**Children’s Mental Health Announces New Service:**

**Intensive Treatment in Foster Care**

**TOPIC**

Intensive Treatment in Foster Care service description, service provision standards, certification process, and rates development

**PURPOSE**

To provide information on the Intensive Treatment in Foster Care benefit for Minnesota Health Care Program participants as described in Minnesota Statutes.

**CONTACT**

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**SIGNED**

CLaire Wilson
Assistant Commissioner
Community Supports Administration

**TERMINOLOGY NOTICE**

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.
Introduction/Purpose
This bulletin serves to inform mental health providers, counties, tribal authorities, health plans, foster parents and youth serving organizations about legislation that was passed authorizing a new benefit to Minnesota Health Care Program (MHCP) participants. This bulletin contains information on service components, eligible providers, the certification process, service delivery payment requirements, and rate development information for Intensive Treatment in Foster Care.

Legislative Authority
The 2013 Minnesota State Legislature passed Laws of Minnesota 2013, Chapter 108, Article 4, Section 26, which amended Minnesota Statutes, section 256B.0946 describing a new clinical intensive mental health service for children living in a family foster care setting. The legislation directs the commissioner of the Department of Human Services to create a certification process and add the service to the MHCP benefit package for children’s mental health.

Background

Therapeutic Support of Foster Care
Since the inception of Minnesota’s children’s mental health system, therapeutic services in foster care have been a key component. The Comprehensive Children’s Mental Health Act, passed by the Minnesota State Legislature in 1989, described a service called “therapeutic support of foster care” which included mental health training, services, supports and clinical supervision for foster families who were caring for children with serious emotional disturbances. Therapeutic support of foster care was added to the Medicaid benefit set in 1994 and comprised a mixture of psychotherapy and skills training for working with the child and foster family. This service was in effect for approximately ten years and was replaced by Children’s Therapeutic Services and Supports (CTSS).

For the past ten years, therapeutic services available to children in foster care placement have been delivered through the Children’s Therapeutic Services and Supports benefit. CTSS services is a flexible benefit set available to children living with their parents or foster parents in the community which can be delivered in the office, home or community setting. CTSS includes skills training, psychotherapy, crisis assistance and mental health behavioral aide services. CTSS is a rehabilitative service designed to help children restore functioning to levels before they experienced symptoms of mental illness and/or to acquire skills that they have not been able to develop because of their mental illness. While these services can be provided in a traditional foster home, relative foster home or treatment foster home, service providers and placing agents found there are a significant number of children who required more support and clinical attention than what was available through the standard
CTSS service package. Through a stakeholder input process, providers and placing agents described the level of clinical consultation, 24/7 phone support and foster parent psychoeducation that was needed to maintain placements for high-need children.

**Treatment Foster Care**

The concept of “treatment foster care” has existed in Minnesota for more than twenty years since 1995. Treatment foster care serves children with special needs but is not necessarily specific to a mental health diagnosis. Treatment foster care homes are licensed through an additional set of guidelines laid out in Minnesota Rules, parts 2960.3300 through 2960.3340. As described in Minnesota Rules, part 2960.3301, treatment teams comprise parents, treatment foster care parents, county case manager, licensed professional directing treatment, treatment foster care social worker and other persons identified by the team. The treatment in these homes is provided by the foster parents in conjunction with others listed on the plan. Treatment foster care home licensing limits the number of children who are allowed to live in the home to two, unless there is a variance and then treatment foster parents need to meet additional criteria and training (Minnesota Rules, parts 2960.3302 and 2960.3303). Child foster parents, including those certified as treatment foster care as described in Minnesota Rules, parts 2960.3300 through 2960.3340 are eligible to receive foster care maintenance payments as specified in Minnesota Statutes, Chapter 256N.

Through the stakeholder input process, placing agents (counties and tribes) expressed difficulties with working with treatment foster homes because those homes were often far away from the county or reservation of residence for the child and family. Placing agents were concerned because often they did not receive current treatment plans for children and children frequently were only receiving skills training without a psychotherapy component. In addition, counties and tribes are required to first consider relatives as foster parents and maintain children in relative or nonrelative foster parents who are permanency options for the foster children, if they cannot safely return to their parents care. This means a foster children initial placement with a relative or in close proximity to their family or school may need to end and they must move to a treatment foster home or group home rather than getting the Intensive Treatment they require in the initial foster home.

The Children’s Mental Health Division started the process of developing a bundled new service for children in foster care in 2005. As a result, the Legislature passed Minnesota Statutes, section 256B.0946 authorizing a Medicaid benefit for treatment foster care. The bundled service was to include targeted case management, psychotherapy and skills training, and family psychoeducational services. This service was to be delivered to children living in treatment foster care settings. Providers of treatment foster care were required to be a licensed child placing agency governed under Minnesota Rules, parts 9543.0001 to 9543.0150 and either a county, an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to
450n, or title 3 of the Indian Self-Determination Act, Public Law Number 93-638, section 638 (facilities or providers), or a non-county entity under contract with a county board. Although the legislation passed, it was not funded. Further development of the service was halted until the spring of 2012.

During the intervening years, we learned more about the children living in our foster care system and effective treatment for children who have suffered from trauma that required changes to the treatment service package. The 2012 Legislative Session made key changes to permanency expectations. DHS Bulletin #16-68-08: Relative Notice Requirements for Children in Foster Care describes the requirements for relative search and placement consideration, permanency planning, and finalizing of permanency plan for court ordered and voluntary placements for treatment, and state implementation of the federal Fostering Connections to Success and Increasing Adoptions Act extending foster care benefits and services for youth over the age of 18. All of these changes require intensive treatment to be available within relative and pre-adoptive placement settings to help achieve timely permanency (through reunification, adoption or a transfer of permanent legal and physical custody to a relative within tight timelines for children). In addition, more foster children are living in family foster care settings.

According to the data provided by Minnesota’s Children in Out-of-Home Care Reports, more than 80 percent of foster children in 2015 spend some time in a family foster home, and more than 25 percent of foster children had a condition of emotional disturbance. Children of color are overrepresented in the out-of-home placement system compared to the number in the general population. In 2015, approximately 45.5 percent of children in out-of-home care were white; 19 percent were American Indian and Alaskan native; 17.5 percent were black or African American; and 2 percent were Asian, native Hawaiian or Pacific Islander. Approximately 15 percent were of two or more races and 1.1 percent had heritage unknown or not reported. Approximately 9 percent indicated Hispanic ethnicity.

It was determined that these populations would benefit from culturally specific service providers. Tribes should be involved in determining who can provide treatment services to enrolled and/or children eligible for enrollment.

In 2015, the number of children in foster care increased by approximately 9 percent from 2014. Although children ages 12–17 continue to comprise the largest group in out-of-home care, Minnesota has seen decreasing numbers of older children and increasing numbers of children under age 12. The age ranges speak to the need of having specialty services to address these early childhood mental health and youth groups.

Children in foster care tend to utilize mental health services extensively, as described by the Faces of Medicaid Project (Pieres, 2013). Nationally, it has been shown that while children in foster care are under 10 percent of the children enrolled in Medicaid, they utilize 38
percent of the child Medicaid expenditures (Pieres, 2013). The Faces of Medicaid Project also stated that children in foster care have a mean behavioral health expenditure of $8,094 per child compared to $7,264 for a child on Social Security Disability (Pieres, 2013). Children in foster care require higher levels of mental health services and coordinated care due to the complexity of their situation.

Furthermore, more is known on how to effectively treat children who are suffering from trauma and Children’s Mental Health has been developing an infrastructure of trained providers of evidence-based practices. In 2007, the legislature passed the Governor’s Mental Health Initiative, which included training dollars for early childhood mental health and evidence-based practices infrastructure development. Through the infrastructure grants, the Mental Health Division at DHS has been able to promote and develop clinicians trained in Trauma Informed Child/Parent Psychotherapy (TI-CPP) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Through a partnership with the AMBIT Network, approximately 500 therapists have been trained in TF-CBT across the State of Minnesota since 2007. Through a partnership with the University of California, San Francisco, 100 licensed clinicians have been or are in the process of being trained in TI-CPP for treating young children and families. A national certification process has been developed for TF-CBT and TI-CPP. Assuring that children receiving intensive services while in foster care are assessed and appropriately treated for trauma is possible due to the infrastructure development within the past 6 years.

**Intensive Treatment in Foster Care**

Intensive Treatment in Foster Care (ITFC) as a MHCP benefit was developed in 2012 through a series of stakeholder groups with counties, tribes, treatment foster parents, mental health providers, advocacy organizations and parents. Keeping in mind the demographic and service needs of the children, it was determined that ITFC needed to be a flexible service package that could be provided to all the members of the child’s family, foster family and members of the permanency plan in any family foster home. Utilizing a family foster care home distinction makes it possible for the service to be available in a traditional or treatment foster home, relative or kinship foster home, or a home licensed by a county, tribe or child caring placing agencies. The inclusion of the child’s parents or pre-adoptive family in the service assists in concurrent and permanency planning, where clinically appropriate.

Specific service delivery payment requirements were developed to respond to needs expressed by the stakeholder groups. Often children in foster care have been to multiple medical and mental health providers without a comprehensive assessment that incorporates all of their previous care; therefore, an extended diagnostic assessment, including an extensive review of records and trauma assessment, needs to be conducted. To combat issues of children experiencing multiple placements or unnecessary hospitalizations, ITFC providers are required to be available by phone 24/7 and coordinate with local regional
crisis response providers. To comply with Minnesota’s initiative to prevent over utilization of psychotropic medications in foster care, the ITFC provider is expected to continually collaborate and consult with the child’s medical providers as well as be aware of the child’s medication regimen and potential side effects. Lastly, ITFC providers will be required to obtain certification in an approved evidence-based practice that targets symptoms caused by trauma by January of 2018. Certified providers of ITFC will have priority in receiving TF-CBT or TI-CPP training through the Children’s Mental Health training grants and opportunities to assure appropriate, quality treatment for children receiving intensive clinical services in foster care.

The new Intensive Treatment in Foster Care benefit will:

- Help children get an intensive clinical mental health service while maintaining child’s foster care placement; this supports placement with relatives, education stability and timely permanency planning
- Use current systems to increase access for children who need an intense level of mental health service
- Create more flexible, coordinated service delivery among all child’s team members (parents, foster parents and professionals)
- Strengthen treatment and permanency planning with consultation, psychoeducation and therapy services to support successful out-of-home placements
- Supports post-permanency by provider transitioning after the permanency is achieved
- Promote evidence-based practices and outcome measures to improve results for children in foster care

### Intensive Treatment in Foster Care Benefit

ITFC is a MHCP benefit that will be available for children living in a family foster care setting who meet the medical necessity criteria for the service, described in Minnesota Statutes, section 256B.0946.

### Client Eligibility

To be eligible for ITFC, the child must be between the ages of 0 to 21 and meet the following criteria:

- Live in a licensed family foster home (where the license holder lives in the home; this includes licensed preadoptive and pre-kinship placements),
- Be a recipient of MHCP,
- Have a diagnostic assessment within the past 180 days that documents a mental illness,
- Have documentation of medical necessity that Intensive Treatment are required to treat symptoms and functional impairments within a foster family setting, and
- Have a level of care determination that demonstrates intensive intervention without 24-hour medical monitoring is required.

ITFC distinguishes itself from other services on the children’s mental health continuum since it is an intensive clinical service that does not require a rehabilitative focus. The
service package focuses on decreasing symptoms and impairments to functioning, but does not require the clinicians to document what capacity the child lacks or was not able to acquire because of her or his mental illness. Medical necessity for ITFC must focus on the child’s current symptomology, functional impairments and placement needs within the family foster home care setting. ITFC also requires particular attention to the child’s service needs due to placement and permanency viability as well as the child’s inability to live with the primary parent(s) or guardian(s) due to the child’s medical need, disruptive behavior or child safety reasons.

Minnesota Statutes, section 256B.0946 specifies that the child needs to be placed in a family foster care setting, including preadoptive and pre-kinship homes, in order to be eligible for ITFC. The statute also states that the home needs to be licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, which include both county and child caring placing (private) agencies licensed homes. Children living in tribally licensed foster homes where the license holder lives in the home are also eligible for Intensive Treatment in Foster Care.

**Service Component and Delivery Requirements**

Intensive Treatment in Foster Care is a bundled service package for children on MHCP. Children receiving ITFC are eligible to receive a combination of these service components over the course of service delivery and these should be noted on the child’s treatment plan.

**Required Service Components:**

- Psychotherapy (individual, family, multifamily and group),
- Crisis Assistance,
- Psychoeducational Services (individual, family, multifamily and group), and
- Clinical Care Consultation.

Because ITFC was developed looking specifically at the treatment and permanency needs of children in foster care within the State of Minnesota, ITFC also has specific service delivery requirements in order to bill and receive payment from MHCP:

- All services must be delivered by a mental health professional or a clinical trainee, as defined in Minnesota Rules, part 9505.0371,
- Each child receiving treatment services must receive an extended diagnostic assessment within 30 days of enrollment in this service unless the child has a previous extended diagnostic assessment that the child, parent and mental health professional agree still accurately describes the child’s current mental health functioning,
- Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible child has received. This information must be reviewed and incorporated into the diagnostic assessment, team consultation and treatment planning review process,
Each child receiving treatment must be assessed for a trauma history, and the child’s treatment plan must document how the results of that assessment will be incorporated into treatment,

Each child receiving services must have an individual treatment plan that is reviewed, evaluated and signed every 90 days using the team consultation and treatment planning process,

Each child must have a crisis assistance plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team,

Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care,

Location of service delivery must be in the child’s home, child care setting, school or other community-based or office setting that is specified on the child’s individualized treatment plan for particular treatment purposes,

Treatment must be developmentally and culturally appropriate for the child,

Services must be delivered in continual collaboration and consultation with the child’s medical providers, and, in particular, with the prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects,

Parents, siblings, foster parents, and members of the child’s permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan, and

Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child’s permanency plan and post discharge mental health service needs.

Service Delivery Definitions:
Clinical care consultation means communication from a treating profession offering treatment to other providers working with the same client to inform, inquire and instruct regarding the client’s symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings. Service settings include, but not limited to, the client’s school, social services, day care, probation, home, primary care, medication prescribers, disabilities services and other mental health providers, and to direct and coordinate clinical service components provided to the client and family.

Psychoeducation services means information or demonstration provided to an individual, family or group to explain, educate and support the individual, family or group in understanding a child’s symptoms of mental illness, the impact on the child’s development,
and needed components of treatment and skill development. This is provided so that the individual, family, or group can help prevent relapse, prevent the acquisition of comorbid disorders and achieve optimal mental health and long-term resilience.

**Team consultation and treatment planning** means coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child’s treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child (unless the team lead or parent deem it clinically inappropriate), and at least two of the following: an individualized education program case manager, probation agent, children’s mental health case manager, child welfare worker (including adoption or guardianship worker), primary care provider, foster parent, and any other member of the child’s service team.

**Eligible Providers**

Eligible providers of ITFC need to have a state certification and a service provision contract with a county or tribe. Children’s Mental Health will begin accepting certification applications once ITFC is added to the Minnesota Health Care Program’s benefit set.

Providers may apply to Children’s Mental Health to be a provider of ITFC services after attending the informational session. Prior to applying, all agencies must send a representative to an informational session that will be held in St. Paul with accessibility through videoconference throughout the state. Further details on the application requirements (including mock file expectations) will be covered in the training. Agencies may not be certified without having a representative attend the training. Registration for the training will be conducted through TrainLink. Providers will be notified via Provider News when the informational sessions are scheduled.

Agencies must document mental health professionals, clinical supervisors and clinical trainees that will be providing ITFC, including information on training and certification in evidence-based practices. Each individual provider of this service must have completed a criminal background check at the time of application. Whenever a new therapist or clinical trainee joins the agency to provide ITFC, a new background check must be conducted requiring the consent form and provider change form to be sent to DHS. Any mental health professional or clinical trainee who does not pass the background check will not be allowed to provide ITFC services. Agencies will be notified if an employee or clinical trainee does not pass the background check. Agencies must provide information on organizational structure and how ITFC services fit into the continuum of care.

Agencies must describe the 24/7 phone availability staffing plan for the service and the agency’s crisis assistance plan and documentation of coordination with local crisis response services. Agencies must create a two-hour ethics training, or documentation of external
education, for all individual clinicians providing ITFC that discusses boundaries relevant to home-based work, working with abused and vulnerable children, having dual roles as therapist and coordinator of services, confidentiality, appropriate touch, and multiple systems work. Agencies will need to create a special informed consent form for this service that describes confidentiality and information sharing within the complexity of working with children, foster families, biological families, placing agents, insurance providers and other systems.

Agencies must also create and submit a mock file that contains the following information:

- Extended Diagnostic Assessment (with a trauma assessment, CASII/ECSII, SDQ, and/or other additional outcome measurements for children ages birth to three)
- Individual treatment plan that is created with a team treatment planning process
- Crisis assistance plan
- Informed consent form
- Service provision contract with county or tribe
- Two weeks of progress notes
- Individual treatment plan review (done at three months of service provision)

In addition to basic certification, individual providers or agencies can get specialty certification demonstrated through a combination of training; education; evidence-based practice certification; child wellness, permanency and mental health outcomes; and history of practice. Specialty certifications will be given in the following domains and posted on the DHS Mental Health Division’s website:

- Early childhood mental health
- Adoption/attachment
- Transition age youth
- African American culturally specific
- American Indian culturally specific
- Dual diagnosis (mental illness and chemical dependency)

Once agencies have state certification, outreach can be done to counties and tribes to work with eligible children who are currently living in family foster care settings. Minnesota Statutes, section 256B.0946 requires that a provider needs both state certification and a “service provision contract” with a county or tribe. For the purposes of this service, a service provision contract shall mean an agreement between the placing agent, tribal representative, foster parent, parent or guardian and child to direct communication and collaboration during the course of ITFC treatment. ITFC providers who are working with children who have both tribal and county involvement must have tribal agreement to the service provision contract.

The service provision contract must be signed by the placing agent, tribal representative, parent, foster parent, child, and ITFC provider describing frequency of team meetings, communication expectations, 24/7 coverage plan, supervisor information, and the process to
resolve disagreements that might materialize during the course of treatment. A sample
service provision contract can be found in Appendix A. Counties or Tribes may require
additional contract terms and conditions.

All clinicians providing services will be required to have certification in Trauma Informed
Child/Parent Psychotherapy (for 0-5) or Trauma Focused Cognitive Behavioral Therapy (for
5-20) by January of 2018.

Recertification

Once agencies have been certified, they will be on a one to three year certification cycle. At
the time of recertification, agencies will need to provide documentation of ethics training
completion. If an employee or clinical trainee’s background study is updated with new
criminal behavior, agencies will be advised immediately to the situation and they will be
dis-enrolled from providing the service. Recertification applications will be approved based
on the following tentative requirements:

- Adherence to employee background checks and ethics training policies
- Certification in evidence-based practices (Trauma Informed Child/Parent Psychotherapy
  or Trauma Focused Cognitive Behavioral Therapy)
- Clinical case documentation standards
- Significant decrease in SDQ scores for children upon discharge
- Decreased use of local crisis and hospital inpatient services during ITFC treatment
- Reduction in out-of-home placement (residential treatment and foster care) days at six
  months and one year post discharge from ITFC.

Billing Rate and Structure:

ITFC is an intensive clinical service that requires 24/7 coverage by a licensed mental health
professional and/or a clinical trainee. In order to provide this service, a clinician needs to
work outside of a traditional outpatient office and be available to clients in crisis beyond
normal business working hours. All appointments (unless documented on a treatment plan)
need to be provided in the foster home, family home, child’s school, day care setting or
other appropriate community based setting.

Clinical services are to be provided to the client group (child, foster parents, foster family,
biological or pre/adoptive family, and anyone who is a part of the child’s permanency plan),
in combination with clinical care consultation to the child’s treatment or service team, for at
least three days a week, totaling six hours of face-to-face treatment time, unless otherwise
described on the treatment plan—especially in relation to transitioning to a different level of
mental health care.

ITFC is a bundled service for MHCP and will be reimbursed at a single day per-client
encounter rate. The single day per-client encounter rate is based on an average of two hours
of clinical service provided each day of service combined with an expectation of phone
consultation and availability for both the client’s family and other service providers and the
need for supervision and consultation within the treatment team. The rate is based on current fee-for-service MHCP rates for similar services (individual and family therapy). Travel time will be submitted along with the ITFC claim. Each single day per-client encounter rate for fee-for-service clients will be $322 (Doctoral rate) along with the provider’s travel time.

Counties should use BRASS code 462 when reporting Intensive Treatment in Foster Care.

**Americans with Disabilities Act (ADA) Advisory**
This information is available in accessible formats for people with disabilities by calling (651) 431-2321 (voice) or toll free at (800) 627-3529 or by using your preferred relay service. For other information on disability rights and protections, contact the agency’s ADA coordinator.
Appendix A

Intensive Treatment in Foster Care
Service Provision Contract Template

Intensive Treatment in Foster Care as defined by Minnesota Statutes, section 256B.0946 is a mental health service eligible for payment under Minnesota Health Care Programs. The following requirements are listed in Minnesota Statutes, section 256B.0946 and described in further detail in the Mental Health Policy Guide and Minnesota Health Care Provider Manual. All providers must have state certification to provide Intensive Treatment in Foster Care and a signed Service Provision Contract with the County or Tribe.

Eligibility Requirements (all must be met):

- Child living in a family foster care setting under the age of 21,
- Has a documentation of a mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20 from a diagnostic assessment within the past 180 days before the start of service,
- Documentation of medical necessity that Intensive Treatment are medically necessary within a foster family setting to treat identified symptoms and functional impairments, and
- A level of care determination conducted by the placing county, tribe or case manager in conjunction with the diagnostic assessment that demonstrates the child requires intensive intervention without 24 hour medical monitoring (or a CASII or ECSII level of 4 or higher).

Covered Services:

All certified providers must have the following service components available for the identified child, foster family, biological family and anyone who may be a part of the child’s permanency plan:

- Psychotherapy (individual, family, group and multi-family group),
- Psychoeducational services (individual, family, group and multi-family group),
- Crisis assistance, and
- Clinical care consultation.

Service Delivery Requirements:

- All services must be delivered by a mental health professional or a clinical trainee, as defined in Minnesota Rules, part 9505.0371,
- Each child receiving treatment services must receive an extended diagnostic assessment within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the child, parent, and mental health
professional agree still accurately describes the child’s current mental health functioning,

• Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible child has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process,

• Each child receiving treatment must be assessed for a trauma history and the child’s treatment plan must document how the results of that assessment will be incorporated into treatment,

• Each child receiving services must have an individual treatment plan that is reviewed, evaluated and signed every 90 days using the team consultation and treatment planning process,

• Each child must have a crisis assistance plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team,

• Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care,

• Location of service delivery must be in the child’s home, day care setting, school or other community-based or office setting that is specified on the child’s individualized treatment plan for particular treatment purposes,

• Treatment must be developmentally and culturally appropriate for the child,

• Services must be delivered in continual collaboration and consultation with the child’s medical providers, and, in particular, with the prescribers of psychotropic medications, including those prescribed on an off-label basis. Members of the service team must be aware of the medication regimen and potential side effects,

• Parents, siblings, foster parents, and members of the child’s permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan, and

• Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child’s permanency plan and post discharge mental health service needs.
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ITFC Provider Agency:

Primary Therapist:

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Backup Therapist:

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Supervisor:

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Roles and Responsibilities:

1) The ITFC Provider or County and Tribe will arrange team treatment planning meetings every _____ weeks and provide _____ days’ notice before the meeting. Each team treatment planning meeting will discuss individual treatment plan goals and objectives with a review of intervention strategy along with the child’s discharge and permanency plan.

- The following plans will be discussed at and reviewed on the following dates:
  - [ ] Out-of-Home Placement Plan
  - [ ] Individual Family Community Support Plan
  - [ ] Child Protective Services Plan
  - [ ] Family Assessment Service Plan
  - [ ] Conditions of Probation
  - [ ] Independent Service Plan
  - [ ] Court Reports

2) Any member of the family or treatment team may request a clinical case conference when there is a disagreement on diagnosis, efficacy and appropriateness of clinical intervention, length of treatment and client’s level of care needs. Any party may call
meetings, consultations or case conferences to optimize and coordinate the care and treatment of the client. All meetings will include the client, parent/guardian and foster parent when clinically appropriate. Based on the severity of the disagreement, supervisors may need to attend clinical case conferences.

3) Voicemails and emails left for ITFC Provider and the County and Tribe will be returned within _____ hours. _____is the back up if the primary worker is unavailable.

4) The ITFC 24/7 phone assistance policy is the following:

5) If there is a change in worker the other parties must be notified within_____.

6) Expected date of discharge from ITFC is ______.

7) Coordination of ongoing services after ITFC

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<th>Coordination Responsibility</th>
<th>Anticipated Start Date</th>
<th>Provider Name &amp; Contact Information</th>
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County or Tribe Signature & Date:

___________________________________________________________

ITFC Provider Signature & Date:

___________________________________________________________

Parent Signature & Date:

___________________________________________________________

Foster Parent Signature & Date:

___________________________________________________________

Child’s Signature & Date:

___________________________________________________________