State law. The policy includes efforts to promote effective case coordination when DCP has become involved in a case that is active with the Preventive Services Provider.

The Provider reports all cases where there is reasonable suspicion of abuse/maltreatment. The staff member with direct knowledge of any allegation(s) of suspected child abuse or maltreatment must personally make a report to the SCR and then notify the Supervisor/Director/person in charge or a designated representative that a report has been made. The person in charge or designated representative is then responsible for all subsequent internal administration necessitated by the report. This may include providing follow-up information to DCP.

All initial or subsequent reports made to the SCR shall include the name, title and contact information for every staff person of the Provider that is believed to have direct knowledge of the allegations contained in the report. Providers must submit form OCFS-2221A to OCFS after an oral report in accordance with *Title 18 NYCRR, Parts 428.10 and 441.7,* and maintain a hard copy in their case record.

For additional information and guidance refer to *Part II Section D* Preventive Services "Safety and Risk Assessments" and "Family Team Conference Model".

Providers shall not take retaliatory personnel action against an employee who made a report to the SCR. Furthermore, no Provider shall impose any conditions, including prior approval or prior notification, upon a member of their staff mandated to report suspected child abuse or maltreatment.

When multiple mandated reporters from the same Provider have direct knowledge of, and/or have reasonable cause to suspect child abuse or maltreatment concerning a particular incident, situation, or occurrence, the Provider shall develop a policy in which only one Mandated Reporter with direct knowledge of the abuse or maltreatment shall make the report to the SCR, so long as the report is accepted. The Mandated Reporter who makes the call to the SCR is required to advise the SCR of the name, title, and contact information for every staff person the Mandated Reporter believes has direct knowledge of the alleged abuse or maltreatment. In cases, cases, the Mandated Reporter shall be the Case Planner, Supervisor or other staff person as directed by the Director/ person in charge or designated representative. Children's Services recommends that this policy be in writing and provided to all Provider staff.

In addition to mandated reports of suspected child abuse and maltreatment, preventive Providers

shall contact OCFS **and** Children's Services where abuse or maltreatment is not immediately suspected as the cause of death for a child in a preventive services case. Within 24 for hours of learning of the death of a child where abuse/maltreatment is not immediately suspected as the cause of death, the preventive Provider must notify OCFS by phone or fax. The Agency Reporting Form for Serious Injuries, Accidents, or Deaths of Children Foster Care and Deaths of Children in Open Child Protective or Preventive Cases form must be completed by the Provider and faxed to OCFS within 72 hours. Any pertinent medical and autopsy reports should also accompany this form. Additionally, the Provider staff/case planner shall notify the SCR of the child's death when abuse/maltreatment is not immediately suspected as the cause of death. The following applies, depending on case planning responsibility:

- If case planning remains with DCP, the case planner shall immediately notify the Assistant Borough Commissioner where the case is active. The Assistant Borough Commissioner will notify OCFS and Children's Services Accountability Review Panel (ARP).
- If case planning is with a foster care agency, the case planner shall notify the Children's Services Shared Response Team (SRT) within the Division of Family Permanency Services (FPS) via phone or fax. The SRT will notify the Accountability Review Panel (ARP).
- If case planning is with the preventive services Provider, the case planner shall notify Children's Services Family Support Services (FSS) via phone and fax and complete the FSS Three hour Report and the FSS Twenty-Four Hour Report. FSS will notify the ARP.

Indicators:

1. The Provider reports all cases where there is reasonable suspicion of abuse/maltreatment.

2. All staff have received training in the mandated reporting of child abuse/maltreatment from Children's Services or equivalent source.

3. Appropriate policies and procedures have been distributed to all staff.

4. Forms OCFS-2221A (the NYS OCFS 'Report of Suspected Child Abuse or Maltreatment'), OCFS Agency Reporting Form for Serious Injuries, Accidents, or Deaths of Children Foster Care and Deaths of Children in Open Child Protective or Preventive Cases form, and Children's Services Three-Hour Reporting for and Children's Services Twenty-Four Hour Report form are completed and submitted in a timely manner.

Documentation: Written procedures; training attendance records; OCFS-2221A in the record only if case has been "Indicated" or still under investigation; interviews with workers.

Note: Provider staff must destroy all copies of OCFS-2221A reports which the SCR has found to be 'Unfounded', and must not retain them in the family's case record.

CASE PRACTICE

CONNECTIONS (CNNX) PARTICIPATION

Standard:

Acceptance of the CNNX system requires that the Provider utilize CNNX for the primary purposes of maintaining and conveying child welfare records concerning children and families served by Provider as well as providing necessary/supporting communications and information. Such records include and are not limited to FASPs, progress notes, certain health information, forms, informed consents, consents for the release of information between services Providers, other applicable documents, and any and all related information concerning the Provider's work with and on behalf of any and all children and family members. Data entry in CNNX must follow the rules and requirements for that system.

Indicators:

- Required information is available in a timely manner on the CNNX system for review by appropriate Children's Services staff.

- Staff are trained and make appropriate use of the system.

Documentation: Case records; CNNX; NYS OCFS Compliance-Scan Reports; POP; 'Program Manual of Standards, Policies and Procedures'.

CASE PRACTICE

GROUP WORK SERVICES

Standard:

The Provider provides space for, where possible, and works cooperatively with other Children's Services Providers (as well as other appropriate Providers) to provide groups in accordance with the needs of program participants and in the several languages spoken by the families in the communities served.

Couples counseling (joint or group activity of any kind), psychotherapy, and/or anger management programs are contraindicated for domestic violence and are not viable therapeutic tools. Abusive partners shall be referred to batterer education programs held once a week for a minimum of twenty-six 26 weeks. Children and survivors of domestic violence must be ensured enhanced safety planning through a coordinated community response, which includes a range of services such as housing, immigration and legal matters; safety planning for victims and children; counseling and support groups with domestic violence service Providers; domestic violence advocacy and legal assistance; services for the elderly and/or disabled; and police intervention and intersection with other key systems.

In addition to those noted above, and in Part II PREVENTIVE SERVICES - REQUIRED SERVICES, Group Work may address and is not limited to: children affected by abuse, neglect and family violence; children with school or behavioral problems; youth development for older teens; child and adult health and development; sexual health and safer sexual activity; self-help/negotiating governmental systems; preparing for employment interviews; and immigration issues.

Indicators:

1. The Provider provides a variety of support groups, parent education groups and workshops in accordance with the needs of participating families, both independently and in conjunction with other Providers and individuals.

2. Groups are conducted in the languages spoken by participating families.

Documentation: CNNX or ADVPO progress notes; group notes (if maintained separately from progress notes); FASPs; curricula, attendance sheets, linkage agreements between/among cooperating Providers and other Providers; PROMIS.

E PREVENTIVE SERVICES - PERSONNEL

*** The following standards and expectations should guide the program's staffing, and the selection, supervision and training of staff.**

CULTURAL COMPETENCE

Standard:

The Provider shall provide culturally and linguistically competent services through staff that is representative of the community served and fluent in the languages spoken by participating children and family members. Such staff should reflect that the Provider is able to assess the needs of the local community and is meaningfully linked to local community resources, and that the program is led and operated with understanding and respect for community 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 immigrant 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 residing in the communities served. As the demographics of New York City communities' changes often, the Provider shall review language data provided by Children's Services every two years and make appropriate changes in staffing to reflect demographic changes.

Indicators:

1. There is at least one professional staff member with the same ethnic/racial identification and language as any group comprising at least five thousand (5,000) persons or ten (10)% of the parents of public school students that speak a language other than English in the community district served by the Provider, and the Provider has at least one bilingual Case Planner for that language. If it is not feasible to hire bilingual/bicultural staff from each different immigrant community group, the Provider has "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.

2. All direct service staff receive cultural awareness and sensitivity training appropriate to the populations served.

3. Essential notices and documents are provided in the families' preferred language or oral explanations are provided.

4. The Provider accepts appropriate referrals from Children's Services for families that are non-English speaking.

Documentation: Bilingual staffing data; client and/or staff interviews; observation; training schedules and attendance sheets; linkage agreements or contracts with community groups; written statement/affirmation from the agency's Executive Director; POP; 'Program Manual of Standards, Policies and Procedures'.

PERSONNEL

STAFF QUALIFICATIONS

Standard:

Providers review prospective staff members' qualifications***** and make hiring decisions in the context of the size of the program. A smaller program (sixty (60) slots) needs a higher proportion of staff with strong child welfare (child protective, foster care or preventive services) experience than does a larger program because of its lack of managerial/Supervisory depth. Basic computer skills are required for all staff.

Providers must attempt to hire staff experienced with the practice and concept of family treatment and in working with domestic violence, mental health, and substance abuse issues.

Program Director – MSW or an equivalent human service graduate degree as approved by Children's Services, and relevant administrative and Supervisory Child Welfare experience. (Required position)

Supervisor – MSW or an equivalent human service graduate degree with at least two (2) years of documented relevant Child Welfare experience. Supervisory experience is preferred, although not necessarily in a formal Supervisory position. (Required position)

Case Planner – BA/BS/BSW or MSW or an equivalent human service graduate degree (preferred). (Required position)

Intake Worker – BA/BS/BSW or MSW or an equivalent human service graduate degree (preferred) with at least two (2) years documented relevant experience. (Recommended position)

Family Team Conference (FTC) Specialist – Children's Services will not require a dedicated Family Team Conference Specialist. Agencies may use their discretion to assign the responsibility for the facilitation of Family Team Conferences in the way they believe will enable them to successfully implement the model. If a dedicated position is created, that staff person must have a 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 (Recommended position).

Parent Aide/Case Aide – High school diploma or General Equivalency Diploma and one (1) 1

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* *All degrees must be from accredited institutions and each request for a Waiver of Qualification Requirements; or approval for a non-MSW Master's, must be accompanied by the prospective staff member's detailed resume. The Provider copies the original degree, or other original written documentation of the degree from the degree granting institution, prior to forwarding it to Children's Services with the resume.*
Children's Services may request copies of transcripts as well as documentation of content and completion of advanced non-degree programs when evaluating the credentials of non-MSW candidates.

year of relevant work in an FRP and/or life experience and/or successful completion of a Children's Services Family Treatment/Rehabilitation Program or similar program (i.e. formerly the Family Rehabilitation Program). Parent Aides working with clients in substance use disorder treatment or recovery have graduated from substance use disorder treatment program and have at least two (2) years of sobriety. (Recommended position)

Professional Staff and Consultants – degree/professional accreditation/ licensure and experience appropriate to the particular position. Psychologists, nurses and others requiring licensure must document each year a current New York State license/registration.

Licensed Psychologist and/or Psychiatrist to conduct evaluations, make recommendations for treatment and assist with staff training.[5]

Qualified Medical Provider staff, including but not limited to: a part-time Registered Nurse (RN), Licensed Practical Nurse (LPN), or Nurse Practitioner.

Credentialed Educational/Vocational Rehabilitation Specialist to conduct educational/vocational assessments, advocate with educational/vocational Providers, assist with educational/vocational placements, provide educational/vocational training for the youth and/or family, and conduct groups as necessary.

Credentialed Alcohol and Substance Abuse Counselor or Trainee (CASAC or CASAC-T) – CASAC or CASAC-T with BA/BS/BSW to provide substance use disorder/use assessments as appropriate.
* Note: CASAC-T may not be able to provide substance use disorder/use assessments and may only be able to provide group support to clients and staff.

Other paraprofessional – High School Diploma/GED and training and experience appropriate to the particular position

Documentation (required):

1. Educational credentials, SCR clearance, fingerprinting report, criminal background check report, job application, resume/relevant experience, date of hire (or promotion/job change if it effects the due date of evaluations), date the last performance evaluation was due, and the date of its completion, probation status if applicable. OR Staff roster*, signed by Executive Director, specifying for each staff member the aforementioned.

2. Copies of (as appropriate to position/qualification requirement) the following:

    a) diploma, final transcript, or equivalent verification from degree granting institution for each staff member; OR

    b) approval of a request for a Waiver of Qualification Requirements by Children's Services Agency Program Assistance (APA) or Program Development (PD).

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5 Providers General Preventive programs are not required to have these positions as consultants, but are expected to have the capacity to conduct mental health assessments either directly or through referrals.

* All staff must be listed and updated in PROMIS whenever a vacancy or new hire occurs.

PERSONNEL

CONSULTANTS

Standard:

Providers that utilize consultants have a signed contract for each consultant for the current City fiscal year and keep a record of the consultative services provided.

Preventive Providers may hire consultants to include, but not limited to:

- psychologists
- psychiatrists
- medical personnel
- licensed social workers and other licensed mental health Clinician
- CASAC or CASAC-T
- domestic violence consultant with experience in safety planning and working with the domestic violence shelter system; training at Children's Aid Society or other domestic violence training

Documentation: Signed Contracts; license if applicable; record of consultant services; case records.

PERSONNEL

VERIFICATION OF CREDENTIALS, REFERENCES AND SCREENING CURRENT AND PROSPECTIVE EMPLOYEES

Standard:

Providers are responsible for appropriate screening of all current and prospective employees.

Indicators:

Criminal History Checks on prospective and current employees (in the case of transfers or promotions) are required for any position that involves potential direct contact with child (ren). Such contact is defined as: contact that entails child supervision or child care responsibilities but not limited to the position of child care workers, case planners/case workers, case planner/caseworker Supervisors, director, parent aide/advocate, and any agency designee who has direct contact with children.

1. All Providers must conduct a Statewide Central Register (SCR) clearance for staff. They must be cleared through a child abuse or maltreatment report via the revised SCR Database Check, form LDSS-3370.

2. Completion of criminal background checks is required as a condition for securing employment for current or preventive agency staff.

3. Preventive Provider staff employed by multi-service Provider agency (agencies authorized under New York State Social Service Law 371(10)) providing foster care in addition to preventive services are required to conduct criminal background checks including fingerprinting processing. Fingerprint based background checks are conducted by the NYS Division of Criminal Justice Services (DCJS). For additional information contact DCJS via email: infoDCJS@dcjs.state.ny.us. While currently there are no laws or regulations requiring agencies to do so, it is prudent to obtain a prospective or current employee's written consent before forwarding his/her fingerprints to DCJS or any other entity.

4. All other preventive agencies should conduct criminal background checks through non-fingerprinting means available through New York State Office of Court Administration (OCA) and DCJS. Children's Services recommends the use of these two entities to help ensure a timely response to the background check request. Visit the website at www.courts.state.ny.us/apps/chrs to download an application form and additional instructions.

Evaluating the results of criminal background checks:
The Provider shall make employment decisions concerning prospective employees (newly hired as well as those being transferred or promoted) with a criminal record in accordance with the

NYS State law.

If the results of a criminal background check indicate the existence of a criminal history, the agency must exercise sound professional judgment about whether to hire an individual with a criminal history. For greater details refer to *OCFS Memorandum 03-OCFS-LCM-12 "Criminal History records for Candidates for Employment (Prospective Hires)," dated August 15, 2003 for guidance.*

Overall, Providers must assess the level of risk to the safety and well –being of children with whom the prospective staff would have contact. This assessment and the decision about hiring should be based upon material gathered from the prospective employee (statement and self-reports about the history of criminal conviction obtained during the screening process) as well as from the criminal background checks. Those two sources should provide information about the number and nature of criminal offenses, when they occur and the subsequent rehabilitative efforts or programs completed by the applicant or prospective employee.

Children's Services expects Provider to apply two basic standards in the decision about whether or not to hire a person with a criminal history, which are based on State law. Providers should deny an application for employment on the basis of criminal conviction if either of the following standards is met:

1.) There is a direct relationship between one or more of the criminal offenses and the specific employment being sought; or
2.) The employment, if granted, would pose an unreasonable risk to the safety and welfare of children.

The assessment and evaluation of an applicant's background should be completed prior to hiring. When a decision is made to hire a candidate who does have a criminal record, the ultimate decision and the basis for it must be documented and signed by the Executive Director of the Provider. However, in certain circumstances, at the discretion of the Executive Director, it may be necessary to hire an applicant prior to the receipt of background clearance. In such cases, agencies may hire applicants for a probationary period of no longer than 3 months. Documentation describing supervision and other measures taken to ensure the safety of children with whom such staff is working should be maintained in confidential personnel files in addition to the pending background clearances once obtained. Agencies also should maintain a log of criminal background checks conducted. Such logs should be made available for review by Children's Services.

For additional information refer to *Children's Services Guidance#2009/08 '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 Hires)," dated August 15, 2003*.

NOTE: At a minimum, the Provider has requested and received the following for each staff member. The personnel file for each employee should contain: documentation of that staff member's educational and licensing credentials; SCR clearance, criminal background check

employment application, resume, education credentials, date the last performance evaluation was due and the date of its completion; original job offer, date of hire (or promotion/job change if it affects the due date of performance evaluations).

Documentation: SCR clearance or requests; Copies of other clearance requests (fingerprinting, criminal background checks and fingerprinting report when appropriate); copies of at least three (3) references; personnel file; original job offer from agency; documentation describing supervision and other measures taken to ensure the safety of children, log of all criminal background checks conducted, 'Program Manual of Standards, Policies and Procedures'.

*__NOTE__: Children's Services recognizes that written requests for references are time consuming and may not be productive. Thus, we expect that the Provider will obtain useful references by telephone and document them in the personnel record prior to making any offer of employment. Although substantive written confirmation generally is difficult to obtain, it is important to seek written acknowledgement that any person named as reference, did in fact speak with the Provider's representative regarding the given candidate for employment.

PERSONNEL

SUSPECTED ABUSE OR MALTREATMENT OF CHILDREN BY PROVIDER'S STAFF

Standard:

If the Provider has reasonable cause to believe that an employee of the Provider has abused, maltreated, neglected, assaulted or endangered the welfare of any child, the Provider shall, immediately report such belief to the SCR, and take appropriate action to remove the employee from the proximity of all children while the matter is being investigated. The Provider shall immediately notify ACS of any Provider reports made to the SCR regarding employees of the Provider.

ACS 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 agrees to fully cooperate with any such investigation.

1. If the SCR makes 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, and ACS and/or the Provider may take appropriate legal action or disciplinary action, if necessary, to accomplish such removal.

2. 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 the proximity of all children. 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.

Indicators:

The Provider reports all cases where there is reasonable suspicion of abuse/maltreatment.

a) Appropriate policies and procedures have been distributed to all staff.

b) Forms OCFS-2221A (the NYS OCFS 'Report of Suspected Child Abuse or Maltreatment'), OCFS Agency Reporting Form for Serious Injuries, Accidents, or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Cases form, and Children's Services Three-Hour Reporting for and Children's Services Twenty-Four Hour Report form are completed and submitted in a timely manner.

Documentation: Personnel file; legal or disciplinary action; SCR report; written requests to Commissioner.

PERSONNEL

SUPERVISION

Standard:

The central goal of Supervisors in preventive services programs is to actively guide and support the work of frontline staff in strengthening families to provide for the safety and well-being of their children, and in taking all appropriate actions to keep children safe. As leaders in child welfare and the purveyors of best practice, Supervisors should focus each day on achieving these positive outcomes. By coaching, supporting and guiding staff to make accurate, comprehensive assessments; to act effectively on those assessments; and to provide a high quality of services, Supervisors have a positive impact on the outcomes achieved for children and families. Moreover, Supervisors ensure that families are provided the help they need, and linkages to a network of community resources and support so they can provide for the safety and well-being of their children.

All Case Planners must receive at least one (1) hour per week of individual supervision for the purpose of professional development from a supervisor with an MSW or equivalent human services graduate degree. We also recommend that Supervisory Case Reviews be done in the context of individual supervision. (See "Supervisory Case Review," *Part II, Section E*).

In the cases where Case Planners and Case Aides and other staff work with families as a team, Providers may meet this standard through weekly supervision with the multi-disciplinary team, including the Case Planner and Case Aide together. However, it is critical that the individual professional development needs of the Case Planner, Case Aide and other staff are also addressed, and Providers may be asked to demonstrate how this will be accomplished. In the event of extended absence or vacancy in a Supervisory position, the Director arranges coverage and is responsible for weekly individual supervision and case reviews.

Professional Development

- As previously stated, all Case Planners must receive at least one (1) hour per week of individual supervision.

- Staff providing Specialized Rehabilitative Services and/or Supportive Services employed by the Provider - including Case Aides and clinical staff- should receive supervision consistent with their level of training, their experience with the population being served and their role with the families. Providers must clearly articulate their decisions regarding the level and frequency of supervision they intend to provide. These decisions should be documented in the personnel records and/or in the Supervisory logs used by the program. Comments regarding the professional development/job performance/training needs of staff should NOT be documented in the Comprehensive Case Record (CNNX or ADVPO progress notes). Instead the Provider shall develop a system of documentation that reflects its supervision practice and captures the ongoing professional development of staff.

- Providers must ensure that all staff who work directly with families receive individual supervision for professional development. In the course of regular supervision, staff should receive consistent guidance related to:
    - Decision making related to the strengthening of families, and the safety and well-being of children;
    - Current job performance as compared with the standards and expectations set for staff;
    - Other areas for development in the supervisee's work; and
    - Support, guidance, assistance and/or training that will be provided to the staff person.

Providers will be asked to demonstrate how they are meeting this standard during routine program monitoring. Supervisors should also keep records of all performance reviews.

NOTE: Children's Services may require more frequent Supervisory sessions, and/or documentation when deemed necessary to advance the program's quality improvement efforts.

Documentation: CNNX or ADVPO progress notes (where appropriate); POP; Supervision Logs; 'Program Manual of Standards, Policies and Procedures'.

PERSONNEL

SUPERVISORY CASE REVIEW

Standard:

Supervisors in Preventive Services Programs shall review all cases on AT LEAST a monthly basis[6] (this includes a review of the case record, in addition to case discussion). Supervisors shall conduct quality assurance case reviews with staff and provide staff with Supervisory support and regular performance evaluations.

Based on the particular circumstances of the case, Supervisors should determine whether a greater frequency of Supervisory case review is necessary in each of the following types of cases:

- Indicated child protective or other high risk case:
- Newborn(s) under six (6) months old in the family;
- Currently under investigation;
- Family in crisis due to parental or youth substance abuse, mental health or domestic violence issues; and/or
- Families in which there has been a critical or traumatic incident or fatality.

Supervisory case review of a case should commence during intake and engagement and continue for the life of the case. Supervisors should meet as frequently as necessary with Case Planners to:

- Ensure - through clear direction, guidance and support - that case planners are making frequent home-based and other contacts with the family;
- Guide Case Planners in assessing the safety and well-being of all children in the home; and
- Review, monitor and assess the quality of services being provided.

Supervisory case reviews must be documented in the case record as a progress note.

For all CWS cases, Supervisory case reviews must be documented in the CNNX case record. For all ADVPO cases, Supervisory case reviews must be documented in the hard copy case record. Supervisory case reviews involving discussions of critical incidences that occur in a family should be documented immediately in the case record. It is recommended that Supervisory case reviews occur in the context of regular supervision (individual and/or group) with the Case Planner(s), Support Staff and Supervisor(s). Supervisory case reviews should include but are not limited to: thorough discussions of past and current case issues and dynamics; assessment of case practice around safety, risk and well-being; exploration of caretaker's and child behavior and how these behaviors are impacting child safety and well-being; exploration of services and the effectiveness of services in mitigating safety and risk concerns; assessment of family service plans and outcomes; careful monitoring of the quality of the casework provided; and clear

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6 Providers using Multi-Systemic Therapy, Functional Family Therapy, or other evidence-based models are expected to adhere to the Supervisory standards set forth by those program models along with the documentation requirement expectations issued by Children's Services.

guidance to staff in an effort to:

- Make sound safety-related decisions based on thorough and consistent assessments, including ending preventive service case decisions;
- Take appropriate actions to provide for child safety and well-being;
- Ensure clear and effective communication with children and families;
- Involve children and families in decision-making;
- Build on families' strengths;
- Provide services that match safety, risk and needs assessments and advance family by strengthening child safety and child well-being;
- Assess the effectiveness of services and make necessary adjustments;
- Meet the required timeframes for all case practice activities; and
- Ensure that all required documentation is maintained in the case record

In the event of extended absences/vacancies in Supervisory positions, the Director arranges coverage and maintains such Supervisory case reviews.

Housing Subsidy Only: Cases that have been designated as "Housing Subsidy Only" should be reviewed and discussed in supervision at least once per month (this includes a review of current progress notes in addition to case discussion). This discussion should include a review of the steps being taken by the case planner to help prepare the family maintain stable housing and avoid foster care placement once the housing subsidy ends. A Supervisory note should be documented in the case record at least once every three months and should include summaries of the supervisor's guidance and the Supervisor's input. More frequent case record reviews must occur if and when those case circumstances impact the safety of the children in the home. Refer to policy #2010/05, Subject: *"Casework Requirements for Housing Subsidy Only Preventive Services Cases"*, dated July 1, 2010.

Documentation: CNNX and ADVPO progress notes; Supervision Logs; case records; POP; 'Program Manual of Standards, Policies and Procedures'.

NOTE: Children's Services may require more frequent Supervisory case reviews, and/or documentation when deemed necessary to advance the program's quality improvement efforts.

PERSONNEL

TRAINING

Standard:

Providers have and implement a written staff development and training plan for each City fiscal year and the Provider shall tailor this plan to meet the needs of the staff and the client population. The plan includes a schedule of sessions planned, topics to be covered, and persons anticipated to provide the training. Also ensures 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 children within a neighborhood-based environment. Training for all direct service staff must include the following topics:

- Assessment and monitoring of child safety and risk;
- Child and adolescent development;
- Client outreach, engagement and retention skills;
- Crisis intervention;
- Culturally competent practice;
- Assessment, service planning, and goal setting;
- Family Team Conferencing (FTC);
- How a parent's history of trauma, or the current presence of violence or other traumas in the household or community, may impact parenting and the acquisition of new parenting skills;
- Identification and Reporting of Child Abuse;
- Interviewing and communication skills;
- New Caseworker Child Welfare Core trainings (when available through Children's Services or other venues);
- Progress Notes documentation;
- PROMIS training;
- Recognizing indicators of developmental delays, and actions to take upon identification;
- Recognizing indicators of substance use disorder/use, and/or mental illness, and actions to take upon identification; and
- The ACS Domestic Violence Practice Guidelines, recognizing indicators of domestic violence (including teen relationship violence, and elder abuse) and actions to take upon identification.

Training for all Supervisors must include but is not limited to:

- New Supervisor Child Welfare Core trainings (when available through Children's Services or other venues); and
- Supervising Safety and Risk Assessment in Child Welfare.

NOTE: Children's Services believes that the needs of our current client family population require that all Case Planners and Supervisors receive training in these areas.

Based on an assessment of staff knowledge/skills and client needs, the following training topics should also be considered:

- Application procedures for public assistance programs and Medicaid or Medicare
- Building Morale and Motivating staff
- Conflict resolution and mediation
- Family systems work
- Group dynamics and group facilitation skills
- Safety in the field for front line staff
- Stress management and secondary trauma
- The prevalence and indicators of trauma in child welfare populations and its mitigation and treatment
- Understanding the impact of trauma, neglect and abuse on the developing child and using that knowledge in our approaches with families
- Working with families in which children experience chronic neglect
- Working with gang-involved youth
- Working with immigrant families
- Working with LGBTQ youth and families
- Working with physically and developmentally disabled clients
- Working with populations with HIV/AIDS, and with chronic or debilitating illnesses
- Working with pregnant and parenting youth

Indicators:

1. The Provider provides at least the required training for new staff and updates incumbents as needed.

2. Training is consistent with staff development needs.

Documentation: Annual Training plan, including curricula, lesson plans, attendance sheets, evaluation forms, evidence of registration, and course completion documentation, when training is offered by other than the Provider; POP; 'Program Manual of Standards, Policies and Procedures'.

PERSONNEL

PERFORMANCE EVALUATIONS

Standard:

All Provider staff receive performance evaluations in accordance with the Provider's policy and procedures which are listed in the manual of procedures and the submitted POP.

Documentation: Staff roster* signed by Executive Director, specifying for each staff member: educational credentials; SCR clearance, fingerprinting report, application, experience; date of hire (or promotion/job change if it effects the due date of evaluations); date the last performance evaluation was due, and the date of its completion; 'Program Manual of Standards, Policies, and Procedures'; POP.

* All staff must be listed and updated in PROMIS whenever a new hire or vacancy occurs.

PERSONNEL

POLITICAL ACTIVITY/RELIGION

Standard:

The Provider's staff does not engage in or promote partisan political activity or religious worship, instruction or proselytizing during the conduct of their employment and work with families and children. The religious affiliation of the Provider or individual staff members should not influence the delivery of services.

Indicators:

1. Provider's written policy prohibits partisan political activity, religious worship, instruction and proselytizing by staff members during the conduct of their jobs.

2. The Provider enforces the written policy.

Documentation: POP; observation; review of personnel; 'Program Manual of Standards, Policies, and Procedures'; case record review.

F PREVENTIVE SERVICES - SITE/MILIEU

** The following standards and expectations should guide the selection, set-up and maintenance of the programs site and facilities.*

DEFINITION OF PROGRAM SITE

The location of an office in a community, the extent to which offices afford privacy and the attractiveness of the facility are all variables that contribute to the retention of staff and the likelihood of family participation in services.

All areas designated by the Provider as work space for direct service staff and where family members are seen by Provider preventive personnel are considered to be program sites whether or not rental costs for that space are included in the program budget. All such sites are to be listed in the appropriate section of the POP.

The Providers are strongly encouraged to develop policies and procedures that will ensure that leases are reviewed by legal counsel. Providers must ensure that leases are within budget parameters. The Providers are required to fulfill Children's Services program requirements.

Indicators:

1. Provider cooperates with Children's Services staff regarding inspection and approval of the site(s).
2. Provider has submitted a POP to the appropriate Children's Services division(s) which indicates the location and use of the program's space.
3. Provider has identified the space to be used for all Children's Services preventive services contracts and submits documentation about annually space costs to the appropriate Children's Services divisions.
4. Provider maintains a written policy regarding location of program site(s) in accordance with their Children's Services contract.
5. Provider staff has received the written policy about the site location and usage.
6. The Provider enforces the written policy.

Documentation: POP; observation; review of personnel/results from exit interviews; 'Program Manual of Standards; Policies and Procedures'; Fiscal audit reports.

NOTE: 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 Development in writing at least 90 days prior to the proposed change.

NOTE: In the event that it becomes necessary to temporarily close the program due to non compliance with Public Health Laws standards or potential health risks the agency is to immediately notify Children's Services. Typical reasons include but are not limited to outbreak of communicable disease or need to clean or disinfect to avoid an outbreak. Written notification of intent to temporarily close the facility and intake with Children's Services monitoring offices.

SITE/MILIEU

ACCESSIBILITY

Standard:

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.

Indicators:

1. All buildings are clearly named and or numbered.

2. All program components have prominent signs directing family members to the correct location.

3. The program has a defined reception area.

Documentation: POP; 'Program Manual of Standards, Policies and Procedures'; Visual observation.

SITE/MILIEU

ACCESSIBILITY – HOURS OF OPERATION

Standard:

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 activity.

Documentation: POP; 'Program Manual of Standards, Policies and Procedures'; Posted schedules; time sheets; observation of staff; pending/active case record review; DCP reports.

SITE/MILIEU

ACCESSIBILITY – AMERICANS WITH DISABILITIES ACT

Standard:

Provider agency sites must comply with the Americans with Disabilities Act 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, 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.

Indicators:

1. The site is accessible to disabled family members; OR

   The Provider has developed plans for accessibility.

   If an existing barrier cannot readily be removed; services are made available through alternative methods and/or locations.

2. The Provider utilizes sign language interpreters and large print informational material.

3. The Provider makes appropriate referrals to programs serving distinct disabled communities.

Documentation: Visual observation; case record review; written referral protocols; POP; 'Program Manual of Standards, Policies, and Procedures'.

SITE/MILIEU

AESTHETICALLY PLEASING/CULTURALLY RELEVANT FACILITIES

Standard:

The Provider's 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.

The service environment is accepting of all families irrespective of race, color, ethnicity, language, disability, or culture.

Specific programs types also ensure that their site/milieu is relevant to that particular population.

Indicators:

1. The site is accessible to all family members; OR

   If an existing barrier cannot readily be removed;

2. Services are made available through alternative methods and/or locations; AND

3. The Provider makes appropriate referrals to programs serving their population type.

Documentation: Visual observation; case record review; POP; 'Program Manual of Standards, Policies, and Procedures'.

SITE/MILIEU

HEALTH AND SAFETY

Standard:

The Provider site complies with all applicable health, fire and safety regulations.

Indicators:

1. Facilities are 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; and

    m. torn carpeting or unsecured rugs/runners, holes in flooring, missing/ broken floor tiles.

2. ALL sites have:

    a. 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;

b. 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;

c. current New York City Fire Department (FDNY) inspection report;

d. appropriate, current Certificate of Occupancy; and

e. adult supervision for all children's activities with age-appropriate ratios of adults to children.

Documentation: Visual observation; physical testing of emergency exits for ease of use; copy of Certificate of Occupancy or documentation of site exemption; schedule and reports of any results of fire drills; FDNY Inspection Report; independent consultants' reports (if any); supervisor's log; work schedules; time sheets; POP; 'Program Manual of Standards, Policies and Procedures'.

NOTE: At times, Providers may deem it prudent to install window-guards even when the law does not so dictate.

SITE/MILIEU

PHYSICAL PROTECTION

Standard:

The physical environment of the program provides for the safety of all the persons on the premises from physical harm, drugs, and other criminal activity.

Indicators:

1. A written security plan which includes:

    a. precautions to be used when dealing with individuals who may be dangerous;

    b. actions to be taken when dangerous or potentially dangerous incidents occur;

    c. the circumstances under which the police are to be called; and

    d. maintaining good relationships with the beat patrol officer and the local police precinct's community relations officer.

2. Only FDNY-approved gates are used on windows that are potentially accessible from outside.

3. All staff have the local police precinct's phone number readily available for emergency use.

Documentation: POP; 'Program Manual of Standards, Policies and Procedures'; visual observation; written security plan; written statement or other documentation of communications to/from local police precinct; staff knowledge of security recommendations.

SITE/MILIEU

SPACE ALLOCATIONS AND PRIVACY

Standard:

The Provider uses all space as listed in the contract budget (as either charged or donated to the preventive program) as indicated in the POP.

The Provider has sufficient space to support the range of services being offered. If the preventive site is used at all for counseling, there is space for it to be conducted in privacy to ensure that confidentiality is maintained.

If the space is being shared with other programs, such use has been described clearly in the POP.

If planned usage of the program site changes during the contract year, the Provider notifies the appropriate Children's Services unit monitoring that program in writing in a timely manner.

Indicators:

1. The program has adequate provision for privacy and confidentiality during counseling.
2. Provider cooperates with Children's Services staff regarding inspection and approval of the program space.
3. Provider has submitted a POP to the appropriate Children's Services division(s) which indicates the location and use of the program's space.
4. Provider has identified the space to be used for all Children's Services preventive services contracts and submits documentation about annually space costs to the appropriate Children's Services divisions.
5. Provider maintains a written policy regarding use of program space in accordance with their Children's Services contract.
6. Provider staff has received the written policy about the space location and usage.
7. The Provider enforces the written policy.

Documentation: POP; review of personnel; 'Program Manual of Standards, Policies and Procedures'; case record review; Fiscal audit reports; correspondence with Children's Services monitoring offices; visual observation.

G PREVENTIVE SERVICES - INTERAGENCY AND COMMUNITY RELATIONS

** The following standards and expectations should guide the Providers interagency and community relations with community partners.*

COMMUNITY/BOARD OF DIRECTORS PARTICIPATION

Standard:

Providers accept as a sound principle that appropriate members of the socio-economic communities served by the Provider's Children's Services-contracted programs are to have the opportunity to contribute to and be informed about policy-making processes; they actively solicit family members' involvement.

Indicators:

1. Community members serve on the Board of Directors, on advisory panels, or on committees of the Board of Directors.

2. Consumer involvement is encouraged.

Documentation: POP; Roster of Board of Directors with members' affiliations identified and current home addresses listed, as well as telephone numbers, and announcements/publicity for community meetings; client family evaluation forms; suggestion box (prominently placed with signage in appropriate languages).

INTERAGENCY AND COMMUNITY RELATIONS

CHILDREN'S SERVICES DCP PROTECTIVE SERVICES / PREVENTIVE PROGRAM COMMUNICATION

Standard:

Providers should attend quarterly meetings (at a minimum) convened by Children's Services. On a semi-annual basis, there shall be a communication (preferably face-to- face) between a DCP Protective Services Office Deputy Director responsible for a specific geographic area and the Program Director of a Provider with responsibility for the corresponding community districts.

Minimum points of discussion may include but are not limited to:

- Referral process issues,
- Family outreach and retention,
- Line staff interactions, and
- Areas of concern.

I**ndicator:** Provider staff meets regularly with Children's Services staff to discuss issues pertinent to program operation and performance.

Documentation: Children's Services' attendance sheets; correspondence between program and appropriate Children's Services offices.

NOTE: Meetings involving groups of preventive program directors, or their designees, with appropriate DCP Protective Services Office Directors can be used very effectively to maintain open communication on critical issues that affect more than one program. Such meetings are held in addition to any individual meetings needed to address issues affecting only a single program.

H PREVENTIVE SERVICES –OTHER ADMINISTRATIVE STANDARDS

CREDITNG CHILDREN'S SERVICES

Standard:

All publications, notices, informational materials, press releases, research reports and public notices prepared and released by a Provider or its personnel include the following statement:

"This program is funded (in part) under an Agreement with the City of New York/NYC Children's Services."

Copies of the material are furnished to the appropriate Children's Services' monitoring office.

Indicator: The Provider credits Children's Services as its oversight body on all correspondence**.**

Documentation: Observation of flyers literature, posters, etc.; media reports; annual reports; public affairs announcements; POP; 'Program Manual of Standards, Policies, and Procedures'; etc.

OTHER ADMINISTRATIVE STANDARDS

DISPOSAL OF CONFIDENTIAL DATA

Standard:

The Provider will consider the case record and any documents contained within it as 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. Provider agencies must comply with New York State laws and regulations regarding record retention and disposal. Please reference *Title 18 NYCRR, part 428.10* and *OCFS' Guidance- 05-OCFS-ADM-02 dated April 19, 2005* for details.

Indicator: The Provider's plan for disposal of confidential data must be approved by Children's Services. Upon request by Children's Services, the Provider will be prepared to demonstrate to the designated Children's Services' representative(s) how the plan is being implemented.

It also includes other types of information including, but not restricted to information/data:

- relative to the Providers of services;
- supplied by vendors on client families;
- supplied by vendors or proposers replying to requests for proposals issued by the Provider;
- related to actual or suspected cases of child abuse or neglect;
- related to medical history of client families;
- related to fraudulent or abusive activity in relation to programs of public assistance and care; and
- regarding financial data, related either to Children's Services or a client family.

Documentation: POP; 'Program Manual of Standards, Policies and Procedures'; case records; visual observation; discussion with staff**.**

***NOTE:** Confidential Information includes all information concerning an applicant and/or recipient of benefits under the Social Services Law which would tend to identify the applicant or recipient. This includes name, address, Social Security number, or other identifiers.

OTHER ADMINISTRATIVE STANDARDS

RETENTION OF RECORDS

Standard:

A. The Provider shall follow the requirements of *Title 18, Section 428.10* of the New York Codes, Rules and Regulations with respect to all records and reports.

B. Pursuant to the provisions of *Title 18, Section 428.10* of the New York Codes, Rules and Regulations, when the sole service provided is Preventive Services, the Provider agrees to retain all records of a child and family receiving Preventive Services for six (6) years after the eighteenth (18^{th}) birthday of the youngest child in the family.

C. Pursuant to the provisions of *Title 18, Section 428.10* of the New York Codes, Rules and Regulations, when Preventive Services are being provided in conjunction with or in addition to foster care, the Provider agrees to retain all records of a child and family receiving services for thirty (30) years following the discharge of the child from foster care. And, when Preventive Services are being provided in conjunction with or in addition to Child Protective Services, the Provider agrees to retain all records of a child and family receiving services for ten (10) years after the eighteenth (18^{th}) birthday of the youngest child named in the report of suspected abuse and maltreatment. When Preventive Services are being provided to cases with unfounded/sealed CPS reports the records are to be retained for 10 years after the date of the intake report. And when Preventive Services are being provided to adopted children the case records are to be retained permanently.

It is incumbent upon the Provider to do a search on CNNX prior to the disposal of any case record to ensure the case did move onto Foster Care or Adoption.

Indicator: The Provider agrees to retain all books, records, and other relevant documents**.**

Documentation: 'Program Manual of Standards, Policies and Procedures'; case records; visual observation; discussion with staff**.**

OTHER ADMINISTRATIVE STANDARDS

FISCAL PLANNING

NOTE: Fiscal issues will be addressed through different documentation including annual budget guidelines, audit controls and reports, and *Federal Form A-133*.

Standard:

The Preventive Services Program Director works collaboratively with the Provider's fiscal department/officer in projecting, modifying and evaluating budgets.

OTHER ADMINISTRATIVE STANDARDS

INVENTORY

Standard: The Contractor shall maintain an updated written list of all equipment and appurtenances purchased through their contract with Children's Services and make such list(s) available for audit by Children's Services and/or New York City Government.

Refer to the Provider's Children's Services contract for additional information.

Documentation: POP; 'Program Manual of Standards, Policies, and Procedures'.

OTHER ADMINISTRATIVE STANDARDS

MONITORING AND EVALUATION

Standard:

To the maximum extent possible at both the case practice and administrative levels, Children's Services collects and monitors performance data to assess, target, and improve program performance to ensure that the stated goals, principles and practice guidelines of the Child Welfare System are being met effectively and appropriately.

The Provider cooperates with the Children's Services' assessment and evaluation systems, providing all information necessary to allow Children's Services to fulfill these evaluations and monitoring responsibilities. The Provider will also work cooperatively with Children's Services to improve program performance, when necessary.

Indicators:

The Provider cooperates with the Children's Services' assessment and evaluation systems, providing all information necessary to allow Children's Services to fulfill these evaluation and monitoring responsibilities. The Provider cooperates with Children's Services to improve program performance, when necessary.

Documentation:

Includes but is not limited to PROMIS data, CNNX case records, paper case records, and other program logs.

OTHER ADMINISTRATIVE STANDARDS

PERFORMANCE-BASED FUNDING

Standard:

The Provider performance in each quarter shall be measured against whether the Provider achieves targets for opening new cases each quarter or other performance indicators. Ten percent (10%) of the Provider's program budget will be performance-based and contingent upon achievement of these performance results.

Documentation: PROMIS Case Tracking Report and Utilization Report; PROMIS data as determined.

OTHER ADMINISTRATIVE STANDARDS

PROGRAM MANUAL OF STANDARDS, POLICIES AND PROCEDURES

Standard:
The Provider shall maintain written program operating standards and procedures and shall submit to Children Services when requested a statement of each of those internal GP Services standards and procedures. Such standards and procedures are designed to ensure the proper delivery of services.

Indicators: The contents of the Program Manual of Standards, Policies and Procedures include but are not limited to the following:

1. A program description and the target population being served:
   How services ensure the safety of children, and address the identified needs of the targeted group as a whole; range of services to be provided to those children and families; facilitating access to the full range of services necessary to address the presenting issues of the population to be served including, but not limited to, a description of services provided directly by the Provider and those referred to other neighborhood Providers; how the Provider integrates a Family to Family philosophy into its provision of Preventive Services that creates a "community of care" for the child comprised of those individuals most central to and concerned about the child's well-being - the child's family, caretaker (if different from the family), and Case Planner, and encourages active involvement of all parties in activities related to promoting the child's well-being.

2. Certificate of Incorporation.

3. By-Laws.

4. Management Practice and Procedures:
   The Provider shall advise Children Services whenever the Provider hires or dismisses a Chief Executive Officer, Chief Fiscal Officer or Program Director of Preventive Services.

5. Statement of personnel policies, practices and procedures:
   a) job descriptions and qualifications;
   b) hiring and selection practices;
   c) performance evaluation timeline;
   d) hiring and selection practices;
   e) grievance procedures;
   f) termination procedures;
   g) benefits;
   h) vacation and leave policy;
   i) salary ranges; and
   j) holidays.

6. Purchasing policies and procedures.

7. Petty cash fund procedure.

8. General fiscal procedures:
   a) fiscal records;
   b) inventory policy, procedure and documented inventory; and
   c) ensuring 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 Children's Services.

9. Intake and case practice procedures including but not limited to:
   a. the method used to identify the targeted population, and the strategy used to perform outreach/engage to these children and families;
   b. screening of new applicants for eligibility;
   c. completing electronic application process;
   d. referral/intake process;
   e. outreach/engagement requirements and strategies-facilitation of rapid engagement, ensuring family participation and retention in preventive programs;
   f. identification of families resistant to services and addressing the particular challenges posed by such families. For instance, engaging in services for domestic violence might pose significant danger particularly if the abusive partner has used social isolation as a tactic;
   g. re-engagement;
   h. strategy for incorporating extended family members, teachers, friends, and recreational personnel into the child's and family's support network, to the extent that such inclusion is deemed appropriate and safe; and
   i. domestic violence universal screening, assessment and referral to appropriate service Providers.

10. Case Practice
   a. SCR reporting;
   b. confidentiality;
   c. the prohibition of waiting lists;
   d. substance use disorder/use services, including the assessment tools and instruments to be utilized and the credentials of staff members making such assessments (under OASAS regulations, assessments are done by CASACs);
   e. assessment of the language literacy and comprehension and writing skills of the children and families to be served and provision of services to address any identified limitations of such skills in a manner that ensures the client family's full participation in and understanding of the services offered by the Provider including the use of interpreter services and/or culturally specific service Providers;
   f. educating and assisting families in recording and maintaining their own medical records/histories, such as through the use of medical passports;
   g. assisting pregnant family members with obtaining quality, neighborhood-based pre-

natal and post-natal counseling and services or pregnancy termination counseling and services;

h. assisting client families in obtaining appropriate housing where housing issues are a presenting problem for the family and stand in the way of the child's safety or health or delay reunification;
i. promoting and monitoring appropriate staff use of housing subsidy services targeted to the eligible preventive service population;
j. education-promoting parent/caretaker involvement in their child's education program;
k. education-training, employment and welfare reform;
l. how the assessment process distinguishes between indicators suggesting the presence of mental health issues and indicators suggesting a lack of basic parenting skills;
m. clear rules of conduct and appropriate boundaries which guide participation in service plan development, interactions in activities, and the sharing of information;
n. case closing process; and
o. provision of post-closing services.

11. Referral Protocols, Linkage Agreements and Monitoring of Family Participation in Referred Services (where a type of service is specified, linkage agreements that include provisions for information-sharing and collaborative service planning must be included)
    a. mental health services, including clinic-based services, as home- and community-based services and family/parent support programs;
    b. substance use disorder/use services, including strategies to encourage and facilitate family participation in prevention programs, treatment for children depending on the exposure to behaviors associated with chemical dependence/substance use disorders, and/or 12-step groups;
    c. organizations providing expert and specialized services to individuals with chronic physical, mental or developmental disabilities;
    d. neighborhood-based employment agencies, vocational training institutions and community college programs;
    e. specialized services such as domestic violence and/or batterer education outside of the community where the child's or family's needs cannot be addressed by Providers within the community;
    f. medical care, including accomplishing related family goals within service plan time frames; and
    g. methods that ensure case planner follow-up on and tracking of all referrals made.

12. Case record maintenance, retention, and confidentiality in compliance with and supporting all existing Federal, State and City laws, rules and regulations including CNNX and PROMIS; and that is consistent with policies, procedures and standards promulgated by Children's Services.

Documentation: 'Program Manual of Standards, Policies, and Procedures'; POP.

NOTE:

a) The Provider shall notify Children's Services in writing within thirty (30)

business days of any changes in its standards, policies and procedures.

b) The Provider's internal standards, policies and procedures shall comply with ACS Policies, including the Preventive Services Quality Assurance Standards and Indicators.

OTHER ADMINISTRATIVE STANDARDS

PROMIS DATA SUBMISSION

Standard:

Each program maintains accurate statistics relating to utilization rate, referrals, staffing, case activity and services provided. These data are submitted to Children's Services for each month by the 10th day of the following month through the PROMIS database. The program designates a minimum of two people as responsible for timely and accurate submission and to be available to respond to Children's Services queries in a timely manner.

Supervisory personnel routinely cross-check for accuracy those data which staff provide in PROMIS against the actual case record.

Documentation: Primary source material (e.g., referral logs/files, administrative staffing records, and case records), is available to cross-check the accuracy of data reported on each in PROMIS.

OTHER ADMINISTRATIVE STANDARDS

PROVIDING EVALUATIONS TO CHILDREN'S SERVICES

Standard:

A copy of any independent program evaluation performed for the Provider is provided to Children's Services within ten (10) days of its receipt by the Provider.

Documentation: POP; copy of report, with appropriate postmark or date-stamped cover letter if hand-delivered.

OTHER ADMINISTRATIVE STANDARDS

PROVIDER SELF-EVALUATION PLAN

Standard:

The Provider engages in ongoing self-evaluation of program performance, at both the case practice and administrative levels, for the purposes of quality improvement. The evaluation and quality improvement format done in consultation with families and staff includes a review of family and programmatic goal achievement, and a review of compliance with Children's Services' case practice and administrative standards. Providers are responsible for analyzing data collected, and for putting in place a system to ensure continuous quality improvement. The Provider's written analysis of data must be made available for Children's Services' review.

The Program Director or other Provider Designee oversees a formal participatory evaluation of the program's performance in consultation with staff and families the program serves. The evaluation format includes a review of goal achievement (family and program) and a review of compliance with Children's Services' case and administrative standards.

Indicators:

The above self-evaluation plan and outcome report must include but is not limited to:

- a review and analysis of objective performance measures, drawn from systems of record data or other sources;
- a review and analysis of case practice, data drawn from case record reviews or other sources; and
- a review and analysis of client/family feedback and staff feedback.

1. The Provider conducts the above self-evaluation at least annually.

2. The self-evaluation uses objective measures of performance, such as percentages of cases averaging at least two (2) casework contacts per month and concrete data indicate whether such contacts with families are made based on assessed need; level of successful outreach, engagement and retention.

3. The client family feedback/consumer satisfaction survey form includes core services and results are summarized, analyzed and made available for review.

Documentation: Self evaluation plan and outcome report; completed client/family and staff feedback forms and analysis; POP.

OTHER ADMINISTRATIVE STANDARDS

REPORTING LEGAL ACTIONS AND COURT PARTICIPATION

Standard:

Providers must report to Children's Services, in writing, within three (3) working days of its initiation, any legal action by or against them which relates to the contract with Children's Services.

Provider must ensure that the staff with substantive knowledge of any given case situation are made available to appear in court when Children's Services determines that a court appearance is necessary based on the particular case circumstances of a child or family receiving or who has received Preventive Services from the Provider. Staff shall also cooperate with Children's Services attorneys in such cases, including, but not limited to, preparation for trial.

Documentation: Copies of legal documents served on/by the Provider; POP; 'Program Manual of Standards, Policies and Procedures'; correspondence relating to legal action; and court participation.

OTHER ADMINISTRATIVE STANDARDS

CHANGE IN CONTRACTOR'S CORPORATE STRUCTURE

Standard:

Any contemplated fundamental change in the Provider's corporate structure (such as a merger with another entity or any fundamental changes in governance) which will affect the provision of services shall be reported to Children's Services in writing at the earliest feasible time, but in no case later than ninety (90) days prior to the contemplated change. In the event that a merger is contemplated, the Provider shall notify Children's Services when a plan of merger is filed with a state agency.

Documentation: Copies of legal documents and/or correspondence relating to legal action.

OTHER ADMINISTRATIVE STANDARDS

SERVICES - PROGRAM OPERATIONS

Standard:

In the POP, which is submitted annually to Children's Services, the Provider describes all services to be provided directly by that program. The program provides directly, or otherwise makes available, all such services throughout the course of the contract. The number of families receiving the services approximates those anticipated in the POP; when this does not occur, the Provider provides written explanation.

Indicators:

1. Services are provided in accordance with the POP.

2. Appropriate explanations are given for exceptions.

Documentation: Case records; attendance sheets; PROMIS-Maintain Program Details Link in Administration Tab; POP.

OTHER ADMINISTRATIVE STANDARDS

SUBCONTRACTING

Standard:

The Provider is responsible for the work of its subcontractor(s) and shall establish a mechanism to monitor the subcontractors and their services to children and families.

Indicators:

1. Services are provided in accordance with the subcontract agreement.

2. The Provider shall provide services in accordance to meeting the child and/or families needs. There is evidence in the case records of communication and coordination of services.

Documentation: FASPs, CNNX or ADVPO progress notes, clinical reports; referral and treatment arrangement(s); signed "Consents for the Release of Confidential Information", correspondence; PROMIS; observation of groups; POP; signed subcontract agreement; and Administrative & Fiscal Reports.

OTHER ADMINISTRATIVE STANDARDS

UTILIZATION RATE

Standard:

The Provider maintains the service capacity agreed upon in their current contract and ensures full utilization of this capacity for families in need of and eligible for services.

"Housing Subsidy Only" cases will count as one half of case, thereby occupying one half of a program slot.

NOTE: "Housing Subsidy Only" cases will not be counted when tracking length of service or determining the percentage of a program's cases that are open for more than twelve (12) or eighteen (18) months for monitoring or program evaluation purposes. Refer to Children's Services Policy #2010/05, Subject: *"Casework Requirements for Housing Subsidy Only Preventive Services Cases"*, dated July 1, 2010.

Documentation: PROMIS Utilization Report.

OTHER ADMINISTRATIVE STANDARDS

CLOSING INTAKE

Standard:

1. The Provider shall notify Children's Services in writing if it deems it necessary to close intake because its Preventive Services program client capacity is at full utilization (one hundred percent (100%) of capacity) and staffing levels do not allow for adequate coverage of additional cases. If intake will be closed for a period of one (1) week or more, written notification of intake closing shall be sent to the appropriate Children's Services personnel at least three (3) business days prior to closing intake.

2. In the event the Provider deems it necessary to close intake and its Preventive Service program is not at full utilization, the Provider shall notify Children's Services immediately by telephone and in writing setting forth the reasons why closing intake is necessary and its plan to remedy the situation. Within five (5) business days of receipt of such notification, Children's Services shall review and discuss these issues with the Provider and the reasons why the Provider deems it necessary to close intake. In the event Children's Services does not respond to the Provider's request to close intake within five (5) business days, the Provider may temporarily close intake until such discussion may take place.

3. Children's Services reserves the right to direct the Provider to close its intake at any time at Children's Services discretion upon ten (10) days prior written notice.

Documentation: Written notification of intent of closing intake, written notice from Children's Services, PROMIS utilization report.

PART III -- SPECIALIZED PREVENTIVE SERVICES

CENTER-BASED RESPITE CARE

This section contains those standards that are specific to Specialized Preventive Services for Center-Based Respite Care. These standards apply in addition to those in *Parts I* and *II* of this document. In some areas, standards in this section are somewhat different from, and may be more stringent than those in *Parts I* and *II*. Where this is the case, the Specialized Preventive Services for Center-Based Respite specific standards take precedence.

Goal of Center-Based Respite Care

Standard:

Specialized Preventive Services for Center-Based Respite Care (CBRC) shall be provided as a preventive service to families when Youth are at imminent risk of foster care placement because parents lack alternative safe places to leave their children for a limited period of time. Care shall be provided twenty four (24) hours each day, seven (7) days each week for a period of up to twenty one (21) consecutive days; except that where a parent is participating in a substance abuse detoxification treatment program, Center Based Respite Care Services may be provided for up to a maximum of thirty (30) consecutive days at a time or longer as needed in certain instances, provided that approval for longer stays is granted by Children's Services. Such approvals for longer stays shall be made at the sole discretion of Children's Services and based on contractor recommendations. Services shall include assessment of children and families, counseling, referral and follow-up services. Services shall also include a toll-free Parent Helpline that callers may access twenty four (24) hours each day, seven (7) days each week.

The goals of this program are to:

1. Reduce and eliminate the need of foster care placement for at-risk children.
2. Protect children and families from abuse and maltreatment due to family crisis.
3. Provide appropriate, safe and temporary care for children while a parent seeks medical care, in-patient substance abuse treatment, or other emergency services that renders them unable to momentarily care for their children.
4. Collaborate with Children's Services and other service Providers in the coordination of service delivery to these families.
5. Conduct assessments and make relevant recommendations to ensure and promote a safe reunification.

Eligibility

Standard:

1. CBRC is deemed appropriate to prevent or eliminate the need to place children in foster care. Services must be provided in accordance with all existing Federal, State, and City

laws, rules, and regulations, and consistent with policies, procedures, and standards promulgated by OCFS and Children's Services and the New York City Department of Health and Mental Hygiene (DHMH) including the following:

a. Providers must adhere to *Title 18NYCRR: Part 435* as it relates to Respite Care Services.
b. Services shall be provided through a center-based model in which all intakes and assessments occur at the facility where the children are housed.
c. Program sites shall meet 'Health Code requirements for Child Care Institutions' and all applicable Federal, State and City regulations for residential settings; see *Title 18NYCRR: Part 442.24* for details. The Provider shall make services accessible to clients with physical disabilities. Strategies for doing so may include, but not be limited to, offering 'Telecommunicating Device for the Deaf' (TDD) service, raising staff consciousness about disabilities, utilizing large print informational reading materials, and establishing referral protocols to programs serving disabled communities.

2. CBRC shall be available for families with children zero to fourteen (0-14) years of age who are eligible for Mandated Preventive Services pursuant to *Title 18NYCRR: Part 430.9.* The intent is to provide parents who lack appropriate support alternatives with a safe place to leave their child(ren) for care for a limited period of time, without having to place the child(ren) in foster care. A family is eligible for CBRC when immediate relief is needed to maintain or restore family functioning. Conditions for which respite care may be provided include, but are not limited to the following:
    a. A child is identified with special needs due to a high level of disturbed behavior, emotional disturbance, or physical or health needs, including any critical illness which has placed excessive or unusual stress upon the parent(s) and /or family, and where temporary relief of this stress will prevent the placement of the child in foster care and maintain or restore family functioning; or
    b. A parent is suddenly hospitalized due to accident, injury, or illness; or
    c. A child has been referred to the ACS Family Assessment Program for PINS diversion services; or
    d. A parent is participating in a substance abuse detoxification program; or
    e. Due to a family's sudden disruption, including homelessness or domestic violence.

    Providers must structure service planning and delivery to support the needs of the child and family.

3. Prior to the provision of CBRC to the family, the parent(s), as listed in *Title 18NYCRR: Part 435.4*, has the right to approve or disapprove the specific CBRC facility where their child(ren) would be placed.
    a. In addition, the parent(s) must provide to the Provider a written statement containing:
        i. The name and telephone number of the child(ren)'s physician(s) or medical service Provider(s);
        ii. Emergency contact number(s) of parents, guardian, or caretaker in the

event the parent cannot be located;

iii. A signed "Authorization for Release of Confidential Information" for the children's medical information; and

iv. Any necessary instructions regarding the child's care in case of a medical emergency.

b. All Providers must ensure that a system is in place to safeguard and account for all psychotropic medication dispensation and recording.

4. CBRC must be terminated upon the request of the parent(s), or the refusal of services by any child ten (10) years or older. Upon the termination of CBRC, the providing agency may facilitate a FTC and explore recommendations for further services or future placement.

Documentation: CNNX and ADVPO progress notes; Case Records; Supervision Logs; 'Program Manual of Standards, Policies and Procedures'; Medication Dispensing Log.

Referral Management Process

Standard:

1. CBRC Providers shall operate the Parent Helpline and channel referrals to the appropriate respite service types and Providers.
2. The availability of CBRC services and the Parent Helpline phone number shall be publicized in the media so that eligible families may be informed about the availability of such services to meet their needs; offer options to alleviate conditions that create risk of foster care placement; and provide an opportunity for assistance to help the family remain intact. Information about the program shall be provided to organizations that may be referral sources.
3. CBRC Providers shall receive referrals from Parent Helpline staff who operate the city-wide toll-free Parent Helpline that is accessible to callers twenty four (24) hours each day, seven (7) days each week.
4. Helpline staff shall also be knowledgeable about a wide range of neighborhood-based resources from which families may obtain services. Staff shall be knowledgeable about DYCD programs, including Respite Care for older children, and shall follow the requisite DYCD referral procedures:

   When callers to the Parent Helpline request Respite Care, Helpline staff must assess the children's safety, eligibility, and the appropriateness of the request, and determine if CBRC is appropriate after assessment of the parent's request for services, the immediate child safety situation, and additional family needs which will require referral and follow-up. In order to avoid additional respite referrals, the Provider should provide the parent and child(ren) with services including assessments, counseling, mental health referrals, housing support , referral and follow-up services, as well as any other supports needed to maintain safety.
5. Professional parent/family counseling shall be available on-site seven (7) days each

week. Given the nature of these services, the Provider shall have a coverage plan so that families may request professional parent/family counseling and receive an "intake interview" at varied hours, including evenings. The CBRC Provider shall have multiple staff members working at all times to ensure adequate staff to child ratios, the capacity to interview and assist new families requesting assistance, and the ability to address any emergencies that may arise, such as urgent needs for medical care.

Documentation: 'Program Manual of Standards, Policies, and Procedures'; CNNX and ADVPO progress notes; case records; Supervision logs; Intake log; Medication Dispensing log.

Services Consistent with Needs

Standard*:*

1. During intake, the CBRC Provider shall be responsible for obtaining all health history information and information about the child's primary care Provider. If the child has a medical condition, the Provider shall make a contact with the child's primary care Provider to obtain any information that may be critical for proper care and supervision of the child during respite placement. The Provider shall assess the health status of all members of the child's household to determine if unaddressed health care needs in a family member are contributing to the need for respite care placement. The Provider shall collaborate with other organizations serving the family, to enable access to the requisite services and to respond to any unaddressed health care needs. The Provider shall ensure that the parent signs a "Consent for Release of Confidential Information" upon placement, so that all information about the child(ren)'s medical health, mental health, education, or other assessments are readily available.
2. When appropriate and feasible, the Provider shall arrange with the DOE for a teacher to be on-site to serve school-aged children consistent with the Department's school year calendar and requirements. During the period of respite provision, the Provider shall ensure that children are up-to-date with their school work, inform parents of any problems encountered in school, and work with school officials to address those problems.
3. When appropriate and feasible, the Provider shall assist families with children suspected of having a developmental disability in making a referral to the DHMH, Early Intervention Provider, DOE, CPSE, and/or the CSE. Referrals can be made by the parents or guardian, the Provider staff, a licensed physician, a judicial officer, or a staff member of a school, preschool program, or early Childhood Direction Center.
4. When appropriate and feasible, the Provider shall also conduct domestic violence screenings and establish protocols for addressing this issue when indicated. The Provider shall also establish connections with battered women's service Providers through local domestic violence task forces. When appropriate, the Provider shall coordinate services with a domestic violence shelter so that battered women seeking shelter can place their children in a CBRC program until shelter accommodations are available.
5. CBRC services shall include, but not be limited to, physical examination and routine

medical care, sleeping accommodation, meals, and behavioral assessments by child care staff. Services provided to parents of admitted children and to their siblings who were not admitted to care, shall include, but not be limited to, temporary relief from child care responsibility, psychosocial assessment(s), counseling, advocacy and referral, transportation, and emergency funds for expenses such as shelter, food, and transportation.

Documentation: 'Program Manual of Standards, Policies, and Procedures'; Intake Log; CNNX or ADVPO progress notes; case records; Supervision logs.

Casework Contacts

Standard:

1. All children shall be **seen and assessed** for safety and risk daily by designated staff.
2. Program staff shall have frequent and regular casework contacts, including extensive home-based casework contacts with the child and family members living in the respite home.
3. Program staff shall provide parents with the opportunity to have at least weekly contacts with their children. The Provider shall develop a protocol that clearly communicates that expectation to staff.
4. All contacts/visits should be documented in progress notes and supervision logs.
5. All contacts between the parent(s) and child(ren) while in placement are to be supervised by the appropriate staff; such contacts must also be documented in progress notes and supervision logs.
6. If the family has an active preventive case, the program should request a CNNX role as a Case Worker for the assigned CBRC worker. Case documentation shall be recorded in CNNX within forty eight (48) hours of activity, and the primary case planner should be updated on case activity at all times during respite placement.
7. All case activity including discharge planning and parent, child or parent/child observations/interactions shall be documented.

Documentation: 'Program Manual of Standards, Policies and Procedures'; CNNX or ADVPO progress notes; case records; Supervision logs; and Medication Dispensing log.

Case Practice

Standard:

1. When children have siblings requiring CBRC, the Provider should allow for placements that keep siblings together, when appropriate.
2. The Provider shall facilitate family visits for children placed in different locations.

3. The Provider shall document, or have the on-site Provider document in a medication-administration log, the person dispensing medication and the child(ren) receiving medication along with the time and date of such practice.
4. All staff shall be trained on medication management.
5. Every parent shall be provided with written guidelines as it relates to CBRC and placement/discharge policies.
6. CBRC shall be provided for a period of up to twenty one (21) consecutive days; except that where a parent is participating in a substance abuse detoxification treatment program, Center Based Respite Care Services may be provided for up to a maximum of thirty (30) consecutive days at a time. Exceptions may be granted by Children's Services staff on a case by case basis to a Provider's request for a longer period of service. Provider staff shall request that exception in writing, documenting why a longer period of services is needed, including expected services termination date, and identifying services and supports that need to be implemented before and after services termination. Provider staff shall document this request in the CNNX system for CWS cases, and in the case record for ADVPO cases. Documentation shall also show that this plan was discussed with the parent/caretaker and all of the case planning staff. When necessary, this plan shall also be discussed at any scheduled FTCs.
7. No family should receive CBRC services for two (2) consecutive periods of placement. A period of seven (**7**) consecutive days must elapse before CBRC services may be provided to family who had previously received that service. After a first period of CBRC services, another assessment of the client's needs must be conducted, and a plan developed to avoid additional CBRC services. When a family returns for services after a previous CBRC placement, the Provider shall also conduct an assessment of the client's needs before that placement to determine if CBRC placement is a necessity; to deter a practice of support and entitlement; and to develop an appropriate plan to set the family on a path to self-sufficiency after CBRC placement is completed. When necessary, this plan should also be discussed at any FTCs. See *Title 18 NYCRR, Section 435.5*, and *Children's Services Procedure No. 106/Bullentin No. 01-2, issued May 1, 2001* for more details.
8. The Provider shall have emergency clothing supplies on hand to provide to the children and/or family as needed.

Documentation: 'Program Manual of Standards, Policies and Procedures'; Agencies placement and discharge policy; Intake Log; CNNX or ADVPO progress notes; case records; Supervision logs; and Medication Dispensing log.

Staffing and Staff Qualifications

Standard:

In addition to any appropriate staff listed in *Part II, Section E - Personnel*, Providers shall identify the following staff to work with this population:

1. **Program Director** who holds an MSW or equivalent human service graduate degree, and at least three (3) years administrative and Supervisory experience. (Required)

2. **Supervisor** who holds an MSW or equivalent human service (including Certified Rehabilitation Counselor {CRC} certification) graduate degree with at least two (2) years documented relevant experience. (Highly Recommended)
3. **Case Planner** who holds a BA/BS/BSW or MSW/equivalent human service graduate degree (Preferred) with at least two (2) years documented relevant experience. (Required)
4. **Family Team Conference Specialist** Children's Services will not require a dedicated Family Team Conference Specialist. Agencies may use their discretion to assign the responsibility for the facilitation of Family Team Conferences in the way they believe will enable them to successfully implement the model. If a dedicated position is created, that staff person must have a 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;**.**(Recommended)
5. **Intake Worker** who holds a BA/BS/BSW or MSW/equivalent human service graduate degree (preferred) with at least two (2) years documented relevant Child Welfare experience. (Recommended)
6. **Child Care Worker Supervisor** High School diploma/General Equivalency Diploma or one year of college (preferred) with at least one year of documented experience working with youth in a group living facility. (Required)
7. **Child Care Worker** High School diploma/General Equivalency Diploma or one year of college (preferred) with at least one year of documented experience working with youth. (Required)
8. Qualified Medical Provider staff, including but not limited to: A part-time RN, LPN, or Nurse Practitioner.

Documentation: 'Program Manual of Standards, Policies and Procedures'; case records and equivalent documentation; personnel files; staff interviews; training schedules and attendance sheets; written statement/affirmation from executive director; staff evaluations.

Staff Training and Development

Standard:

In addition to the trainings discussed in '*Training', Part II, Section E*, Provider staff shall receive specialized training, certification, and recertification in accordance with all Children's Services and New York State regulations. Providers shall also adhere to the following parts listed below.

1. Training must be up-to-date and reflect awareness of and skill in addressing children's service needs. Training topics shall include behavior modification, ethnicity, cultural, sexual identity, clinical interventions, on infection control and universal precautions to avoid transmission of infectious diseases.
2. Providers shall ensure that all on-site child care staff is adequately trained in medication administration and management.
3. Provider staff shall receive training on the medical and emotional issues involved in caring for children with HIV/AIDS and other chronic illnesses, and on the emotional

needs of children who have parents with HIV/AIDS and other chronic illnesses.
4. All Provider staff shall be trained in understanding and utilizing emergency medical protocols.

Documentation: 'Program Manual of Standards, Policies and Procedures'; case records and equivalent documentation; personnel files; staff interviews; training schedules and attendance sheets; written statement/affirmation from executive director; staff evaluations.

Site/Milieu

Space Changes

Standard:
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 Development in writing at least 90 days prior to the proposed change.

Documentation: Correspondence with Children's Services monitoring offices.

Temporary Closure

Standard:
In the event that it becomes necessary to temporarily close the Respite program due to non compliance with Public Health Laws standards or potential health risks the agency is to immediately notify Children's Services. Typical reasons include but are not limited to outbreak of communicable disease or need to clean or disinfect to avoid an outbreak.

Documentation: Written notification of intent to temporarily close the facility and intake with Children's Services monitoring offices.

Disaster Plan

Standard:
The Provider disaster plans shall incorporate general disaster planning information; detail the procedures to be followed in caring for 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 Youth in the Provider's care, both during and after the disaster or emergency.

Providers shall provide such families with emergency preparedness information and emergency contact numbers to call and check on the safety and status of their Youth following a disaster or evacuation.

OCFS recommends that disaster plans include, but not be limited to, the following information:

- where the Provider of respite to 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 Youth, including identification for the child(ren)/youth (birth certificate, Social Security number, 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.

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 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

Documentation: "Program Manual of Standards, Policies and Procedures"; POP.

SPECIALIZED PREVENTIVE SERVICES

YOUTH WHO HAVE BEEN SEXUALLY EXPLOITED

This section contains those standards that are specific to Specialized Preventive Services to Families with Youth Who Have Been Sexually Exploited. These standards apply in addition to those in *Parts I and II*. In some areas, standards in this section are somewhat different from, and may be more stringent than, those in *Parts I and II*. Where that is the case, the Specialized Preventive Services for Youth Who Have Been Sexually Exploited specific standards take precedence.

Goal of Specialized Preventive Services for Youth Who Have Been Sexually Exploited

Standard:

The program is designed to address the safety and wellbeing of families with youth who have been sexually exploited and where the behavior of the youth and or caretaker places the child at risk of foster care placement or replacement. The model calls for treatment to be guided by a comprehensive assessment and multi-disciplinary approach involving different interventions in order to meet the needs of the families that are being served. The families are to receive all the support, treatment, and understanding necessary to meet their physical, emotional, chemical dependency/use, developmental and psychological needs, in a manner where the youth are able to be maintained in their homes or another family setting, which provides them with the skills necessary to live healthy, productive, and self-sufficient adult lives. Youth who have been sexually exploited are to receive the services necessary to reduce their vulnerability to exploitation in the future.

The primary focus of case activities will be on rebuilding the relationship between the youth and family and exploring and managing any barriers to a positive relationship. Helping both family and youth resolve and move past these issues is expected to strengthen the family ability to provide a safe and nurturing environment within which the youth's recovery will be supported.

Some youth who participate in this program would step down from a Sexually Exploitation Specialized Family Foster Care or Residential program upon being stabilized and discharged. Due to troubled family relations and/or safety issues; a small percentage will reside with non family members in these instances the PPRS Provider may be expected to work with the youth, and both the youths caretaker and the birth family. The recommended caseload for this program is 1:12.

This program's goal is to help families acquire appropriate skills in understanding and supporting sexually exploited youth (boys, girls and transgender youth), and to create a plan to help the youth and family heal. Services should be personalized to meet the need(s) of each member of the family, strengthen supports relations and stabilize the youth and family and enlist the family in understanding the youth's emotional and service needs..

The objectives of this service are to:

1. Provide the support, treatment, and understanding necessary to meet the youth and family broad range of physical, emotional, and developmental needs;
2. Emphasize each family member's and the family's goal in recovery planning and goal setting;
3. Actively engage the youth and family members in activities that promote self-esteem and empowerment;
4. Provide separate ongoing peer support/self evaluation groups for each family member;
5. Help the youth identify coping skills so that they reduce their vulnerability to future exploitation;
6. Provide the family with trauma education and interventions; and
7. Promote protective behavior, anger management, and self care.

Services shall be provided in a manner that ensures the safety of the youth and seeks to preserve, support, and strengthen the family, when appropriate.

Outcomes for Youth

- Youth will have increased level of self esteem and self worth.
- Youth will have the ability to develop and form healthier peer relations.
- Youth will have improved family/caretaker relations.
- Youth will be educated about the practice of safe sex.
- Youth will be less traumatized by past events.
- Youth will have more success in school.
- Youth will be involved in age appropriate extra curricular activity.
- Youth will have improved personal functioning, including consistency and stability overtime.
- Youth will have ability to process healthy versus unhealthy/toxic relationships.

Eligibility

Standard:

1. The program shall provide services in a manner that ensures the safety of the child(ren)/youth, and seeks to preserve, support, and strengthen the family, when appropriate. Programs must adhere to *OCFS and OTDA Regulations for 'Anti-Trafficking Statue': 09-OCFS-ADM-01*.
2. This specialized population includes but is not limited to the following:
   a. Youth who have been victims of sexual grooming,
   b. Youth victimized for the advancement of sexual gratification or profit for example; prostituting a child, creating or trafficking in child pornography, sexually explicit performances by a child such as dance at strip clubs, work in topless clubs or massage parlors, and
   c. Youth who have participated in survival sex / sex for favors; i.e., gang initiation..
3. Providers shall follow the OCFS and Children's Services regulations regarding safety and risk. Thus, if the abuser continues to pose a risk to the minor Youth in the home, then

placement in foster care or removal to another "safe haven" may become necessary.

Documentation: 'Program Manual of Standards, Policies and Procedures'; referral forms; intake logs; CNNX and ADVPO progress notes; case records and equivalent documentation; Supervisory logs; interviews with program staff.

Referral Management Process

Standard:

1. It is expected that approximately ninety (90)% of the families in this Specialized Preventive Program will be referred from Children's Services and other designated Children's Services components; ten (10)% will be self-referred or referred from local community organizations. The high priority referral sources will be DCP, Preventive Programs, Residential Care and Family Foster Care for youth being discharged to their family or caregivers, and the Courts. The Provider is expected to work closely with the referral sources to ensure effective coordination of referral and services provision. Note: Court – referrals will be made by the court liaisons. This procedure will need to be developed by ACS.

2. Children's Services' approval is not required for families referred from other services; however, Children's Services will monitor Providers to ensure that such families meet the formal criteria for Specialized Preventive Services program.
3. Providers are expected to work closely with the Children's Services referral process as indicated in the '*Children's Services Referrals-Priority' and 'Children's Services Referrals – Notification and Face-to Face Transition Meeting' Part II Section D.*
4. Providers shall establish referral and communication linkages with hospitals, nursing care facilities, specialty clinics, foster care programs, places of worship, schools, New York City Family Courts, and support organizations that service families with sexually exploited children.
5. Providers shall also establish and maintain linkages with other organizations, including but not limited to: neighborhood-based programs, OASAS-licensed substance abuse treatment programs and OMH-licensed treatment facilities in the event that the exploited youth or other family members need these services. Providers shall adhere to additional requirements indicated in the *'Services Consistent with Needs' Part II, Section D.*

Documentation: 'Program Manual of Standards, Policies, and Procedures'; referral forms; CNNX and ADVPO progress notes; case records and equivalent documentation; FASPs; assessments/evaluations; and discussions with program staff.

Services Consistent with Family Needs:

Standard:

The Provider should design services to:

a. promote healing;

b. limit Youth's Post-Traumatic Stress Disorder symptoms and traumagenic beliefs reflecting self-blame, vulnerability and powerlessness;
c. increase Youth's overall psychosocial functioning;
d. empower the family and educate them about the effects of this trauma while providing coping mechanisms; and
e. reduce the risk of foster care placement/replacement.

Many of the youth will have a history of running away, truancy, mental health issues, domestic violence, substance abuse, and gang involvement, long history with the child welfare system and or criminal justice system, dysfunctional families, unstable homes and/or suffer from post traumatic stress disorder. Some youth may have probation officers or may play an active role in a criminal court case.

The youth's caretaker will often have similar issues to the teen, often there will be friction about the youth remaining in the home and resistance to the family participating in preventive services and/or cooperating with the criminal justice system.

It is also expected that in some instances that the sexual exploitation will continue and staff and family/caretakers will need to be savvy about identifying ongoing abuse. Re-victimization and being victimized on multi levels is a common occurrence. Some youth will have patterns of running away or disappearing for days or weeks at time, this pattern is likely to continue.

Program staff shall continue to work with the family during these periods, to help the family understand the youth's behavior and prepare them to respond appropriately when the youth returns. During the youth's absence Specialized Preventive staff will maintain contact with other Providers with whom the youth may be engaged, to guide the family, if possible, in reaching out to encourage the youth to return home.

In order to serve this specialized population:

1. The Provider shall design and provide a highly structured, therapeutic model. Working with such populations may involve advocating relocating the youth and/or family to a safer environment. Intensive psychological and psychiatric services shall be available on a regular basis through partnerships with licensed Providers. Individual, group, and family counseling shall be provided to address the trauma of sexual exploitation.
    a. Provider staff shall conduct an assessment to identify issues that underlie the symptomatic behavior exhibited by the youth, (including but not limited to sexual acting-out); prioritize the service needs of the family and child(ren)/youth; and provide the required services to meet those needs and empower the families in the healing process.
    b. Provider staff shall provide risk and needs assessments, concrete and support services, and individual, group and family counseling tailored to the special needs of each family.
    c. Provider staff shall develop appropriate service plans, provide necessary crisis intervention, refer family members to other Providers for appropriate services, and maintain linkages with those Providers as needed.

d. Provider staff shall conduct preliminary and periodic assessments of each youth and family, consistent with the standards articulated in the *'Child Safety Assessment', 'Family Assessment and Service Plan', and 'Complete Assessments' Part II, Sections B, and D.*

2. Providers shall adopt or develop a treatment model that is aimed at treating and educating the family, as well as teaching staff/service Providers how to address repressed feelings, repair the sense of self, and manage counter-transference and personal biases during treatment. The program shall develop an interdisciplinary treatment team to review service plans and determine changes necessary to improve the emotional and physical well-being of the youth and the family.

   a The Treatment Team should include the family and treatment staff/therapist, and other collateral Provider staff. The Treatment Team shall identify and focus on the specific needs of each family member and design services which addresses the effects of the trauma on their psyche.
   b The treatment plan may also include steps for the offender if he/she maintains contact with the family. Program staff shall make a careful assessment that includes both clinical and legal/law enforcement consultation before beginning to work with the offender.

   The model will consist of more than one clinical modality, to effectively address the needs of youth and families. The Specialized Preventive program will include and collaborate with professional Providers from a variety of disciplines, in order to guide the development of the individualized needs of the youth and family. Modalities to be used may include: Family Systems Treatment, Attachment Regulation Competency (ARC) and or treatment models targeting the effects of complex trauma, substance abuse treatment, individual psychotherapy, sibling support groups, mother groups, dyadic treatments etc.

   The model allows the program the flexibility to be innovative and creative in addressing the individualized needs of the youth and families. It is imperative there be well-trained, experienced staff to work within the context of a highly structured program. The safety of youth, family members, staff, and the community will need to be taken under consideration and included in the service plan.

3. The Provider shall design a comprehensive "healing" plan to assess the child/family and record their level of progress. All staff shall be thoroughly trained in the implementation of this plan.

4. Within thirty (30) days of referral, the Provider shall assemble a clinical diagnostic team composed of, but not limited to Program Director, Supervisor, Psychologist or other clinician, Case Planner, a CASAC, and medical staff to determine the most appropriate services and treatment plan for each child.

5. Program staff shall offer clinically-oriented psychosocial assessments, and connect

families to community-based services. Program staff shall have the ability to assess families and make appropriate service connections concerning a wide range of issues, including but not limited to: substance abuse, educational difficulties, sexual health (including sexually transmitted infections and HIV/AIDS), trauma and mental illness, histories of child abuse/sexual abuse, domestic violence (including teen relationship abuse), unemployment, and substandard housing. Program staff shall also have the ability to assess for psychological or psychiatric conditions that require emergency referral to a hospital for immediate treatment. Program staff shall assess on a regular basis whether each child/youth is receiving appropriate services based upon current functioning and given his or her presenting issues.

6. Program staff shall offer specialized parenting skills' training that addresses the specific concerns and stresses associated with caring for a child/youth that was sexually exploited.

7. Program staff shall assist parents in recognizing the need for respite from caretaking responsibilities both for themselves and for siblings of the identified child. Program staff shall help parents plan strategies to obtain regular relief, which may include on-site activities at the Provider site.

8. Program staff shall have regular contacts with the family to address needs/concerns and emergencies and maintain frequent, regular, face-to-face contact, primarily home-based, during the provision of services to the family members residing in the home and external resources whenever possible**.**

   Program staff shall provide Family Therapy, to support family and youth addressing issues which may otherwise interfere with the youth being successfully re-integrated into the family. These may include the family's judgment and criticism of the youth's behavior, based both on the societal stereotypes, and on the public embarrassment the family has suffered as a result of the youth's behavior. It may also be necessary to address longstanding parent-child issues which contributed to the child becoming a runaway/throwaway and becoming vulnerable to exploitation. Program would develop individualized safety and respite plans for youth at risk of flight, resuming sexual exploitation activity and for those in stressed living environments.

9. Program staff shall develop linkages and strong working relationships within the community, which will be utilized to assist with monitoring the youth and assisting the family

10. Provider staff shall provide the following additional services:
    a. Independent living skills for young parents and appropriate adolescents;
    b. HIV/AIDS prevention education;
    c. Formation of alumni group for program graduates; and
    d. Safe and supportive environment where youth feel safe.

11. Provider shall provide a direct emergency hotline number that callers may access during the evening and on weekends, seven (7) days each week to help avert crises and help

stabilize families.(Note: The emergency hotline number must be a contact number managed by the Provider.)

Documentation: 'Program Manual of Standards, Policies and Procedures'; case records and equivalent documentation; Supervision Logs; service plans and FASPS; discussions with program staff; client feed-back forms.

Casework Contacts

The Program shall adhere to *Part II, Section D* - 'Casework Contacts'. In addition, the program staff shall maintain frequent, regular, face-to-face weekly, primarily home-based contacts with the family.

- The Case Planner shall conduct two (2) contacts during a four (4) week period. One (1) of these contacts must be conducted in the home.
- Specialized Rehabilitative and Support Services staff shall conduct two (2) contacts during a four (4) week period. One (1) of these contacts must be conducted in the home.
- If the Specialized Rehabilitative and Support Services are unable to make contact with the family, the Case Planner is responsible for making the recommended contacts.

Staffing and Staff Qualifications

Standard:

The Provider shall develop an interdisciplinary treatment team to review service plans and determine changes necessary to improve the emotional and physical well-being of the youth and the family. The Interdisciplinary Treatment should comprise staff listed in '*Staff Qualifications*' *Part II, Sections E*; in addition, Providers should hire the following full-time staff:

1. **Program Director** who holds a MSW or equivalent human service graduate degree, administrative and Supervisory experience. (Required).
2. **Supervisor** who is a LCSW or licensed equivalent with a human service graduate degree with at least two (2) years documented relevant trauma-informed experience. (Required)
3. **Case Planner** who holds an MSW or equivalent human service graduate degree (**license preferred**) with at least two (2) years documented relevant Child Welfare experience. (Required)
4. **Case Aide/Parent Aide/Youth Advocate/Mentor** who holds a High school diploma or General Equivalency Diploma and one (1) year relevant work experience and/or completion of FRT (formerly FRP)**. (Recommended)
5. **Family Team Conference Specialist** Children's Services will not require a dedicated Family Team Conference Specialist. Agencies may use their discretion to assign the responsibility for the facilitation of Family Team Conferences in the way they believe will enable them to successfully implement the model. If a dedicated position is

created, that staff person must have a 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. (Recommended)

6. **Intake Worker** who holds a BA/BS/BSW, or an MSW/equivalent human service graduate degree (preferred) with at least two years documented relevant Child Welfare experience. (Recommended)

The interdisciplinary treatment should also comprise the following part-time staff or Consultants, but not limited to:

1. Licensed **Psychologist** or LCSW - to conduct psychological evaluations, make recommendations for treatment, and assist with staff training as necessary;
2. Licensed Therapist or LCSW including but not limited to sexual abuse specialist, group therapist or psychotherapist;
3. **Educational/Vocational Rehabilitation Consultant** Certified Rehabilitation Counselor preferred;
4. Qualified Medical Provider staff, including but not limited to a part-time RN, LPN, or Nurse Practitioner; and
5. **CASAC** who holds at least a Bachelor's degree to provide substance use disorder/use assessments.

All Consultants will participate in Treatment Team Forums and FTCs when deemed appropriate. Members of the Clinical Diagnostic Team shall participate in monthly clinical team conferences, for families where monthly reviews are necessary, to review treatment progress, assess ongoing needs, and identify and address barriers to achievement of service plan goals.

Staff Training and Development

Standard:
The Provider shall continually assess and train staff appropriately. In addition to the trainings discussed in *'Training' Part II, Section E,* Provider staff shall receive specialized training, certification, and recertification in accordance with all Children's Services and New York State regulations. Providers shall also adhere to the following parts listed below.

- 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 pimp 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;
- Behavior management system;
- Sensitivity training; and

- Understanding and advocating with multi legal systems (Criminal, Juvenile and Family)

Documentation: 'Program Manual of Standards, Policies, and Procedures'; CNNX or ADVPO progress notes; case records and equivalent documentation; personnel files; staff interviews; training and attendance sheets; staff evaluations.

Caseload Ratio

Standard:

The recommended caseload for this program is 1:10 with an average annual caseload of twelve (10) per Specialized Preventive case planner. New York State OCFS regulations require that a preventive services Provider shall assign a family to no more than one case planner at a time.

Documentation: CNNX and ADVPO progress notes; Supervisory Logs; service plans and FASPs.

SPECIALIZED PREVENTIVE SERVICES

DEAF OR HEARING IMPAIRED CHILDREN AND ADULTS

This section contains those standards that are specific to Specialized Preventive Services for Deaf and Hearing Impaired Children and Adults. These standards apply in addition to those in *Parts I and II*. In some areas, the standards in this section are somewhat different from, and may be more stringent than, those in *Parts I and II*. Where that is the case, the Specialized Preventive Services for Deaf and Hearing Impaired Children and Adults specific standards take precedence.

Goal of Specialized Preventive Services for Deaf and Hearing Impaired Children and Adults

Standard:

The goal of this program is to provide specialized services to families when children are at risk of foster care placement, and one or more children and/or parent(s) in the family is deaf and/or hearing impaired. These services shall be provided in a manner which ensures the safety of the child(ren) and seeks to preserve, support, and strengthen the family, when appropriate.

Eligibility

Standard:

Families are eligible for services if:

1. A family member's hearing loss is such that they are unable to hear or understand speech and must rely on vision for communication; or
2. A family member is hard of hearing and frequently communicates using a combination of strategies that rely on residual auditory ability enhanced by a hearing aid or assistive listening device and often supplemented through lip-reading or other visual means.

Documentation: 'Program Manual of Standards, Policies and Procedures'; case records; Intake logs; CNNX and ADVPO progress notes; FASPS; service plans; monthly reports; interviews with program participants.

Referral Management Process

Standard:

1. It is expected that approximately sixty-five (65)% of the families to be served by the Provider will be referred from Children's Services and other designated Children's

Services components; thirty-five (35)% will be self-referred or referred from local community organizations.

2. Children's Services' approval is not required for referrals from other sources; however, Children's Services will monitor programs to ensure that such families meet the formal criteria for Specialized Preventive Services Program.
3. Providers are expected to work closely with the Children's Services' DCP-Borough Office and other referral sources to ensure effective coordination of referrals and services provision. Additionally, Providers will adhere to the Children's Services' "referral process" as indicated in *Part II, Sections D.*
4. In addition to the standards articulated in *Part II, Section C – Permitted Services and Section D – Case Practices "Advocacy and Referral", "Services Consistent with Need" and "Addressing Reasons for Indication"*, the following standards apply:
    a. The Provider shall establish linkages with health and mental health Providers, hospitals, schools, adult educational/vocational programs, advocacy, and support organizations that serve families with deaf/hearing impaired children or adults. The Provider shall also establish referral and communication protocols with such institutions and organizations, including provisions for information-sharing and collaborative service planning.
    b. The Provider should establish a linkage with the American Sign Language Organization and other organizations that serve families with children who are Deaf or Hearing Impaired, hospitals, specialty clinics, foster care programs, places of worship, schools and New York City Family Courts.

Documentation: 'Program Manual of Standards, Policies and Procedures'; case records; CNNX or ADVPO progress notes; FASPS; service plans; monthly reports; interviews with program participants.

Services Consistent With Need

Standard:

The Program shall provide:

1. Support, treatment, and understanding for a deaf or hearing impaired person who relies on sign language. The Americans with Disabilities Act (ADA) requires the provision of a qualified sign language interpreter when that service is needed, to ensure effective communication.
2. Services to facilitate parents' adjustment to being deaf or hearing impaired or having a child/youth with this condition; and to provide appropriate early intervention including auditory learning, language and communication skill development.
3. Options for the family and child's education and counseling in other than American Sign Language, if the family/child desires and/or consents.
4. Advocacy for the family with the Department of Education to secure appropriate educational services for deaf/hearing impaired Youth, and to ensure appropriate communication with deaf/hard of hearing parents.

5. Access to recreational services/activities, including but not limited to integration with non-hearing impaired children and adults, and those exclusively for the hearing impaired. Some examples of such activities are parent retreats, picnics, athletic activities, summer camps, and support groups.
6. Assistance in obtaining access to assistive technology, including adaptive, assistive, and rehabilitative devices that help promote greater independence for people with disabilities. Assistance shall include referrals to the Early Intervention (EI) Program Assistive Technology unit for children who are 3 years old and younger.
7. Advocacy on behalf of the children and families to assist children and their family members in navigating governmental and private sector service systems to the extent required to successfully address the family's needs. Advocacy shall include, but not be limited to, interactions with the Medical Assistance Program, the Social Security Administration (SSA), health insurance Providers, the Human Resources Administration (HRA), and the New York City Housing Authority (NYCHA).
8. Linkages to parent support groups qualified to address the specific needs of the family according to the child's particular disabilities and conditions. Such organizations are Children of Deaf Adults (CODA), Parents of Hearing Impaired Children, etc.
9. Counseling groups for both parents and siblings to allow them to learn and share techniques for dealing with the emotions and family stresses of coping with and caring for special needs children. The Provider must convene and promote groups for deaf/hearing impaired teens that offer opportunities to socialize. In addition, the contractor must convene groups for children of deaf/hearing impaired parents.

Documentation: 'Program Manual of Standards, Policies and Procedures'; CNNX and ADVPO progress notes; case records and equivalent documentation; Supervision Logs; service plans and FASPS; discussions with program staff; client feed-back forms.

Casework Contacts

The Program shall adhere to *Part II, Section D* - 'Casework Contacts', in addition, the program staff shall provide the following:
During the initial phase of service provision, program staff shall maintain frequent, regular, weekly, face-to-face contacts, primarily home-based, with the family.

- The Case Planner will conduct two (2) contacts during a four (4) week period. One (1) of these contacts must be conducted in the home.
- Specialized Rehabilitative and/or Support Services staff shall conduct two (2) contacts during a four (4) week period. One (1) of these contacts must be conducted in the home.
- If the Specialized Rehabilitative and Support Services are unable to make contact with the family, the Case Planner is responsible for making the recommended contacts.

When the family has made sufficient progress on service planning goals, program staff shall assess, provide, and document a minimum of two (2) contacts per month by the Case Planner, Specialized Rehabilitative and/or Support Services.

- The Case Planner shall be responsible for one (1) of these contacts.

- One (1) contact must be conducted into the home.

Documentation: 'Program Manual of Standards, Policies and Procedures'; CNNX and ADVPO progress notes; service plans and FASPs; supervision logs; case records and equivalent documentation.

Staffing and Staff Qualifications

Standard:

In addition to any appropriate staff listed in *Part II, Section E - Personnel*, Providers shall identify the following staff to work with this population:

1. **Program Director** who holds an MSW or equivalent human service graduate degree, and at least three (3) years administrative and Supervisory experience. (Required)
2. **Supervisor** who holds an MSW or equivalent human service (including Certified Rehabilitation Counselor {CRC} certification) graduate degree with at least two (2) years documented relevant experience; fluency in American Sign Language. (Required)
3. **Case Planner** who holds a BA/BS/BSW or MSW/equivalent human service graduate degree (Preferred) with at least two (2) years documented relevant experience; fluency in American Sign language. (Required)
4. **Family Team Conference Specialist** Children's Services will not require a dedicated Family Team Conference Specialist. Agencies may use their discretion to assign the responsibility for the facilitation of Family Team Conferences in the way they believe will enable them to successfully implement the model. If a dedicated position is created, that staff person must have a 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; fluency in American Sign Language **.**(Recommended)
5. **Intake Worker** who holds a BA/BS/BSW or MSW/equivalent human service graduate degree (preferred) with at least two (2) years documented relevant Child Welfare experience. (Recommended)

The interdisciplinary treatment should also comprise the following part-time staff or Consultants:

1. Licensed **Psychologist** or LCSW- to conduct psychological evaluations, make recommendations for treatment and assist with staff training;
2. Licensed **Psychiatrist-** to conduct psychiatric evaluations, make recommendations for treatment and assist with staff training; and
3. Qualified Medical Provider staff, including but not limited to a part-time RN, LPN, or Nurse Practitioner.

All Consultants shall participate in Treatment Team Forums and FTCs when deemed appropriate.

Provider must ensure that the provision of a qualified sign language interpreter is available when that service is needed during health care

Documentation: 'Program Manual of Standards, Policies and Procedures'; Personnel files; supervision logs; staff interviews; observation; training schedules and attendance sheets; evaluations.

Caseload Ratio

Standard:

The recommended caseload for this program is 1:12 (with an average annual caseload of twelve (12) per Specialized Preventive case planner). NYS OCFS regulations require that a preventive services Provider shall assign a family to no more than one case planner at a time.

Documentation: 'Program Manual of Standards, Policies and Procedures'; CNNX and ADVPO progress notes, case records and equivalent documentation; Supervisory Logs; service plans and FASPS.

Accessibility of Services

Standard:

In addition to the standards articulated in the *Part II, Section F 'Site Milieu'*, the following apply:

1. The Provider shall ensure that all aspects of the site and programming are accessible to deaf/hearing impaired individuals. Strategies for doing so include, but are not limited to:
    a. TDD service on all phone lines;
    b. hiring staff who are fluent in American Sign Language;
    c. utilizing staff with extensive understanding of deaf/hearing impaired culture; and
    d. appropriate structural site accommodations, such as flashing fire alarms.

2. Providers shall:
    a. Promote parent and community involvement; and
    b. Establish linkage with Providers to arrange transportation for the families to their appointments.

Documentation: 'Program Manual of Standards, Policies, and Procedures'; CNNX or ADVPO progress notes; case records; staff interviews; observation.

SPECIALIZED PREVENTIVE SERVICES

FAMILY TREATMENT & REHABILITATION PROGRAM

This section contains those standards that are specific to Family Treatment & Rehabilitation Program services. These standards apply in addition to those in *Parts I* and *II* of this document. In some areas, standards in these sections are somewhat different from, and may be more stringent than those in *Parts I* and *II*. When this is the case, the Family Treatment & Rehabilitation Program (FT/R) specific standards take precedence.

Goal of Family Treatment & Rehabilitation

Standard:

The program is designed to address the safety and wellbeing of children in high-risk families when a caretaker or child's substance use or mental health disorder places the child at risk of foster care placement or replacement. The model calls for treatment to be provided in three phases: Initial, Baseline and Stabilization. The service plan is guided by comprehensive assessments and a multi-disciplinary approach involving different interventions in order to meet the needs of the families that are being served. The expected case duration is an average of twelve months.

The FT/R utilizes a team approach to assess, diagnose and treat each family member's needs by providing clinical interventions in the home and/or office, and utilizing the Clinical Diagnostic Team (CDT) composed of, licensed therapist, Credentialed Alcohol Substance Abuse Counselor (CASAC), Case Planner, Psychologist Consultant, and Psychiatrist Consultant as well as other Providers who work with the family to assist in the development of an initial treatment plan and service delivery. Treatment service plans should be based on assessed needs of the family and build skills in the child/youth and family, to assist them in managing their behaviors and strengthening their protective capacity.

Based upon case circumstances and risk and safety factors, Providers will use their discretion to decide which cases will be discussed monthly at the team meetings, in order to review treatment progress, assess ongoing needs, and identify and address barriers to achievement of service plan goals. Additionally, the team will develop a strategy to monitor the progress of goal achievement, assess transition of families from one phase to another and ensure that children & families struggling with on-going mental health and/or substance use disorders have timely access to short-term services on-site, while awaiting more long-term services to be provided in the community.

The goal of the FT/R is to provide services to high-risk families when the caretaker's or child's substance use or mental health places the child at risk of foster care placement or replacement.

Additionally, this goal includes:

a. Strengthen families by appropriately assessing clients' substance use disorder and/or mental health illness and providing or linking them with ongoing treatment and support;
b. Prevent child abuse and maltreatment, promoting the safety of children, and reducing the number and percentage of children receiving services who are the subject of subsequent abuse and neglect reports;
c. Reduce the number of placements into foster care for children receiving FT/R services;
d. Maintain the stability of families who have recently been reunited from foster care and are impacted by substance use disorder and/or mental illness;
e. Serve children and their families in their neighborhood of origin; and
f. Promote optimal child health, well-being, and development.

Outcome for Family
The caretaker and/or youth's metal health and/or substance use disorder will be stabilized.
The caretaker will develop a better sense of self.
The caretaker will establish healthier boundaries.
The caretaker will improve his/her ability to care for child(ren) in a safe and age-appropriate manner.
The youth will respond appropriately to parenting.
The youth will develop a healthier relationship with family and peers.
The youth will show improvement in scholastic attendance and/or academic performance.

Eligibility

Standard:

The program shall provide intensive clinical interventions to families in which the caretaker's and/or child's substance use disorder and/or mental illness or an infant born with a positive toxicology for alcohol or illicit substances places a child at risk of removal to foster care. Families referred to the program may be suffering from substance use disorder and mental illness including but not limited to:

- Schizophrenia Disorders;
- Mood disorders, including depression;
- Impulse control disorders;
- Post-traumatic stress disorders;
- Oppositional disorders;
- Anxiety disorders;
- Conduct disorders;
- Alcohol dependency; and
- Substance use disorder; and/or

- Dependency on prescription drugs.

Documentation: 'Program Manual of Standards, Policies and Procedures'; referral forms; intake logs; CNNX and ADVPO progress notes and equivalent documentation; Supervisory logs; interviews with program staff.

Referral Management Process

Standard:

1. The Provider is expected to work closely with the referral sources to ensure effective coordination of referral and services provision. Children's Services, New York City's Department of Homeless Services, New York City Housing Authority and ACS 'foster care Providers will make 90% of the referrals to the FT/R; and 10% of the referrals will be self-referred or originate from local community organizations. Additionally, FT/R will adhere to the Children's Services referral process as indicated, *Part II, Section D 'Case Practices'.*
2. Children's Services approval is not required for families referred by other sources; however, Children's Services will monitor programs to ensure that such families meet the formal criteria for FT/R.
3. The Provider will receive referrals for high-risk families whose needs have not been successfully addressed in General Preventive programs due to parent or child mental health conditions and/or substance use disorder/use that place the child at risk of placement or replacement.
4. Cases will be identified for referral to the FT/R programs by the Child Protective Specialist (CPS); and the decision to refer cases to the programs will be made as needed in consultation with ACS' Clinical Consultation Team and/or the co-located Credentialed Alcohol Substance Abuse Counselor (CASAC). The PPRS Liaison will make the referrals to the Providers.
5. The families referred may or may not have recent mental health evaluation. Thus, FT/R Providers are expected to have the capacity to make evaluations or have them performed through their mental health partnerships. These evaluations are expected to be completed by the 60th day after acceptance of referral.
6. FT/R Providers shall establish and maintain linkages included but not limited to neighborhood-based programs, OASAS licensed substance use treatment programs, and OMH licensed treatment facilities. Additionally, FT/R Providers will adhere to all requirements indicated in *Part II, Section B & D 'Required Services' and 'Case Practices'.*

Documentation: 'Program Manual of Standards, Policies, and Procedures'; referral forms; CNNX and ADVPO progress notes and equivalent documentation; interviews with program staff.

Services Consistent with Family Needs

Standard:

The following services will be provided to families in the FT/R programs:

1. Supportive counseling, individual, and family therapy in the family's home, the Provider's office, or both. Recreational services and group therapies are utilized to assist and support ongoing symptom stabilization and relapse-prevention.
2. Clinical interventions utilizing a multi-disciplinary team approach consisting of licensed therapists, CASACs, and case planners to identify and address underlying issues that impairs a family's ability to function well and remain intact. Additionally, consultants will be hired to assist the team in the development of treatment plans and service delivery.
3. A team approach to assess, diagnose and treat each family member's needs. Within the thirty (30) calendar days of case receipt the team will determine the most appropriate treatment plan for each child and family. Additionally, the program will develop a strategy to ensure that families struggling with on-going mental health and/or substance use issues have timely access to services both on-site and/or in the community.
4. Monthly clinical team meetings, for families where monthly reviews are necessary, to review treatment progress, assess ongoing needs, and identify and address barriers to achievement of service plan goals.
5. The FT/R consists of three phases:

    - *The Initial Phase* is the continuation of the engagement efforts that began upon acceptance of the referral, to engage and retain clients in services. Within thirty (30) days of the case responsibility date, the CDT will determine the most appropriate treatment goal(s) for each child and family member based on assessed needs and/or recommendation from the referral source. Safety and risk factors should be closely monitored, as families in this phase may be more fragile. Urine drug screening, compliance with medication (if needed) and appointments, are an integral part of this phase, along with establishing a working alliance with community Providers working with the families. Families in this phase will require 2-3 casework contacts per week based upon assessments. Each child in the household should be seen once per week during this phase. The Provider staff will:

        a. Complete psychosocial assessments, which should incorporate such information as family history, children's developmental history, history of presenting problems, prior treatment, mental health status, medical history, psychiatric hospitalizations, psychotropic medications, substance use history, and domestic violence history, etc.
        b. Complete screenings, which include substance use, mental health, trauma and domestic violence. Educational evaluations should be considered for families involving teens with a history of academic challenges, and early childhood evaluations for families with infants/pre-school age children (under the age of six). Staff/consultant should

utilize an effective and comprehensive screening tool to properly evaluate the needs of the family.

c. Assess the family support systems that are established and work with the family to strengthen or reestablish relationships.

- *The Baseline Phase* generally takes place once the family has been engaged in services **at least** four weeks, and the Provider determines in consultation with the substance use treatment Provider and/or mental health clinician that a baseline of sobriety has been achieved and/or there is stability of current mental health symptoms. The focus of the work is to gain a deeper understanding of the family dynamics and the underlying interpersonal and social conditions that contributed to the need for a preventive referral, and help the family take the necessary steps to bring about the desired change. During this phase, the staff should complete or obtain any outstanding evaluations to determine the scope of needs, and the type of services/interventions that are needed for each of family member. Families in this phase will require one home visit per week and each child in the household should be seen at least once per month. The Provider staff will:

  a. Coordinate services with other Providers in order to monitor the family's progress in treatment;
  b. Assess parent(s') and/or child(ren's) participation in program services on an ongoing basis. Lack of participation in some programs may indicate that the services being offered are incompatible with the needs of family members and advocacy may be needed;
  c. Continue to provide counseling services (individual, family and/or group) with the goal of helping the family build skills to better manage their behaviors, assist the family in maintaining their stability, nurture healthier relationships and monitor the children's safety and wellbeing;
  d. Assess the degree to which the support system is functioning as planned; and
  e. Conduct ongoing assessment, develop new goals and revise existing goals as needed.

- *The Stabilization Phase* offers services and provides casework contacts at a reduced level. Moving families into this phase of services should be based on the assessed needs of the parent(s) and child(ren). Risks to children have been significantly reduced and significant goal achievements have been attained. Generally, families are engaged in a treatment program for substance use and/or mental health disorders, and are responding to the treatment; caretakers are becoming more attuned to the needs of their children, and are beginning to meet some of those needs; teens/youth are showing some improvement in their school attendance and/or academic performance, and/or are awaiting placement in an appropriate educational setting; they may also pose less disruptive behaviors at home; infants born with positive toxicology or pre-school age children have been assessed for delays; and if needed, are enrolled, or are awaiting placement in an Early Intervention program, day care program, or other Early Childhood

Education program. Families in this phase will require two home-based contacts per month and each child in the household should be seen at least once per month. The Provider staff will:

a. Monitor the stability of the family and maintain communication with other treatment Providers;
b. Continue to provide services needed to help the family attain agreed upon goals;
c. Advocate on behalf of families to obtain pending services with other city agencies, community Providers, etc;
d. Assess the family for case closing. If the Provider determines that a higher level of services is needed, the Provider will return the family to a more intensive level of service based on their current assessment of the family's needs, and must increase the frequency of casework contacts as required; and
e. Services in this phase should not continue for more than six (6) months.

6. When a child has not been seen within the above timeframes, the Provider must use alternate mechanisms to assess the child's safety, such as collateral contacts with school or child care Provider. Diligent efforts to meet this expectation should be clearly documented throughout the life of the case.

7. Case planners will transition families through each Phase of Service Provision, with guidance from the CDT and with Supervisory approval documented in the progress notes (CNNX or ADVPO).

8. In the event a caregiver relapses, programs resume the increased level of casework contacts required during the initial phase of service until the Provider assesses that a baseline of sobriety has been reestablished. It is vital that FT/R staff closely monitor the risk and safety of children residing with the parent during this very critical phase of treatment.

Documentation: 'Program Manual of Standards, Policies and Procedures'; case records and equivalent documentation; Supervision Logs; service plans and FASPS; discussion with program staff; client feedback forms.

NOTE: It must be clearly documented in the FASP and progress notes what phase the family is in at any given time.

Casework Contacts

Standard:

The FT/R staff maintains frequent, regular, face-to-face contact -- primarily home-based in the early stages of participation in services -- with all family members residing in the home.

In order to provide the casework contacts required, the Provider of specialized

rehabilitative services or supportive services must be an *employee* or *contractor* of the preventive service Provider agency. In addition, the contacts must be directed, arranged, or coordinated by the Case Planner. Such contacts must be documented in the progress notes, either by the supportive services/rehabilitative service Provider or by the case planner.

Contacts by Providers Other Than Case Planners

- Providers of Specialized Rehabilitative Services - defined as assessment, diagnosis, testing, psychotherapy, and specialized therapies provided as a component of a service plan to a child and/or family by a person who is an LCSW, Licensed Psychologist, Licensed Psychiatrist or other recognized licensed therapist in human services, or is a licensed or qualified individual including, but not limited to, a registered nurse or an alcohol or substance use counselor.
- Providers of Supportive Services - defined as those services provided as a component of a service plan to a child and/or family including, but not limited to, parent aide services, homemaker services, home health aide services, parent training services, housekeeper/chore services, and home management services.

Important note: In all situations in which the specialized or supportive Provider does not make the maximum number of casework contacts permissible, the case planner is ultimately responsible for all required casework contacts. If the case planner is unavailable to make the minimum number of contacts, the supervisor is responsible for arranging appropriate and sufficient coverage.

Frequency and Intensity of Casework Contact Requirements

Families may enter an FT/R program with a range of needs, and that, over the life of a case, there is variation in the level of intensity required. This requirement sets minimal standards that are consistent with the intensive level of service expected of these programs, while allowing Providers to adjust the level of intensity at certain points in their work with each family, based on an assessment of risk and need. Therefore, the Provider is expected to document clearly and promptly in the progress notes the assessment that leads to a decision to *decrease or increase* the frequency of casework contacts and home visits in a particular case.

At all times throughout the case, the current frequency of contacts deemed to be necessary by the Provider should be clearly noted in the progress notes by the supervisor. The Provider is expected to monitor child safety and risk throughout the life of the case, and to increase the intensity of contact with the family whenever that is warranted by the current circumstances of the family. Regular, documented communication and consultation with the substance use and/or mental health treatment Provider serving the family should inform the Provider's assessment of the level of contacts needed.

During the Initial phase of service provision, the Provider will determine whether two (2) or three (3) contacts per week are necessary for a particular family taking into account the following factors:

- The circumstances that led to the referral. For child protective referrals, the Provider is expected to review the results of the investigation, and to discuss with the child protective specialist how he/she assesses safety and risk in the family before making a decision that a family only requires 2 contacts per week during the Initial Phase of service.
- The age of the child(ren). Any case involving an infant under the age of six months shall be presumed to require 3 contacts per week, including 2 home visits per week, during the Initial Phase of service. Most cases involving young children (6 months to 5 years) who are not currently enrolled in school or in full-time child care programs will also require 3 contacts per week during the Initial Phase of service.
- Whether the family member with a substance use disorder and/or mental illness is a caregiver of the children. For example, if the family has been referred due to an adolescent's substance use, and that adolescent is not the caregiver for a younger child, the Provider may assess whether 2 or 3 contacts per week will be appropriate during the Initial Phase of service. Similarly, if a substance abusing parent is currently living outside the home (and this living arrangement has been verified), the Provider may transition the family more quickly to the next Baseline Phase of service (as described below).
- The caregiver's substance use and/or mental health history, substance(s) of choice, and current involvement in treatment. For example, if the caretaker has not yet entered treatment, or is beginning treatment, 3 contacts per week will typically be required during the Initial Phase of service. If the caretaker has already completed a period of treatment, and has established a baseline of sobriety or is close to doing so, the Provider may assess whether 2 contacts per week would be sufficient.

During the Baseline Phase of service provision, when a baseline of sobriety and/or stability of mental health symptoms has been established a minimum of one (1) contact per week is required.

  - The Case Planner must make at least 2 contacts with the family in any 4 week period. If the substance abusing family member is the caregiver of the children, both contacts must be in the home. If the family has been referred due to adolescent substance use, where the adolescent is not the caregiver for a younger child, the Provider may assess whether one of these contacts could best be held in an alternative location but in all cases the Case Planner must make at least one home-based contact per month.
  - The balance of the required contacts may be made by either the Case Planner or the Specialized Rehabilitative or support Service Staff. If the substance abusing family member is the caregiver of the children, each of these contacts must be in the home. If the family has been referred due to adolescent substance use, where the adolescent is not the caregiver for a younger child, the Provider may assess whether a portion of these contacts could best be held in an alternative location.

FT/R Providers will consider a range of factors in determining whether a "baseline" of sobriety and/or stability of current mental health symptoms have been achieved. Consultation with the substance use and/or mental health treatment Provider should inform this assessment.

The caretaker **mental health disorder** can be said to have achieved a "baseline" when she/he:

- is determined to be psychiatrically stable by a licensed mental health clinician
- is not assessed to be a danger to self or others
- is keeping MH appointments
- is observed to have attained a reduction of mental health symptoms
- oriented in the three spheres (Oriented to person, place & time) appears to be accepting of medications as prescribed
- improving patterns of interaction with others—especially children

The caretaker with **substance use disorder** can be said to have achieved a "baseline" when she/he:

- is meaningfully engaged in treatment for substance use disorder (this must be confirmed with the treatment Provider)
- is beginning to take responsibility for her/his actions
- is establishing a pattern over time of negative urine tests
- improving patterns of interaction with others—especially children

During the Stabilization Phase of Service Provision when the Provider assesses that a reduction in intensity is appropriate, risks to children are significantly reduced, and the family has made sufficient progress on service planning goals, a minimum of two (2) home visits per month is required. The Case Planner must make at least one (1) home visit per month. The second required home visit may be made by the Case Planner or the Specialized Rehabilitative or Support Service Staff.

- If the Provider determines not to terminate services as planned, the Provider will return the family to a more intensive level of service based on their current assessment of the family's needs, and must increase the frequency of casework contacts as required.
- The stabilization phase of service provision should not continue for more than six (6) months.

Documentation: 'Program Manual of Standards, Policies, and Procedures'; CNNX and ADVPO progress notes and equivalent documentation; supervision logs; service plans; FASPS; discussions with program staff; client feed-back forms.

NOTE: If there is no identified substance use need, the CASAC shall not have to provide services to a family. This should be clearly documented in the case record.

Staffing and Staff Qualifications

Standard:

1. **Program Director** who holds a MSW or equivalent human service graduate degree, administrative and Supervisory experience. (Required)
2. **Supervisor** who is an LCSW or Licensed Mental Heath Professional with at least two (2) years of documented relevant experience. (Required)
3. **Licensed Mental Health Clinician** who is a LCSW or Mental Health Professional (i.e., Licensed Therapist – Marriage and Family, Art, Drama or Mental Health Practitioner, Psychiatric Nurse, Psychologist). (Required position, if no established partnership with MH Provider).
4. **Case Planner** who holds a BA/BS/BSW or MSW/equivalent human service graduate degree (preferred) with at least two (2) years documented relevant Child Welfare experience. (Required)
5. **Credentialed Alcohol and Substance Abuse Counselor (CASAC or CASAC-T)** who holds a Bachelor's degree to provide substance use disorder/use assessments. (Required)
6. **Case Aide/Parent Aide** who holds a High School diploma or General Equivalency Diploma and at least one (1) year of appropriate experience working with a similar population or successful completion of and graduation from Children's Services-contracted FT/R or similar program (i.e. former FRP program). Parent Aides working with clients in substance use disorder treatment or recovery have graduated from substance use disorder treatment program and have at least two (2) years of sobriety. (Recommended)
7. **Family Team Conference Specialist** Children's Services will not require a dedicated Family Team Conference Specialist. Agencies may use their discretion to assign the responsibility for the facilitation of Family Team Conferences in the way they believe will enable them to successfully implement the model. If a dedicated position is created, that staff person must have a 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. (Recommended)
8. **Intake Worker** who holds a BA/BS/BSW or MSW/equivalent human service graduate degree (preferred) with at least two (2) years documented relevant Child Welfare experience. (Recommended)

The interdisciplinary treatment shall also comprise of the following part-time clinical staff or Consultants:

1. Licensed **Psychologist-** to conduct psychological evaluations, make recommendations for treatment and assist with staff training.
2. Licensed **Psychiatrist-** to conduct psychiatric evaluations, make recommendations for treatment and assist with staff training.

All consultants will participate in the Clinical Diagnostic Team meetings and Family Treatment Conferences when deemed appropriate.

Staff Training and Development

The Provider shall continually assess and train staff appropriately. In addition to the trainings discussed in *'Training' Part II, Section E,* the following trainings are suggested:

- An overview of dual diagnosis and its epidemiology;
- Adolescent substance use/engagement & motivation for treatment;
- Working with families of dual diagnosed clients;
- Indicators of mental health disorders;
- Indicators of substance use disorders;
- Identifying and treating youth/adults with mental health disorders;
- Identifying and treating youth/adults with substance use disorders;
- Medication (self and prescribed);
- Intergenerational trauma; and
- New findings on adolescent development pertaining to Substance Use and Mental Health Disorders.

Caseload Ratio

Standard:

The recommended caseload for this program is 1:10 with an average annual caseload of ten (10) per FT/R case planner. New York States OCFS regulations require that a preventive services Provider shall assign a family to no more than one case planner at a time. Individual caseloads significantly higher than ten (10) are not recommended because of the level of services families required.

Documentation: CNNX and ADVPO progress notes, Supervisory Logs; service plans and FASPS.

Accessibility

Standard:

In addition to the standards articulated in *Part II, Section 'Site Milieu"* the following applies:

a. The service environment shall be accepting and supportive of families who have substance use disorder and/or mental health problems.

Documentation: 'Program Manual of Standards, Policies and Procedures'; CNNX and ADVPO progress notes; case records.

SPECIALIZED PREVENTIVE SERVICES

SPECIAL MEDICAL AND DEVELOPMENTAL PREVENTIVE PROGRAM

This section contains those standards that are specific to Specialized Preventive Services for Special Medical and Developmental Preventive Programs. These standards apply in addition to those in Parts I and II. In some areas, standards in this section are somewhat different from, and may be more stringent than those in Parts I and II. Where this is the case, the Specialized Preventive Services for Special Medical and Developmental Preventive Program specific standards take precedence.

Goal of Specialized Preventive for Special Medical and Developmental Preventive Program

Standard:
The goal of this model is to link intellectually disabled/developmentally disabled, and/or medically fragile persons to long-term supports and services that can be sustained once participation in the specialized preventive program has ended. Additionally, this specialized preventive program assists a terminally ill parent identify a future permanency resource and help them prepare for the transfer of custody of his/her children. Providers offering this specialized preventive program will strive to reduce all safety and risk issues within the family, that left unaddressed, would warrant foster care placement. Services should be personalized to meet the need(s) of the child(ren)/youth, parent and families.

Eligibility

Standard:

The Provider shall offer Specialized Preventive Services to families in which a child or parent has medical and/or developmental needs; and a child is at risk for foster care placement. This includes:

1. Families with children or parents who suffer from medical conditions and/or developmental disabilities which include, but are not limited to the following conditions:
    - Intellectual Disability
    - Autism Spectrum Disorder;
    - Severe neurological impairments including traumatic brain injuries, epilepsy progressive encephalopathy (mitochondrial disease) and non-progressive encephalopathy (cerebral palsy) ;
    - Down Syndrome or other genetic/hereditary syndromes;
    - Severe neuromuscular disorders or severe disabilities including Osteogenesis Imperfecta;
    - Oxygen-dependent and airway-compromised children;
    - Neural tube defects (spina bifida) and neuro-developmental disabilities;
    - Significant dysfunction of major organ systems (e.g., heart, kidney, liver);

- Diabetes and severe endocrine disorder;
- Significant hematological disorders, such as sickle cell disease;
- Severe burns and physical trauma resulting in physical disabilities;
- A dependency on devices such as a feeding tube and wheelchair;
- Received or is receiving chemotherapy and other complex modes of managements of serious and/or chronic illnesses;
- HIV and/or AIDS who are on a combination drug therapy, as well as HIV-exposed children whose HIV status has not yet been determined;
- AIDS and HIV-related illness;
- Severe persistent asthma;
- Cystic Fibrosis;
- Hematologic malignancies.

2. Families in need of early permanency planning services where a parent is diagnosed with one or more diseases, including but not limited to: cancer, sickle cell disease, renal failure, end-stage cardiac diseases, multiple sclerosis, Alzheimer's disease, and HIV/AIDS. Early permanency planning services shall support families in planning for a permanent home and for the care of their children upon the caregiver or parent's death or inability to care for their children. The Provider shall assist parents in preparing and having significant input in the future care and custody their children to minimize their children's trauma due to their parent's illness and the impending changes in custody.

3. There is a risk of foster care placement of an child with special medical needs and/or developmental disabilities, who is medically ready for discharge from a hospital, and without the provision of specialized preventive services to assist the family, the family will not adequately be prepared for the child's return home and ongoing care, and foster care placement may become necessary.

Documentation*:* 'Program Manual of Standards, Policies, and Procedures'; referral forms; CNNX and ADVPO progress notes and equivalent documentation; discussions with program staff.

Referral Management Process

Standard:

1. It is expected that approximately sixty-five (65) % of the families served by this Specialized Program will be referred from Children's Services and other designated Children's Services components; and thirty-five (35) % will be self-referred or referred from local community organizations.
2. Children's Services approval is not required for families referred from other sources; however, Children's Services will monitor programs to ensure that such families meet the formal criteria for the special medical and developmental population.
3. The Provider is expected to work closely with the Children's Services Borough

Office and other referral sources to ensure effective coordination of referrals and services provision. Additionally, Providers will adhere to Children's Services referral process as indicated in *Part II, Sections D. "Referral and Outreach", "Referral Process and Follow-up File", "Children's Services Referrals", "NYCHA Referrals", "Waiting Lists" and "Intake and Engagement".*

Documentation: 'Program Manual of Standards, Policies, and Procedures'; referral forms; CNNX and ADVPO progress notes and equivalent documentation; discussions with program staff.

Services Consistent with Family Needs

Standard

For families with children with special medical needs and/or developmental disabilities, the Provider shall offer services which include but are not limited to:

1. Conducting periodic assessments of each child and family consistent with the standards articulated in *Part II, "Eligibility", "Family Assessment and Service Plan", Complete Assessments* as well as those outlined below:
    a. Offering a highly structured home-based therapeutic environment that identifies and focuses upon the specific needs of each caretaker/child with a severe developmental disability. Providers shall identify and focus upon the specific needs of each child with a severe disability and/or severe medical problems. It is essential that the Provider not only address the needs of each child but also work closely with his/her parents and siblings to educate and support all family members regarding the child's special needs and the needs of each sibling, to help them understand the child(ren)'s needs and prepare them for living with the effects of the disability. Staff shall ensure maximum safety, supervision and support for children and their families; this perspective shall inform assessments and service plans described above. Intensive homemaking, and homecare shall be available through the Provider's own services or via its linkages.
    b. The assessment of need for long-term residential placement for those children and parents who may need a bridge to permanency (as specified in the 'Goal' section above), should begin at admission to the preventive program, and be reassessed on an ongoing basis; referrals for residential care should be made well in advance of the time for placement for such services.
2. Providing on-going counseling to help families cope with their living conditions. Caretaker/children will receive individual, group (depending on level of functioning), and family counseling as appropriate to eliminate their vulnerability to abuse. All children/youth should be assessed for past trauma and presenting trauma symptoms; children/youth who have experienced trauma and/or loss, including the loss of physical integrity and health, 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.

3. Advocating for the family to secure appropriate educational services for children who have special needs or for children who require Early Intervention.
4. Creating opportunities for recreational services that are both integrated with non-developmentally delayed children and adults as well as activities that are exclusively for children who have special needs. Some examples of such activities include parent retreats, picnics, athletic activities, summer camps, support groups, etc.
5. Establishing linkages with the following entities:
    a. hospitals, nursing care facilities, places of worship; schools; New York City Family Courts; advocacy and support organizations that serve families with children with special medical needs and disabilities. The Provider shall establish referral and communication protocols with such institutions and organizations.
    b. OPWDD Developmental Disability Services Office (DDSO) in their borough, Article 16 clinics and Home and Community Based Service Waiver programs. Developing a plan to gather information and gain access to Community Medicaid Coordination-reimbursable programs for children and/ or caretakers with developmental disabilities.
    c. Parent support groups qualified to address the specific needs of the family according to the child's particular disabilities and conditions.

For those families with a parent who is suffering from a progressively chronic terminal illness, the Provider shall provide services which include but is not limited to:

1. Working with the parent to identify a resource who will assume responsibility for the child(ren) upon the parent's death or incapacitation. The parent may specify a relative or friend to become a legal guardian or pre-adoptive foster parent.
2. Making every effort to prevent foster care placement other options must be assessed and ruled out before foster care is considered. Among the other options that should be explored are community-based services, other Preventive Services, and the availability of relatives or friends who might be able to care for the child (with or without support) outside of foster care when transfer of care becomes necessary.
3. In the event that a relative or friend is identified as the foster parent, the Provider, through the partnership with the foster care Provider must have a home study conducted. Individuals certified to become pre-adoptive foster parents must receive simultaneous supervision and assistance from the Provider and the foster care Provider. The prospective foster parent and the Provider should make a commitment to work toward adoption. The adoption process should not be initiated until the parent is deceased or upon the direction of the parent while he or she is alive.
4. Should no resource be identified, the Provider must work with the parent to create a voluntary placement agreement that will transfer actual care and custody to the Children Services' Commissioner once the parent and/or guardian dies or becomes incapacitated. The Provider shall rely on the partnership with a foster care Provider to assist in identifying a pre-adoptive foster parent, and coordinate contact between the parent, child(ren) (where appropriate), and prospective foster parents. When preventive services and foster care services are provided to the same family, preventive staff and foster care staff shall coordinate service planning.

Documentation: 'Program Manual of Standards, Policies, and Procedures'; referral

forms; CNNX and ADVPO progress notes and equivalent documentation; case records; service plans and FASPS; Special Assessments and Evaluations; monthly reports; discussions with program staff.

Case Practice

Standard:

In addition to those standards articulated in the *Part II, Section D, "Case Planner and Caseworkers Functions",* the following standards apply:

1. Within thirty (30) days of case referral, the Provider shall assemble a Interdisciplinary Team (IT) composed of, but not limited to, the Program Director, Supervisor, Case Planner, Medical Personnel, Psychiatrist/Psychologist, and Educational/Vocational/Occupational Specialist to determine the most appropriate services and treatment plan for each child.
2. The Provider shall offer on-going counseling to help families cope with their circumstances. The specialized needs of each family will require intensive follow-up. Families may experience stress and need to talk about what is going on in the family as a result of their complex medical and/or custody issues.
3. The Provider shall assist the family in maintaining an easily accessible packet of information on the child's and/or parent's condition, medications, health care Provider(s) and other pertinent information for use as reference by Emergency Medical Services in case of an emergency;
4. Providing special needs children, when such children have capacity to understand, with a health care and personal hygiene information specific to their medical 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; information about medication; and the use of medical equipment and other devices necessary for the treatment and maintenance of the condition.
5. Providing specialized parenting skills training that address the specific concerns and stresses associated with caring for a child with a developmental disability or special medical needs. Additionally, in the case of a terminally ill parent, training to address issues around effective coping strategies, stress/anger management, and death and dying issues and other transference issues. All training must be sensitive and responsive to the needs of specific parent categories, including teen parents and non-English speaking parents.
6. The Provider shall ensure provision of group work or mentoring support for children and/or other family members to help them learn/develop coping mechanisms needed to live with a parent with a severe/critical medical condition, and teach them how to recognize emotional triggers and use positive skills to offset negative patterns and prepare them for grief and loss.
7. The Provider shall assist parents in recognizing the need for respite from caretaking responsibilities both for themselves and for their children. The Provider shall help parents plan strategies to obtain regular relief, which may include on-site activities at the Provider.

8. The Provider shall to arrange transportation for the families to their appointments and to the program offices when needed and desired.
9. Assisting the parent or guardian in making arrangements for the eventual transfer of care and custody of the child to the Children's Services Commissioner by means of a written voluntary placement agreement when Children's Services determines that a child is at significant risk of placement within the next eighteen (18) months because the custodial parent or legal guardian of the child is suffering from a progressively chronic or irreversibly terminal illness, and there is neither a relative nor a close friend to assume legal guardianship of the child.
10. If foster care placement is necessary, all efforts to involve the family members in the planning must be undertaken. Eligibility for foster care shall be on a voluntary basis, not the result of a Family Court Neglect proceeding.
11. On-going assessment of the parent's and child's needs, and on-going counseling for the family to help them manage with their circumstances in the following areas:
    a. Grief and Loss
    b. Stress/Anger Management
    c. Child Custody Issues
    d. Effective Coping Strategies
12. Conducting regular case conferences to assist the family in the development of the voluntary placement agreement where the parent has the right to negotiate visitation and the provision of certain services. If a foster care agency has partnered with the Provider, they should be included in these conferences. Additionally, other agencies working with the family should participate in these case conferences.
13. If the child(ren)'s are placed in foster care, the foster care Provider shall assume the main responsibility for service provision for the family in accordance with foster care regulations.
14. The case planner will have monthly contact with each medical Provider and sociak service organizations working with the family.

Documentation: 'Program Manual of Standards, Policies, and Procedures', CNNX and ADVPO progress notes and equivalent documentation; case records; Supervision Logs; service plans and FASPS; evaluations; discussions with program staff; client feed-back forms.

Casework Contact

Standard:

During the Initial Phase of service provision, Provider Staff shall maintain frequent, regular, face-to-face contact, primarily home-based, with the family members residing in the home and external resources whenever possible. Casework contacts are as follows:

a. Case Planner conducts two (2) contacts with the family, and at least one (1) contact monthly should be in the home.
b. Nurse to conduct at least one (1) visit within the month, this contact should be in the home.

c. Case Aide (optional) conducts two (2) contacts monthly; one (1) of these contacts should be conducted in the home.

When the Provider assesses that the family has been stabilized and progress toward service planning goals have been achieved, the casework contacts are as follows:

- The Case Planner will make at least two (2) contacts during the month.
- The Case Planner will make at least one (1) home visit per month.
- Based on assessed needs, the Nurse, Case Aide and other members of the Interdisciplinary Team will conduct visits as necessary.

Progress notes must clearly reflect the phase the family is in resulting in the level of casework contacts.

Documentation: Program Manual of Standards, Policies, and Procedures', CNNX and ADVPO progress notes and equivalent documentation; case records; Supervision Logs; service plans and FASPS; evaluations; discussions with program staff; client feed-back forms.

Staffing and Staff Qualifications

Standards:

The Provider shall develop an Interdisciplinary Team (IT) to review service plans and determine changes necessary to improve the emotional and physical well-being of the child and the family. The CDT shall comprise staff listed in the *Part II, Section E- "Staff Qualifications", "Consultants",* as well as the following full-time staff:

1. **Program Director** who holds a MSW or equivalent human service graduate degree, administrative and Supervisory documented relevant experience working/ this population. (Required)
2. **Supervisor** who is a Licensed Clinical Social Worker or Licensed equivalent with a human service graduate degree with at least two (2) years documented relevant Child Welfare experience. (Required)
3. **Case Planner** who holds a BA/BS/BSW or MSW/equivalent human service graduate degree (preferred) with at least two (2) years documented relevant Child Welfare experience. (Required)
4. **Case Aide/Parent Aide** who holds at least one (1) year of appropriate experience working with a similar population or successful completion of and graduation from Children's Services FT/R or similar program (i.e. former Family Rehabilitation Program). (Strongly recommended)
5. **Nurse** who holds RN or NP experience working with Developmental Disabilities and Spec. Medical Population. (Required)
6. **Family Team Conference Specialist** Children's Services will not require a dedicated Family Team Conference Specialist. Agencies may use their discretion to assign the responsibility for the facilitation of Family Team Conferences in the way they believe will enable them to successfully implement the model. If a dedicated position is

created, that staff person must have a 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 (Recommended).

The Interdisciplinary Team shall also be comprised of the following part-time staff or Consultants:

1. **Licensed Psychologist** who holds a license and is currently registered to practice in New York State. The Psychologist will conduct psychological evaluations, make recommendations for treatment and assist with staff training.
2. **Licensed Psychiatrist** who holds a license and is current registered to practice medicine in New York State. The Psychiatrist will conduct psychiatric evaluations, make recommendations for treatment and assist with staff training; and
3. **Educational/Vocational Rehabilitation Specialist** who holds a BSW/BS/BA and Certified Rehabilitation Counselor. The Education/Vocational Rehabilitation Specialist will conduct educational/vocational assessments, advocate with educational/vocational Providers, assist with educational/vocational placements, provide educational/vocational training for the youth and/or family, and conduct groups as necessary**.**

Note: All consultants shall participate in ITs and FTCs when deemed appropriate.

Staff Training and Development

Standard:

1. Training for all Provider staff shall include extensive background information about the needs of this population. This shall include information on specific types of special medical illness and developmental disabilities, and how they may affect the family dynamics. It is important to highlight that children in these families are at high risk of child abuse and foster care placement.
2. A course on case management/service coordination for interviewing and counseling persons with DD, medically fragile children and parents with critical illnesses and their families. Topics should include: methods of interviewing, methods of counseling, confidentiality, documentation, identifying need for crisis intervention, conflict management skills, reinforcing professional boundaries, overview of Developmental Disabilities, First Aid /CPR, signs and symptoms of DD, Person Centered Planning, Guide to Understanding the Supports and Services Offered by New York State OPWDD and effective Strategies for Crisis Intervention and Prevention (SCIP).

Documentation: Program Manual of Standards, Policies, and Procedures'; staff interviews; training schedules and attendance sheets; personnel files; written statement/affirmation from Executive Director; staff evaluations.

Caseload Ratio

Standard:

The recommended caseload for this program is 1:10 with an average annual caseload of twelve (10) per specialized preventive case planner. NYS OCFS regulations require that a preventive services Provider shall assign a family to no more than one case planner at a time.

Documentation: CNNX and ADVPO progress notes; Supervisory Logs; service plans and FASPS.

Accessibility of Services

Standard:

In addition to the standards in the *Part II, Sections F "Site/Milieu",* the following standard applies:

1. The service environment shall be accepting families with chronic medical and mental health conditions, and those with developmental disabilities.

Documentation: 'Program Manual of Standards, Policies, and Procedures'; CNNX and ADVPO progress notes; case records.