Amendment Approval Form

CONTRACT AMENDMENT

Contract No. 19DCF0015
Amendment No. 2 of 2
Term of Contract: 07/01/18 to 06/30/23

The Contract between North American Family Institute, Inc.(NAFI Connecticut, Inc.) and the Department of Children and Families which was executed by the parties on 06 / 28 / 18, and subsequently amended on 12/03/18 (1 of 1), is hereby further amended as follows::

1 The total maximum amount payable under this contract is decreased by $677,705.00 from $27,732,680.00 to $27,054,975.00.

2 The increase in funding of $2,268,750.00 is due to the addition of the Multi-Systemic Therapy for Emerging Adults (MST-EA) – Hartford/ Manchester/New Britain Program effective 12/01/18. Services to be provided by the contractor are described on page 3 through page 10 of this amendment.

3 The increase in funding of $2,268,750.00 is due to the addition of the Multi-Systemic Therapy for Emerging Adults (MST-EA) – Bridgeport/Milford/Waterbury Program effective 12/01/18. Services to be provided by the contractor are described on page 11 through page 18 of this amendment.

4 The decrease in funding of (-$5,215,205.00) is due to the removal of the Therapeutic Foster Care Program from the contract effective 07/01/18. The service is paid by invoice in the LINK System. Services to be provided by the contractor are described on page 19 through page 45 of this amendment.

5 The Contractor shall adhere to the approved budget negotiated with the Department, in compliance with Part I, Section E, Clause 3 of the original Contract. The approved budget as modified above consists on page 46 of this Amendment.

6 Refer to Contract Funding Face Sheet, page 2 of 47, for program values by state fiscal year.

All provisions of this contract, except those specifically changed by this Amendment, remain in full force and effect.

PART I. SCOPE OF SERVICES, CONTRACT PERFORMANCE, BUDGET, REPORTS AND OTHER PROGRAM- SPECIFIC PROVISIONS

The Contractor shall provide the following specific services for the 7 program(s) and shall comply with the terms and conditions set forth in this Contract as required by the Agency, including but not limited to the requirements and measurements for scope of services, Contract performance, quality assurance, reports, terms of payment and budget. No sections in this Part I shall be interpreted to negate, supersede or contradict any section of Part II. In the event of any such inconsistency between Part I and Part II, the sections of Part II shall control.

CONTRACT FUNDING FACE SHEET

Provider Legal Name - NAFI Connecticut, Inc.

NOTE: KEEP PROGRAM TYPES TOGETHER FOR PROGRAMS THAT ARE FUNDED FROM MULTIPLE SIDS.

PROGRAM TYPE	TOTAL FUNDING PERIOD	SID *	CFDA#	SFY '19	SFY '20	SFY '21	SFY'22	SFY'23	TOTAL
Therapeutic Group Home- Corbin House	07/01/18-06/30/23	16138	n/a	$ 920,274.00	$ 920,274.00	$ 920,274.00	$ 920,274.00	$ 920,274.00	$ 4,601,370
Therapeutic Group Home- Tress Road	07/01/18-06/30/23	16138	n/a	$ 920,570.00	$ 920,570.00	$ 920,570.00	$ 920,570.00	$ 920,570.00	$ 4,602,850
Multisystemic Therapy (MST)	07/01/18-06/30/23	16116	n/a	$ 687,389.00	$ 687,389.00	$ 687,389.00	$ 687,389.00	$ 687,389.00	$ 3,436,945
Multisystemic Therapy (MST)	07/01/18-06/30/23	16141	n/a	$ 437,850.00	$ 437,850.00	$ 437,850.00	$ 437,850.00	$ 437,850.00	$ 2,189,250
Multisystemic Therapy (MST)- Problem Sexual Behavior-Region 3 & Manchester	07/01/18-06/30/23	16141	n/a	$ 486,043.00	$ 486,043.00	$ 486,043.00	$ 486,043.00	$ 486,043.00	$ 2,430,215
Therapeutic Group Home-Thomaston Group Home	07/01/18-06/30/23	16138	n/a	$ 1,051,369.00	$ 1,051,369.00	$ 1,051,369.00	$ 1,051,369.00	$ 1,051,369.00	$ 5,256,845
Multi-Systemic Therapy for Emerging Adults (MST-EA)-Hartford/Manchester/New Britain	12/01/18-06/30/23	16141	n/a	$ 288,750.00	$ 495,000.00	$ 495,000.00	$ 495,000.00	$ 495,000.00	$ 2,268,750
Multi-Systemic Therapy for Emerging Adults (MST-EA)-Bridgeport/Milford/Waterbury	12/01/18-06/30/23	16141	n/a	$ 288,750.00	$ 495,000.00	$ 495,000.00	$ 495,000.00	$ 495,000.00	$ 2,268,750
Total				$ 5,080,995.00	$ 5,493,495.00	$ 5,493,495.00	$ 5,493,495.00	$ 5,493,495.00	$ 27,054,975

*** SID # SUBJECT TO CHANGED - FOR DCF INTERNAL USE ONLY**

SCOPE OF SERVICES

The Contractor will provide the following specific services for the **Intensive Home Based Services: Multisystemic Therapy for Emerging Adults** program and will comply with the terms and conditions set forth as required by the Department, including but not limited to the requirements and measurements for scope of services, contract performance, quality assurance, reports, terms of payment and budget. No provisions will be contained in this Part I that negate, supersede or contradict any provision of Part II. In the event of any such inconsistency between Part I and Part II, the provisions of Part II will control.

<table>
<tr><th colspan="3">Program Specific Information</th></tr>
<tr><td colspan="2">Contractor Legal Name:

Service Type:
Multisystemic Therapy for Emerging Adults</td><td>Program Name: (if applicable)

MST for Emerging Adults (MST EA) Team 2</td></tr>
<tr><td colspan="2">Towns Served:
All towns served by the Hartford, Manchester, and New Britain Area Offices</td><td>DCF Area Offices Served by program:
☐ Bridgeport ☐ Middletown ☐ Norwich
☐ Danbury ☐ Milford ☐ Torrington
☒ Hartford ☒ New Britain ☐ Waterbury
☒ Manchester ☐ New Haven ☐ Willimantic
☐ Meriden ☐ Norwalk-Stamford ☐ Statewide</td></tr>
<tr><th colspan="3">Program Contact Information</th></tr>
<tr><td colspan="2">Program Contact:
Diane Thompson</td><td>Title:
Project Director</td></tr>
<tr><td>Phone:
860 519-6125</td><td>Fax:
860 284115</td><td>Email Address:
dianethompson@nafi.com</td></tr>
<tr><td colspan="2">Fiscal Contact:
Diana Bennett</td><td>Title:
Business Manager</td></tr>
<tr><td>Phone:
860 284-1177 x 217</td><td>Fax:
860 2841125</td><td>Email Address:
dianabennett@nafi.com</td></tr>
<tr><th colspan="3">Program Site(s) Information</th></tr>
<tr><td colspan="2">Address # 1:
49-51 Wethersfield Avenue, Hartford CT 06106

Address #2:
20 Batterson Park Road, Farmington CT O6032</td><td>Contact Person (Name, Title, Phone, Email)

Diane Thompson, Project Director
860 519 6125 cell
860 284-1125 Fax</td></tr>
</table>

A portion of this program's funding is provided through the Federal Temporary Assistance to Needy Families Block Grant; requirements in Part I, Section D. 5.of this contract apply to this program.

A. DESCRIPTION, CAPACITY AND FUNDING

1. Service Description

Multisystemic Therapy for Emerging Adults (MST-EA) was designed for young people aged 17-21 at the highest risk for negative outcomes – those with multiple co-occurring problems and extensive systems involvement. The Connecticut MST-EA program will serve youth between their 17th and 21st birthdays who (1) are aging out of foster care or involved in the child welfare system and (2) have a behavioral health condition(s) (i.e., serious mental health and/or substance use disorders). The model developers in Oregon will provide Quality Assurance for both MST-EA teams under a separate contract.

2. Contract Capacity

The MST-EA Team 2 will provide **16** slots, serving **33** individuals annually, based upon an average treatment duration of 7-8 months.

3. Third Party Reimbursement

a. The Contractor is required to enroll as a Medicaid provider with the Department of Social Services and to seek to negotiate a reimbursement rate from third party commercial payers for services offered through this contract.
b. The Contractor is expected to bill for third party payment for participants covered by any government or private insurance program.
c. No family will be refused services based on ability to pay and/or insurance coverage.

4. Vouchers for Clients

Budgets must include flex funds of an average $500 per client. This would include funds therapists can use for treatment such as contingency management for substance use, funds the team would use to overcome clients' barriers to achieving goals (e.g., clothing for job interviews), and funds the team's coaches and therapists would use for prosocial activities.

B. SERVICE DELIVERY REQUIREMENTS

1. Target Population

There are 2 MST-EA teams primarily serving separate geographic areas of DCF Area Offices:

- Team 1 will serve the Bridgeport, Milford and Waterbury Area Offices.; and
- Team 2 will serve the Hartford, Manchester and New Britain Area Offices.

The youth referred must be between their 17th and 21st birthdays; aging out of foster care or involved in the child welfare system; and have a serious behavioral health condition(s) (i.e., mental health and/or substance use disorders).

The DCF Area Office identified Gatekeeper (Regional Resource Group staff) will identify appropriate referrals of DCF-involved youth, based upon the current MST-EA Inclusionary and Exclusionary Criteria, who will then be served by the Contractor. The current **MST-EA INCLUSION AND EXCLUSION CRITERIA are:**

Inclusion Criteria (appropriate referrals)

- Youth aged 17-20 years (up to their 21st birthday)
- A current behavioral health condition:
  - Serious mental illness (other than or in addition to Attention Deficit Hyperactive Disorder, Conduct Disorder, or Oppositional Defiant Disorder) and/or
  - Substance use
- Stable housing or plan to achieve stable housing
- DCF involvement at the time of referral

(continued)

Youth *also can* have:

- Justice Involvement
- Physical aggression
- School problems: truancy, suspensions, and/or expulsions
- A trauma/abuse history
- Eligibility for adult mental health or substance abuse services
- May include:
    - Aging out of foster care populations
    - Prison re-entry populations
    - Individuals in supported housing programs
    - Individuals living on their own, with family or friends, in foster care, or in group homes

Exclusion Criteria (inappropriate referrals)

- CANNOT be actively suicidal, homicidal, or psychotic at the time of referral; that is, those who pose an urgent risk and need hospitalization/inpatient treatment prior to safely living in the community. These referrals can be re-considered when release/discharge from hospitalization/inpatient treatment is approaching.
- NO EVIDENCE of stable housing or plan for stable housing in the community. Group homes, foster home, and supervised living can be accepted. Cannot currently be homeless, in a shelter, or couch surfing without a primary address; or in a hospital, locked residential unit, or in detention.
- CANNOT have a significant history or a pattern of problem sexual behaviors.
- CANNOT have Autism, Pervasive Developmental Disorders, or Intellectual Disability that would prevent or limit the effect of psycho-therapeutic treatments.
- CANNOT have pending charges at referral that are likely to require incarceration that would interfere with treatment completion. These referrals can be re-considered when release/discharge from incarceration is approaching.

2. Referral Process

The primary referral source will be DCF Gatekeepers from the Regional Resource Group who will call the MST-EA supervisor directly.

Referrals to outlying towns in the Area Offices' catchment area will be accepted on a case-by-case basis, as negotiated between the referral source and the MST-EA supervisor based upon the availability of a therapist, location of the therapist's other cases, the driving time between them, and other relevant factors.

When needed (because of staff vacancy, location of therapist's other cases, and other relevant reasons), Team 1 therapists can take cases in Team 2's geographic area, and vice versa, in order to serve as many youth as possible.

All MST-EA English forms must be translated into Spanish.

The Contractor will be available to accept assigned clients from referral sources Monday - Friday, 52 weeks per year during routine business hours. The Contractor will accept all clients who meet admission criteria above for MST-EA.

3. **Operating Hours**
The Contractor will incorporate a flexible schedule that accommodates service provision in order to best meet the needs of individuals and families served. In practice, the Contractor will offer flexibly scheduled services that are available to the client individuals and families 24 hours per day 7days per week 365 days per year. As such, services will be provided 52 weeks per year, generally between 8 am to 7 pm Monday to Friday. Weekend hours can be provided depending upon client's needs.

Location	Hours of Operation
49-51 Wethersfield Avenue, Hartford CT 06106	8am – 8 pm with afterhours on-call availability 24 hrs/day,7days/week, 365 days/week

4. Crisis Coverage
The Contractor will provide 24-hour emergency and crisis intervention services to the young adult and their families by phone or pager, and / or home visit, as needed by the client's situation. Weekend and after hours coverage is provided on-call by the MST EA team on a rotating basis.

For youth under 18 (or 19 if she/he is still in school) years of age, the Contractor can contact the local DCF funded mobile crisis services in those cases where the Contractor's services cannot stabilize the crisis situation.

5. Initial and On-going Contact with Individuals and Families
The initial visit with the transition-aged youth client by the MST-EA staff will include, the clinical supervisor and/or MST-EA therapist, and will occur within 72 business hours of referral. The youth will have 24 hours a day, 7 days a week access to the clinical staff from their MST-EA team.

6. Assessment and Individualized Treatment Plan
As determined by the model developers, the Contractor will complete a comprehensive assessment for each individual served through this contract that will result in the formulation of a DSM V diagnosis and an individualized treatment plan. This initial assessment will be completed in 30 days, and revisited again in 90 days, with written progress reports provided to the involved DCF staff.

A licensed clinical supervisor will have oversight over the assessment. The assessment will include a clinical integration of the adults and children in the transition-aged youth's social network, including medical, psychosocial, education and treatment histories. The assessment will address the needs of the transition-aged youth within the context of the social community including the identification of any specialized needs. The Contractor will use all of the assessment and other tools, as required by the MST-EA model protocol.

7. MST EA Treatment Approach
The Contractor will provide standard MST-EA services with the young adult. Clinical services are delivered in home, school, work, and/or neighborhood settings at times convenient to the transition-aged youth. Therapists are available to respond 24 hours a day, 7 days a week.

In addition to core services, the Contractor will implement the following service components specific to the Multi- Systemic Therapy for Emerging Adults (MST-EA) model:
a. treatment of both antisocial behavior & serious behavioral health conditions;

b. engagement and development of the client's naturally occurring Social Network to facilitate sustainability of treatment changes;
c. MST-EA coaches provided by the MST-EA Team;
d. mental health, substance use, and trauma Interventions, including urine drug screens;
e. sustainability planning for housing and independent living skills;
f. development and planning for career goals;
g. improvement of relationship skills;
h. coordination of medical and psychiatric care
i. parenting curriculum (for clients who are pregnant or have children);
j. drug screening generally occurs 1 time per week, with more frequency if needed (i.e., the young adult has a child living with him/her or she is pregnant); and
k. coordinate with psychiatric services in the community. Therapist supports young adult in accessing those services.

8. Training

All new and current MST-EA staff will participate in all required training provided by the model developers, including the following:

a. Supervisors and therapists are required to attend six days of specialized training in the model and complete independent study prior to this in-person training. Supervisors are also required to attend the supervisory training.
b. Supervisors and therapists also participate in bi-annual booster sessions, periodic (as-needed) webinars, weekly on-site clinical supervision for treatment teams, and weekly consultations.
c. Coaches are also required to attend training with the MST-EA Supervisor to understand the treatment families are receiving.

9. Length of Service

The Contractor will formally review and document decision making regarding length of service on a monthly basis. The young adult, his or her DCF social worker, and others as deemed appropriate will be invited to participate in these decisions.

Length of service for the intensive clinical portion of treatment with the therapist will range from 4-12 months (average is 7-8 months) with each young adult, depending upon his or her needs. The maximum length of stay with the MST-EA coach is 14 months.

The clinical services may be extended beyond 12 months with authorization from DCF Clinical Director or his/her designee and the Program Oversight and Development Coordinator.

10. Staffing Model

The Contractor will maintain the following staffing model:

TEAM 2

Position	FTE
Clinical Supervisor	1.0 FTE
MST EA Therapists	4.0 FTE
MST EA Coaches	1.5 FTE

The **Clinical Supervisor** will be a licensed individual with, at minimum, a master's degree in a human services field, and a minimum of three (3) years of experience in the delivery of clinical services.

Therapists will be clinical professionals who have a Masters degree in a behavioral health field, and are licensed or working towards their licensure. New MSW graduates must have passed their initial LMSW exam before they can be hired by the Contractor.

MST EA coaches will have a Bachelor's degree (preferred) and/or lived experience, with some experience working in the human services, social work, psychology or related field. They must have the ability to function as a positive mentor and engage young adults in prosocial, skill building activities.

11. Caseload

Each MST-EA therapist will maintain a caseload of 4 young adults for an annual total of 16 cases per team. For new therapists hired after start-up (i.e. while they are still learning the interventions), the caseload is ramped up to a full caseload of 4 over a 2 month period following their completion of the MST-EA training. The expectation is that therapists will see each client three (3) times a week.

Any client referred to MST-EA who meets the inclusionary criteria and his/her involved family members must be served, regardless of their primary language. It is preferred that at least one staff on the MST-EA team be bilingual for Spanish. If this is not possible, the Contractor will provide translation services for any client or their involved family members who do not have English as their primary language. These translation services must be provided in the setting and at the time where and when the service needs to occur.

12. Supervision and Consultation

The Contractor will participate in the following supervision, consultation and training activities, as required by the MST-EA model:

a. Group supervision and consultation will occur 1 - 2 times a week, each session lasting 1 ½ - 2 hours;
b. Supervisor may have additional consultations each week with a model expert, as needed;
c. Individual supervision occurs on an as-needed basis, as determined by the MST-EA consultant and/or the MST-EA Clinical Supervisor;
d. Supervisor must provide supervision to MST-EA coaches by phone calls or meetings before and after each client session;
e. Initial training in the MST-EA model;
f. Bi-annual booster training;
g. Other team trainings may be more frequent than bi-annual boosters, although more frequent boosters may result in shorter (1/2 day) boosters. This is decided by the model developers who oversee the team(s).
h. Provide information necessary for the TAMs calls to the youth on the caseload. The Therapist Adherence Measures (TAMs) are collected by an outside agency, & determine each therapist's adherence to this MST mode. Monthly phone calls to each family provide answers to questions that determine the model fidelity.
i. Team members will complete any other necessary QA activity required by the MST-EA consultant.

As required by the MST-EA consultants, the Contractor will attend all required meetings, collect required data, provide the necessary reports, participate in interviews, and attend the required training sessions, as referenced above.

13. Linkages to Community Services

The Contractor will develop linkages with the youth and adult community services that will be used by the transition-aged youth clients. These include mental health and substance use services that are funded by

the Department of Mental Health and Addiction Services; programs available through the Department of Public Health and municipal services; services funded by the criminal and juvenile justice systems; housing programs; vocational programs; faith-based services; self-help groups; parent support services; and other programs and services available in the community and/or funded by DCF.

14. Service Linkage, Transition and Closure

Clients will be discharged or stepped down from the MST-EA program when treatment goals and objectives have been met and the client no longer requires the intensive level of intervention initially identified.

The Contractor will attend any DCF-initiated meetings for the clients such as permanency teaming and discharge planning.

The Contractor will develop and implement a step-down or aftercare plan that is understood and supported by the emerging adult client. The step-down portion of MST-EA will mainly be provided by MST-EA coaches, under the supervision of the supervisor. The Contractor will ensure that appropriate linkage with alternative and/or transition services are in place prior to any discharge from services. The transition-aged youth, as well as their referring agencies will be full partners in all discharge planning.

C. DATA AND OUTCOME REPORTING REQUIREMENTS

1. Reporting Requirements

a. The Contractor will submit to the Department of Children and Families the required reports necessary for monitoring and evaluation.

b. The Contractor will submit individual, client level data to the Department's Provider Information Exchange (PIE), or other information system as required by the Department. The Contractor will ensure that the data submitted under PIE, or other system, is in conformance with the applicable data specifications and pick lists. Furthermore, the data must use the conventions and logic as determined by the Department to ensure accurate, unduplicated client counts. This data will, as set forth by DCF, be sent to the Department and/or the Department's designated vendor(s) at an interval specified by DCF.

c. The Contractor will submit MST-EA reports to the MST-EA Expert, such as weekly supervision logs and any other required data/reports.

d. The Contractor will submit monthly written reports to appropriate DCF staff for each case including treatment goals, plans, and progress to date in each area.

e. The therapists will administer and keep up-to-date records of urine drug screens.

2. Outcome Measures

The Contractor will work to achieve the following outcomes:

a. 80% of all youth in the program will be living in the community (a safe and/or sustainable community-based location such as a house, apartment or community group home) at the time of discharge from the program as measured by out-of-home placements and shelter use as per DCF/DMHAS/housing report, when available, and by client self-report and clinician evaluation;

b. 95% of all youth in the program will not be homeless at the time of discharge from the program as measured by client self-report and clinician evaluation;

c. 60% of all youth in the program will be actively enrolled in school during the school year and/or employed in a job at the time of discharge as measured by school or work attendance records and client self-report;

d. 75% of all youth in the program will have no new legal charges during the last two months of MST-EA treatment (not including probation violations), for an offense committed during that time, as measured by official arrest records and client self-report;

e. 85% of all youth in the program will have no new legal charges for drug related offenses during the last two months of MST-EA treatment, for an offense committed during that time, as measured by official arrest records and client self-report;

f. 70% of all youth in the program will be completely abstinent of alcohol and drug use (excluding marijuana/THC and medical marijuana) during the last 30 days of treatment as measured by drug screens, client self-report, and clinical evaluations;

g. 60% of all youth in the program with a documented alcohol and/or drug use history will demonstrate a clear reduction of alcohol and drug (excluding marijuana/THC and medical marijuana) abuse as measured by drug screens, client self-report, and psychiatric evaluations;

h. 60% of all youth in the program with a documented marijuana/THC use history will demonstrate a clear reduction of THC use as measured by urine drug screens, client self-report, and psychiatric evaluations;

i. 70% of all youth in the program with a documented history of mental health problems will demonstrate a clear reduction in mental health symptoms as measured by clinical evaluation, client self-report, and out-of-home placements (not including supported housing);

j. 70% of all youth in the program will improve communication skills and reduce conflict with family, friends, partners, and community members at the time of discharge as measured by clinical evaluation.

k. 65% of all youth in the program will complete treatment with the majority of goals fully met and sustainable as measured by goals completed on the youth's treatment plan;

l. 80% of all youth in the program will complete a course of treatment (mutually initiated ending by client and therapist after a minimum of 4 months treatment) as measured by clinical evaluation.

AG Approval Date: 10/25/18

SCOPE OF SERVICES

The Contractor will provide the following specific services for the **Intensive Home Based Services: Multisystemic Therapy for Emerging Adults** program and will comply with the terms and conditions set forth as required by the Department, including but not limited to the requirements and measurements for scope of services, contract performance, quality assurance, reports, terms of payment and budget. No provisions will be contained in this Part I that negate, supersede or contradict any provision of Part II. In the event of any such inconsistency between Part I and Part II, the provisions of Part II will control.

<table>
<tr><th colspan="3">Program Specific Information</th></tr>
<tr><td colspan="2">Contractor Legal Name:

Service Type:
Multisystemic Therapy for Emerging Adults</td><td>Program Name: (if applicable)

MST for Emerging Adults (MST EA) – Team 1</td></tr>
<tr><td colspan="2">Towns Served:
All towns served by the Bridgeport, Milford and Waterbury Area Offices</td><td>DCF Area Offices Served by program:
☒ Bridgeport ☐ Middletown ☐ Norwich
☐ Danbury ☒ Milford ☐ Torrington
☐ Hartford ☐ New Britain ☒ Waterbury
☐ Manchester ☐ New Haven ☐ Willimantic
☐ Meriden ☐ Norwalk-Stamford ☐ Statewide</td></tr>
<tr><th colspan="3">Program Contact Information</th></tr>
<tr><td colspan="2">Program Contact:
Diane Thompson</td><td>Title:
Project Director</td></tr>
<tr><td>Phone: 860 519 6125</td><td>Fax:
860 284 1125</td><td>Email Address:
dianethompson@nafi.com</td></tr>
<tr><td colspan="2">Fiscal Contact:
Diana Bennett</td><td>Title:
Business Manager</td></tr>
<tr><td>Phone:
860 284 1177 x 217</td><td>Fax:
860 284-1125</td><td>Email Address:
dianabennett@nafi.com</td></tr>
<tr><th colspan="3">Program Site(s) Information</th></tr>
<tr><td colspan="2">Address # 1:
295 Washington Ave, Hamden CT 06518

Address #2:
20 Batterson Park Drive, Farmington CT
Suite 301</td><td>Contact Person (Name, Title, Phone, Email)

Diane Thompson, Project Director
860 519-6125
dianethompson@nafi.com</td></tr>
</table>

A portion of this program's funding is provided through the Federal Temporary Assistance to Needy Families Block Grant; requirements in Part I, Section D. 5. of this contract apply to this program.

A. DESCRIPTION, CAPACITY AND FUNDING

1. Service Description

Multisystemic Therapy for Emerging Adults (MST-EA) was designed for young people aged 17-21 at the highest risk for negative outcomes – those with multiple co-occurring problems and extensive systems involvement. The Connecticut MST-EA program will serve youth between their 17th and 21st birthdays who (1) are aging out of foster care or involved in the child welfare system and (2) have a behavioral health condition(s) (i.e., serious mental health and/or substance use disorders). The model developers in Oregon will provide Quality Assurance for both MST-EA teams under a separate contract.

2. Contract Capacity

The MST-EA Team 1 will provide **16** slots, serving **33** individuals annually, based upon an average treatment duration of 7-8 months.

3. Third Party Reimbursement

a. The Contractor is required to enroll as a Medicaid provider with the Department of Social Services and to seek to negotiate a reimbursement rate from third party commercial payers for services offered through this contract.
b. The Contractor is expected to bill for third party payment for participants covered by any government or private insurance program.
c. No family will be refused services based on ability to pay and/or insurance coverage.

4. Vouchers for Clients

Budgets must include flex funds of an average $500 per client. This would include funds therapists can use for treatment such as contingency management for substance use, funds the team would use to overcome clients' barriers to achieving goals (e.g., clothing for job interviews), and funds the team's coaches and therapists would use for prosocial activities.

B. SERVICE DELIVERY REQUIREMENTS

1. Target Population

There are 2 MST-EA teams primarily serving separate geographic areas of DCF Area Offices:

- Team 1 will serve the Bridgeport, Milford and Waterbury Area Offices.; and
- Team 2 will serve the Hartford, Manchester and New Britain Area Offices.

The youth referred must be between their 17th and 21st birthdays; aging out of foster care or involved in the child welfare system; and have a serious behavioral health condition(s) (i.e., mental health and/or substance use disorders).

The DCF Area Office identified Gatekeeper (Regional Resource Group staff) will identify appropriate referrals of DCF-involved youth, based upon the current MST-EA Inclusionary and Exclusionary Criteria, who will then be served by the Contractor. The current **MST-EA INCLUSION AND EXCLUSION CRITERIA are:**

Inclusion Criteria (appropriate referrals)

- Youth aged 17-20 years (up to their 21st birthday)
- A current behavioral health condition:
  - Serious mental illness (other than or in addition to Attention Deficit Hyperactive Disorder, Conduct Disorder, or Oppositional Defiant Disorder) and/or
  - Substance use
- Stable housing or plan to achieve stable housing
- DCF involvement at the time of referral

(continued)

Youth *also can* have:

- Justice Involvement
- Physical aggression
- School problems: truancy, suspensions, and/or expulsions
- A trauma/abuse history
- Eligibility for adult mental health or substance abuse services
- May include:
    - Aging out of foster care populations
    - Prison re-entry populations
    - Individuals in supported housing programs
    - Individuals living on their own, with family or friends, in foster care, or in group homes

Exclusion Criteria (inappropriate referrals)

- CANNOT be actively suicidal, homicidal, or psychotic at the time of referral; that is, those who pose an urgent risk and need hospitalization/inpatient treatment prior to safely living in the community. These referrals can be re-considered when release/discharge from hospitalization/inpatient treatment is approaching.
- NO EVIDENCE of stable housing or plan for stable housing in the community. Group homes, foster home, and supervised living can be accepted. Cannot currently be homeless, in a shelter, or couch surfing without a primary address; or in a hospital, locked residential unit, or in detention.
- CANNOT have a significant history or a pattern of problem sexual behaviors.
- CANNOT have Autism, Pervasive Developmental Disorders, or Intellectual Disability that would prevent or limit the effect of psycho-therapeutic treatments.
- CANNOT have pending charges at referral that are likely to require incarceration that would interfere with treatment completion. These referrals can be re-considered when release/discharge from incarceration is approaching.

2. Referral Process

The primary referral source will be DCF Gatekeepers from the Regional Resource Group who will call the MST-EA supervisor directly.

Referrals to outlying towns in the Area Offices' catchment area will be accepted on a case-by-case basis, as negotiated between the referral source and the MST-EA supervisor based upon the availability of a therapist, location of the therapist's other cases, the driving time between them, and other relevant factors.

When needed (because of staff vacancy, location of therapist's other cases, and other relevant reasons), Team 1 therapists can take cases in Team 2's geographic area, and vice versa, in order to serve as many youth as possible.

All MST-EA English forms must be translated into Spanish.

The Contractor will be available to accept assigned clients from referral sources Monday - Friday, 52 weeks per year during routine business hours. The Contractor will accept all clients who meet admission criteria above for MST-EA.

3. **Operating Hours**
The Contractor will incorporate a flexible schedule that accommodates service provision in order to best meet the needs of individuals and families served. In practice, the Contractor will offer flexibly scheduled services that are available to the client individuals and families 24 hours per day 7days per week 365 days per year. As such, services will be provided 52 weeks per year, generally between 8 am to 7 pm Monday to Friday. Weekend hours can be provided depending upon client's needs.

Location	Hours of Operation
295 Washington Ave, Hamden CT 06518	8 am -8 pm with after-hours on-call availability 24/per day, 7 days/week, 365 days/year

4. Crisis Coverage
The Contractor will provide 24-hour emergency and crisis intervention services to the young adult and their families by phone or pager, and / or home visit, as needed by the client's situation. Weekend and after hours coverage is provided on-call by the MST EA team on a rotating basis.

For youth under 18 (or 19 if she/he is still in school) years of age, the Contractor can contact the local DCF funded mobile crisis services in those cases where the Contractor's services cannot stabilize the crisis situation.

5. Initial and On-going Contact with Individuals and Families
The initial visit with the transition-aged youth client by the MST-EA staff will include, the clinical supervisor and/or MST-EA therapist, and will occur within 72 business hours of referral. The youth will have 24 hours a day, 7 days a week access to the clinical staff from their MST-EA team.

6. Assessment and Individualized Treatment Plan
As determined by the model developers, the Contractor will complete a comprehensive assessment for each individual served through this contract that will result in the formulation of a DSM V diagnosis and an individualized treatment plan. This initial assessment will be completed in 30 days, and revisited again in 90 days, with written progress reports provided to the involved DCF staff.

A licensed clinical supervisor will have oversight over the assessment. The assessment will include a clinical integration of the adults and children in the transition-aged youth's social network, including medical, psychosocial, education and treatment histories. The assessment will address the needs of the transition-aged youth within the context of the social community including the identification of any specialized needs. The Contractor will use all of the assessment and other tools, as required by the MST-EA model protocol.

7. MST EA Treatment Approach
The Contractor will provide standard MST-EA services with the young adult. Clinical services are delivered in home, school, work, and/or neighborhood settings at times convenient to the transition-aged youth. Therapists are available to respond 24 hours a day, 7 days a week.

In addition to core services, the Contractor will implement the following service components specific to the Multi- Systemic Therapy for Emerging Adults (MST-EA) model:

a. treatment of both antisocial behavior & serious behavioral health conditions;
b. engagement and development of the client's naturally occurring Social Network to facilitate sustainability of treatment changes;
c. MST-EA coaches provided by the MST-EA Team;

d. mental health, substance use, and trauma Interventions, including urine drug screens;
e. sustainability planning for housing and independent living skills;
f. development and planning for career goals;
g. improvement of relationship skills;
h. coordination of medical and psychiatric care
i. parenting curriculum (for clients who are pregnant or have children);
j. drug screening generally occurs 1 time per week, with more frequency if needed (i.e., the young adult has a child living with him/her or she is pregnant); and
k. coordinate with psychiatric services in the community. Therapist supports young adult in accessing those services.

8. Training

All new and current MST-EA staff will participate in all required training provided by the model developers, including the following:

a. Supervisors and therapists are required to attend six days of specialized training in the model and complete independent study prior to this in-person training. Supervisors are also required to attend the supervisory training.
b. Supervisors and therapists also participate in bi-annual booster sessions, periodic (as-needed) webinars, weekly on-site clinical supervision for treatment teams, and weekly consultations.
c. Coaches are also required to attend training with the MST-EA Supervisor to understand the treatment families are receiving.

9. Length of Service

The Contractor will formally review and document decision making regarding length of service on a monthly basis. The young adult, his or her DCF social worker, and others as deemed appropriate will be invited to participate in these decisions.

Length of service for the intensive clinical portion of treatment with the therapist will range from 4-12 months (average is 7-8 months) with each young adult, depending upon his or her needs. The maximum length of stay with the MST-EA coach is 14 months.

The clinical services may be extended beyond 12 months with authorization from DCF Clinical Director or his/her designee and the Program Oversight and Development Coordinator.

10. Staffing Model

The Contractor will maintain the following staffing model:

TEAM 1

Position	FTE
Clinical Supervisor	1.0 FTE
MST EA Therapists	4.0 FTE
MST EA Coaches	1.5 FTE

The **Clinical Supervisor** will be a licensed individual with, at minimum, a master's degree in a human services field, and a minimum of three (3) years of experience in the delivery of clinical services.

Therapists will be clinical professionals who have a Masters degree in a behavioral health field, and are licensed or working towards their licensure. New MSW graduates must have passed their initial LMSW exam before they can be hired by the Contractor.

MST EA coaches will have a Bachelor's degree (preferred) and/or lived experience, with some experience working in the human services, social work, psychology or related field. They must have the ability to function as a positive mentor and engage young adults in prosocial, skill building activities.

11. Caseload

Each MST-EA therapist will maintain a caseload of 4 young adults for an annual total of 16 cases per team. For new therapists hired after start-up (i.e. while they are still learning the interventions), the caseload is ramped up to a full caseload of 4 over a 2 month period following their completion of the MST-EA training. The expectation is that therapists will see each client three (3) times a week.

Any client referred to MST-EA who meets the inclusionary criteria and his/her involved family members must be served, regardless of their primary language. It is preferred that at least one staff on the MST-EA team be bilingual for Spanish. If this is not possible, the Contractor will provide translation services for any client or their involved family members who do not have English as their primary language. These translation services must be provided in the setting and at the time where and when the service needs to occur.

12. Supervision and Consultation

The Contractor will participate in the following supervision, consultation and training activities, as required by the MST-EA model:

a. Group supervision and consultation will occur 1 - 2 times a week, each session lasting 1 ½ - 2 hours;
b. Supervisor may have additional consultations each week with a model expert, as needed;
c. Individual supervision occurs on an as-needed basis, as determined by the MST-EA consultant and/or the MST-EA Clinical Supervisor;
d. Supervisor must provide supervision to MST-EA coaches by phone calls or meetings before and after each client session;
e. Initial training in the MST-EA model;
f. Bi-annual booster training;
g. Other team trainings may be more frequent than bi-annual boosters, although more frequent boosters may result in shorter (1/2 day) boosters. This is decided by the model developers who oversee the team(s).
h. Provide information necessary for the TAMs calls to the youth on the caseload. The Therapist Adherence Measures (TAMs) are collected by an outside agency, & determine each therapist's adherence to this MST mode. Monthly phone calls to each family provide answers to questions that determine the model fidelity.
i. Team members will complete any other necessary QA activity required by the MST-EA consultant.

As required by the MST-EA consultants, the Contractor will attend all required meetings, collect required data, provide the necessary reports, participate in interviews, and attend the required training sessions, as referenced above.

13. Linkages to Community Services

The Contractor will develop linkages with the youth and adult community services that will be used by the transition-aged youth clients. These include mental health and substance use services that are funded by the Department of Mental Health and Addiction Services; programs available through the Department of Public Health and municipal services; services funded by the criminal and juvenile justice systems; housing

programs; vocational programs; faith-based services; self-help groups; parent support services; and other programs and services available in the community and/or funded by DCF.

14. Service Linkage, Transition and Closure

Clients will be discharged or stepped down from the MST-EA program when treatment goals and objectives have been met and the client no longer requires the intensive level of intervention initially identified.

The Contractor will develop and implement a step-down or aftercare plan that is understood and supported by the emerging adult client. The step-down portion of MST-EA will mainly be provided by MST-EA coaches, under the supervision of the supervisor. The Contractor will ensure that appropriate linkage with alternative and/or transition services are in place prior to any discharge from services. The transition-aged youth, as well as their referring agencies will be full partners in all discharge planning.

C. DATA AND OUTCOME REPORTING REQUIREMENTS

1. Reporting Requirements

a. The Contractor will submit to the Department of Children and Families the required reports necessary for monitoring and evaluation.

b. The Contractor will submit individual, client level data to the Department's Provider Information Exchange (PIE), or other information system as required by the Department. The Contractor will ensure that the data submitted under PIE, or other system, is in conformance with the applicable data specifications and pick lists. Furthermore, the data must use the conventions and logic as determined by the Department to ensure accurate, unduplicated client counts. This data will, as set forth by DCF, be sent to the Department and/or the Department's designated vendor(s) at an interval specified by DCF.

c. The Contractor will submit MST-EA reports to the MST-EA Expert, such as weekly supervision logs and any other required data/reports.

d. The Contractor will submit monthly written reports to appropriate DCF staff for each case including treatment goals, plans, and progress to date in each area.

e. The therapists will administer and keep up-to-date records of urine drug screens.

2. Outcome Measures

The Contractor will work to achieve the following outcomes:

a. 80% of all youth in the program will be living in the community (a safe and/or sustainable community-based location such as a house, apartment or community group home) at the time of discharge from the program as measured by out-of-home placements and shelter use as per DCF/DMHAS/housing report, when available, and by client self-report and clinician evaluation;

b. 95% of all youth in the program will not be homeless at the time of discharge from the program as measured by client self-report and clinician evaluation;

c. 60% of all youth in the program will be actively enrolled in school during the school year and/or employed in a job at the time of discharge as measured by school or work attendance records and client self-report;

d. 75% of all youth in the program will have no new legal charges during the last two months of MST-EA treatment (not including probation violations), for an offense committed during that time, as measured by official arrest records and client self-report;

e. 85% of all youth in the program will have no new legal charges for drug related offenses during the last two months of MST-EA treatment, for an offense committed during that time, as measured by official arrest records and client self-report;

f. 70% of all youth in the program will be completely abstinent of alcohol and drug use (excluding marijuana/THC and medical marijuana) during the last 30 days of treatment as measured by drug screens, client self-report, and clinical evaluations;

g. 60% of all youth in the program with a documented alcohol and/or drug use history will demonstrate a clear reduction of alcohol and drug (excluding marijuana/THC and medical marijuana) abuse as measured by drug screens, client self-report, and psychiatric evaluations;

h. 60% of all youth in the program with a documented marijuana/THC use history will demonstrate a clear reduction of THC use as measured by urine drug screens, client self-report, and psychiatric evaluations;

i. 70% of all youth in the program with a documented history of mental health problems will demonstrate a clear reduction in mental health symptoms as measured by clinical evaluation, client self-report, and out-of-home placements (not including supported housing);

j. 70% of all youth in the program will improve communication skills and reduce conflict with family, friends, partners, and community members at the time of discharge as measured by clinical evaluation.

k. 65% of all youth in the program will complete treatment with the majority of goals fully met and sustainable as measured by goals completed on the youth's treatment plan;

l. 80% of all youth in the program will complete a course of treatment (mutually initiated ending by client and therapist after a minimum of 4 months treatment) as measured by clinical evaluation.

AG Approval Date: 10/25/18

Scope of Services

The Contractor shall provide the following specific services for the **Therapeutic Foster Care** program and will comply with the terms and conditions set forth as required by the Department, including but not limited to the requirements and measurements for scope of services, contract performance, quality assurance, reports, terms of payment and budget. No provisions shall be contained in this Part I that negate, supersede or contradict any provision of Part II. In the event of any such inconsistency between Part I and Part II, the provisions of Part II shall control.

<table>
<tr><th colspan="3">Program Specific Information</th></tr>
<tr><td colspan="2">Contractor Legal Name:
NAFI Connecticut, Inc.
Service Type:
Therapeutic Foster Care</td><td>Program Name: (if applicable)
Professional Parent Program</td></tr>
<tr><td colspan="2">Towns Served:
Statewide</td><td>DCF Area Offices Served by program:
☐ Bridgeport ☐ Middletown ☐ Norwich
☐ Danbury ☐ Milford ☐ Torrington
☐ Hartford ☐ New Britain ☐ Waterbury
☐ Manchester ☐ New Haven ☐ Willimantic
☐ Meriden ☐ Norwalk-Stamford ☒ Statewide</td></tr>
<tr><th colspan="3">Program Contact Information</th></tr>
<tr><td colspan="2">Program Contact:
Elizabeth Sitler</td><td>Title:
Director of Foster Care Services</td></tr>
<tr><td>Phone:
203-509-0483</td><td>Fax:
860-284-1125</td><td>Email Address:
lizsitler@nafi.com</td></tr>
<tr><td colspan="2">Fiscal Contact:
Diana Bennett</td><td>Title:
Business Manager</td></tr>
<tr><td>Phone:
(860-284-1177</td><td>Fax:
(860) 284-1125</td><td>Email Address:
DianaBennett@nafi.com</td></tr>
<tr><th colspan="3">Program Site(s) Information</th></tr>
<tr><td colspan="2">Address # 1:
Hartford Square West
75 Charter Oak Street, Suite 1-305
Hartford, CT 06106</td><td>Contact Person (Name, Title, Phone, Email)
Elizabeth Sitler, Program Director
860-560-7324; lizsitler@nafi.com</td></tr>
</table>

A. DESCRIPTION, CAPACITY AND UNIT OF SERVICE

1. Definitions

a. "SED" refers to a child/youth that has one or more mental disorders as identified in the most recent edition of the *DSM,* other than a primary substance use disorder or developmental disorder, that results in behavior that is inappropriate to the child's age according to expected developmental norms and meets one or more of the following criteria: as a result of the mental disorder, the child has substantial impairment in at least two of four areas: self-care, school functioning, family relationships, or ability to function in the community; the child is at risk of removal from the home or has already been removed from the home; the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; the child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder; or the child meets special education eligibility requirements.

b. "At Risk" includes, but is not necessarily limited to: a child's diagnosis; disruptive behaviors in home, school and/or community-settings; suicidal or homicidal thoughts; self-mutilation; sexual acting out; running away; substance use; and/or challenges with activities of daily living due to behavior.

2. Service Description

Therapeutic Foster Care (TFC) is an intensive, structured, clinical level of care provided to children with serious emotional disturbance (SED) within a safe and nurturing family environment. Children in TFC receive daily care, guidance, and modeling from specialized, highly trained, and skilled foster parents. TFC families receive support and supervision from private foster care agencies with the purpose of stabilizing and/or ameliorating a child's mental/behavioral health issues, facilitating children's timely and successful transition into permanent placements (e.g., reunification, adoption, or independent living), and achieving individualized goals and outcomes based upon a comprehensive, multifocal care plan.

3. Contract Catchment and Capacity

The Contractor will serve children Statewide. Referrals will be approved by The Department's Regional Foster Care and Adoption Services Unit (FASU) and received from designated Service Area Lead Agencies (SALAs). The Contractor shall be expected to maintain capacity to serve a minimum of **37** TFC level children at any given point in time.

4. Funding

a. Per Diem

The Contractor will be paid a per diem rate for each TFC assessed and identified child. A letter specifying the total per diem payment and the required distribution of that payment will be issued at the time of contract execution. The TFC family per diem is to cover and include all expenses set forth in DCF Policy 36-55-25.4, unless otherwise specified.

At least ten dollars ($10.10) of the Contractor's portion of the per diem payment for each child must be set aside to purchase wrap-around services for that child. The Contractor shall accrue these funds to a separate account upon receipt of monthly payments from the Department. In recognition of varying lengths of placement and varying needs among the children, expenses from this account need to average $10.10/day/child. The

Contractor shall maintain an accounting flow report that shows the name of each child in placement, number of days in care each month, the amount deposited for that child and the date, amount and payee for each expenditure on behalf of that child. This report shall be aggregated for each child and provided to the Department on a quarterly basis. An annual compilation based on State Fiscal Year shall be submitted no later than July 15.

The TFC rate shall only apply to children entering care who are assessed by the Department to meet the eligibility criteria for TFC. The Contractor shall receive a per diem administrative rate for foster children placed in the TFC program who do not meet the eligibility criteria for this service (e.g., siblings who are not SED and relatives). The TFC family shall receive a regular DCF foster care per diem rate for any non-clinical foster child placed in their home to cover board and care. This regular DCF foster care per diem rate will be consonant to the child's age (i.e., 0-5, 6-11 or 12 and older).

Finally, the per diem rate to the Contractor may be adjusted during the contract period to include COLA increases or pass through modifications. Per diem rates are established by the Commissioner of DCF or his/her designee.

b. Payment Terms

Retrospective monthly payments, based upon invoices submitted by the Contractor for the placements active in the previous month, will be made through the DCF LINK system. The Contractor is solely responsible for the timely accurate submission of invoices upon the format approved by the Department. The Department reserves the right to recoup any overpayment identified at any time after payment has been made.

c. Over-night Pre-Placement Visits for Children transitioning from a Residential Setting or Hospital

With prior approval from the Therapeutic Foster Care Liaison (TFCL) or a FASU Manager, each pre-placement over-night visit that a child has, the Contractor shall be reimbursed at the standard TFC per diem rate minus the $10.10 wraparound amount. Each overnight visit must be of (12) or more continuous hours spanning between two calendar dates (e.g., visiting starting at 5pm on May 1, ending at 9am on May 2). Foster Parents will also be reimbursed at the standard per diem rate for each overnight visit.

d. Payments While a Child is Hospitalized

The Contractor may be reimbursed for up to 14 days at the full per diem rate while a child is hospitalized, in a sub-acute/ Psychiatric Residential Treatment Facility, in a crisis stabilization bed, or other setting that would constitute a dual placement, if there has been an agreement that the child will be returning to the same foster home or another appropriate therapeutic foster family resource has been immediately identified. This "up to 14 days" arrangement must be approved by a FASU and CPS Manager. Additional days will be considered on a case-by-case basis and must be approved by the DCF System or Clinical Program Director, or his/her designee(s). Requests that are seeking reimbursement for a child who is or will be in a dual placement beyond 29 days shall require authorization by the DCF Regional Administrator, or his/her designee.

In order to potentially approve the proposed dual placement arrangement, the Contractor will be required to submit a detailed Dual Placement form to the FASU Manager by the 10th day of hospitalization if it appears likely that hospitalization beyond 14 days will be needed. That plan shall evidence the activities and types of and frequency for contact by the TFC agency and the foster family while the child is hospitalized. The TFC agency

shall also set forth the position(s) that will be providing the identified activities. In addition, the Contractor shall be required to engage in the normally expected visitation, contact, and support requirements for the foster child and the foster family as set forth in this contract. This shall include, but is not limited to, fulfilling the required visits to the foster home, contact with collaterals, submission of progress summaries to the child's DCF social worker, and complying with client level data collection requirements.

DCF reserves the right to adjust/reduce the per diem that the Contractor and foster family receives consonant with those identified activities. The Department also has the right to pay the Contractor, including their foster family, on an hourly basis rather than a per diem based upon the information in the final, DCF FASU approved Dual Placement Support Plan.

B. SERVICE DELIVERY REQUIREMENTS

1. Licensure

The Contractor shall maintain licensure as a Connecticut Child Placing Agency (CPA). The Contractor, their staff, sub-Contractors, and agents must comply with all federal, state and local statutes, regulations, codes, ordinances, certifications and/or licenses applicable to a fully executed TFC contract and program. Failure to maintain licensure in good standing as a CPA in Connecticut may result in termination of this contract.

2. Cross Contractor Partnerships

The Contractor shall work collaboratively with the other TFC providers in their region and those across the state. This shall include the Contractor working in partnership with other CPAs and the Department with respect to joint foster family recruitment and retention, cultural and linguistic competency, and cross agency training opportunities. The Contractor will participate in activities such as workgroups intended to inform TFC system improvements. This shall also include participation in the development of an integrated web-based portal regarding foster care information, and a single, cross provider training calendar.

The Contractor shall participate in the established SALA structure and shall partner with their designated SALA(s), which shall serve in a TFC referral distribution, TFC catchment quality assurance and leadership role. This will include making ongoing timely payments to an identified fiduciary to support SALA functions. The amount of the Contractor's financial contribution will be determined based on a formula using utilization data. Frequent failure of the Contractor to make full and timely payments to the SALA, as determined by the Department, will require corrective actions and could result in loss of contracted capacity or contract termination. The Contractor will sign all necessary releases to support the sharing of information with and from the SALAs.

The Contractor shall share all program service, foster home, recruitment, retention, training, quality assurance, statistical and other information with the identified Area Office and Central Office designee/s to support the oversight of the effectiveness of TFC services within their identified catchment area. The Contractor will share Information about foster home recruitment, training, licensing and capacity as needed with the SALAs.

The Department will initiate and oversee any corrective action activities arising due to non-compliance on the part of the Contractor with the elements in this Contract. The Contractor shall work with the Department to develop and carry out, as necessary, any corrective action plans.

3. Target Population

Children, ages 6-17, with SED and complex behavioral health care needs who require placement outside of their home and who are at risk of placement in a more restrictive placement setting are eligible for TFC services. These will be children who have multiple systems involvement and require services from multiple agencies. They may have experienced numerous placement failures due to a serious diagnosis and/or behavioral issues that require treatment. Their mental, behavioral, or emotional disorders will have resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities. The Contractor shall also place and serve adolescents with SED who are pregnant and/or parenting young children.

Youth over the age of 17 may, if determined appropriate and necessary by the Department, remain in TFC through age 23 if they are still in school or in a work program. The Contractor must demonstrate that they and their proposed TFC home have early childhood mental health training and expertise.

Children under age six are not within the target population for this service and may not be categorized as or placed in TFC, or funded at a TFC rate, unless determined eligible and approved by the DCF Regional Administrator or his/her designee(s). They may, however, be placed at the regular DCF foster care plus administrative rate, in a TFC home with a sibling aged 6 or older who requires this intensive level of care.

4. Length of Service

TFC is intended to be time-limited, concluding with reunification, adoption, transfer of guardianship, or independent living. Children's length of stay in TFC, however, will be based upon their individual needs, clinical progress, and permanency goals. The Contractor shall, in partnership with a child's DCF social worker; the child, foster parents; birth family; and other core service providers develop a care plan and engage in permanency teams that aggressively seek to support the child's receipt of and/or timely transition into the most normative and least restrictive permanent care setting possible. The Contractor shall document on a quarterly basis in each child's case record its efforts and concrete plans (e.g., actions and time-frames) to facilitate their expeditious transition to permanent care settings.

5. Referrals

All referrals for TFC will be vetted through DCF's area office. The designated Therapeutic Foster Care Liaison (TFCL) will gate-keep all referrals to this service, including those identified as emergencies. The TFCL will submit the referral to the SALA assigned to their Region. The Contractor shall accept referrals from the SALA, including TFC-E and Statewide TFC referrals in order to support the timely match and placement of all referred children/youth.

The TFC referral form will provide the Contractor with background and clinical information about the TFC eligible child. The Contractor shall review this form and any other submitted material to assist with the timely identification of an appropriate home to meet the needs of the identified child. The Contractor will respond to the SALA promptly, but in not more than five (5) business days, ideally less, to indicate whether they are able to offer a family as a potential match or not. Frequent failure of the Contractor to respond timely to a referral, as determined by the Department, will require corrective actions and could result in loss of contracted capacity or contract termination.

The Contractor shall routinely accept referrals for possible emergency placement into their TFC homes. An "emergency placement" is defined as a referral that requires immediate or up to a 48 hour placement. Examples of children who meet the criteria for an emergency placement include, but are not limited to: Children or youth who are under a 96 Hour Hold, Orders of Temporary Custody (OTC's), and Bench OTC's. Disruptions from CORE and TFC foster homes where another placement is needed within 48 hours, and children or youth who are discharged from a hospital, residential, or group care setting that meet the TEI requirements and require a foster care placement within 48 hours.

The Contractor will attend weekly referral meetings convened by the SALA for those Regions that they are committed to serving.

DCF area office TFC referral discussion meetings, while not required, may also be held. These meetings (e.g., Managed/Integrated Service System or TFC Network meetings) may include participation from other community providers as a means to aid with comprehensive, child specific planning. The Contractor will be required to attend these area office meetings, congruent with their designated catchment area(s). The Contractor shall be prepared to discuss potential matches for the presented children, including having completed the Foster Family Profile form. Such meetings, however, shall not delay the processing, review or matching of any referral. The inability of DCF staff to attend or participate in such meetings shall not delay or impede the timely match of any TFC referral.

6. Rejections and Ejection

The Contractor shall be able to match and place referred children in a timely manner. High numbers of referral rejections by the Contractor, as determined by the Department, will result in corrective actions and could result in a loss of contracted capacity or contract termination. In the event that a child is unable to be maintained in their TFC home, the Contractor will be expected to identify another suitable TFC home for that child within their existing pool of families. They will also be expected to partner with the SALA assigned to the Region where the child's case is served. As needed, the Contractor will also partner with other SALAs and TFC agencies to identify potential resources within the therapeutic foster care network as needed. While the Contractor shall notify the child's DCF social worker, the TFCL and any other designated DCF regional office staff of any actual or potential disruptions, the Contractor shall not, however, expect DCF to identify an alternate foster care resource. The Contractor shall closely monitor all placements. Should the Contractor determine that a placement is in jeopardy, it shall immediately seek to convene a permanency team meeting with the child's team inclusive of the DCF worker, the foster family, the TFCL, any other designated DCF regional office staff, other key collaterals, natural supports, and the child, to devise a plan in collaboration with the area office, to preserve the placement or identify other viable options should the placement disrupt.

If a TFC family insists on the removal of a child against the advice of the Contractor and DCF, the family will not be considered for any new placement until an acceptable corrective plan that better enables them to care for TFC level children is developed and implemented. High numbers of disrupted placements, as determined by the Department, will require corrective actions and could result in loss of contracted capacity or contract termination.

7. Matching and Child Specific Recruitment

The Contractor shall ensure the recruitment of a sufficient number and diverse pool of foster homes both to meet the Department's Regional and Statewide needs for foster homes and to enable the best possible matches

between children and TFC families. The Contractor shall be responsible for obtaining and reviewing all necessary information to ensure a good fit between a referred child and their foster parent(s).

The Contractor must ensure that the needs, preferences, and wishes of the individual children to be served are taken into consideration when a match decision is being made. Meeting with, engaging, discussing and surveying of the individual child and birth families, as appropriate, to aid with a match to the most appropriate and effective placement resource shall occur. Similarly, the Contractor will actively engage foster parents in the match process. Foster families are to have an opportunity to dialogue about and have their informational needs addressed by or through the Contractor to ensure a successful match. The Contractor will be required to share relevant information (e.g., Foster Family Profile) that may assist with successful match making.

The Contractor must identify and communicate to the SALA the availability of a match within five (5) business days from the date in which the referral is submitted. For emergency placement requests, a response must be generated the same day, or as congruent with the designated time frame needed for placement.

The Contractor will also engage in child specific recruitment and family search and engagement to further support the development of a child's permanency team. As the Department will be referring children with specialized clinical and other care needs, the Contractor may be required to find homes that are or can be tailored to the particular needs of a given child. The Contractor shall discuss the need for and receive approval from the child's CPS staff, the TFCL, or other designated DCF area office staff to begin a child specific recruitment.

8. Pre-Placement Visits and Placement

As part of the matching process and as a means to support an effective and stable transition into a TFC family setting, the Contractor shall ensure that pre-placement visits occur. The Contractor will facilitate the following types and numbers of pre-placement events for all children accepted into their service, except as waived by the FASU Manager in the event of an emergent placement:

a. one or more Informal meeting(s) (e.g., casual meeting as part of a group event, activity, etc.);
b. at least 3 day visits (3 hours or more in duration). Day visits can include but are not limited to, visits in the home, community, and congregate care setting;
c. at least 1 over-night stay. The Contractor shall be reimbursed at the standard TFC per diem rate minus the $10.10 wraparound amount for each over-night pre-placement visit. Each overnight visit must be of (12) or more continuous hours. Foster Parents will also be reimbursed at the standard per diem rate for each overnight visit;
d. additional day visits (of at least 3 hours or more in duration) will be reimbursed at half of the foster parent's per diem rate and half of the per diem administrative rate minus the $10.10 wraparound amount.
e. Foster Parents may be reimbursed for transportation costs for travel that exceed a 25 mile radius with the approval of the FASU or CPS Manager. The reimbursement rate will be set at the established government rate.

Children's birth families are (except where a safety issue is present) to be integrated into pre-placement visitations as a means to establish their meaningful involvement at the inception of placement into the therapeutic foster care programming.

Children shall be placed with a suitable foster family within 45 calendars days from the date in which the referral is received by the TFC agency.

9. Waivers

The Contractor shall be limited to placing only one TFC level child/youth into each foster home. The placement of siblings and kinship placements will be an exception to this requirement. Although a waiver is not formally required for kin placements, notification of the placement must be given to the FASU PM and CPS chain of command assigned to all of the children placed in the home, within 24 business hours of placement. The Contractor shall initiate a discussion with the area office CPS staff to ensure that the needs of all children in the home are being met and to develop of service provision plan if necessary. A service provision plan should include any wraparound and support services to best preserve and monitor all of the children in the home.

The Contractor may apply for a waiver to allow an additional non-related, TFC level child to be matched to a home with a current placement. The application for such a waiver is expected to be infrequent; reserved for additional placement into well experienced foster homes that have a demonstrated history of successful and stable placements, cooperation with DCF, and the requisite skills and training to ensure high level outcomes for all children in or to be placed into the home. Waiver requests to place more than one TFC level child are submitted to the area office Regional Administrator.

10. Service Domains

a. **Recruitment and Retention**

The Contractor shall recruit and maintain a pool of foster homes sufficient to meet the identified contract service capacity. The Contractor shall develop and implement an annual recruitment and retention plan. That plan must be submitted to the Office for Children and Youth in Placement (O'ChYP) for review and approval no later than July 1 of each year. The Contractor must ensure that the plan is data driven and, at a minimum, articulates the number of families to be recruited and maintained, demographic and geographic goals, activities, resources, and person(s) responsible for achieving the established recruitment and retention goals. The Contractor's agency specific recruitment and retention plan shall be developed as informed by and congruent with the applicable regional TFC recruitment and retention plan.

The Contractor will also partner with O'ChYP, the DCF Area Offices, and other TFC providers to support the collaborative recruitment and retention of foster families, contributing to the identified annual total statewide TFC family net increases as set forth by O'ChYP. The Contractor will also utilize marketing and branding materials as identified by the Department.

In addition to general recruitment efforts, the Contractor shall engage in targeted recruitment and child specific tasks which will include the following responsibilities:

i. Develop and implement a child-specific recruitment plan for each assigned child;
ii. Participate in child and family permanency team meetings including, but not limited to: ice breakers, round tables, and individual, joint, and large team meetings;
iii. Intensive recruitment and engagement activities and application of extreme recruitment tools to discover and identify potential resources (e.g., case mining, record reviews, family finding tools, Lexis Nexis);
iv. Actively recruit permanent resources for assigned children including individuals connected to the child, biological relatives, families seeking to adopt, and any other resource that may lead to permanency for the child;

v. Facilitate public relations efforts to recruit and match potential families and children;
vi. Conduct initial interviews with clients interested in adopting a waiting child;
vii. Monitor successful recruitment efforts as well as stay up to date on recruitment campaigns locally and nationally;
viii. Establish relationships with referred children and maintain collaborative relationships with social workers, case managers, therapists and other members of case management teams;
ix. Attend training and consultation opportunities and implement models such as 3,5,7 permanency model, intensive search and engagement, and extreme recruitment;
x. Support and partner with the Department in efforts to determine child's strengths, challenges and preparedness for adoption.

Child Specific Permanency Placement Services Program (PPSP) contracts may, at the discretion of the Department, be entered into with the Contractor to compensate them for extraordinary child specific recruitment campaigns that exceed the caseload capacity of the recruiter. Approval from the DCF Regional Administrator, or his/her designee(s) must be obtained in order to enter into a PPSP agreement. Denial of a request to enter into a PPSP contract will not alleviate the Contractor from engaging in child specific recruitment.

b. **Pre and Post Licensing Training**

The Contractor shall ensure that prospective and licensed TFC parents receive intensive preparation and training in order to meet the specialized and complex needs of the children to be served in their home. They must receive at least 37 hours of training before a child is placed into their home. Thirty (30) of these hours are required to come from the provision of the Model Approach to Partnerships in Parenting (MAPP) curriculum. Under exceptional circumstances, group training may be supplemented with individual training using the "Deciding Together" MAPP training curriculum that comports with the same number of required hours.

Prospective foster parents must receive an additional seven (7) hours of training that serve to enhance their skills and knowledge regarding the clinical and therapeutic needs of the children that will be placed in their care. In households where there are two adult caregivers, the secondary foster parent (i.e., Foster Parent 2) has the same licensing requirements as Foster Parent 1.

TFC families will also complete no less than twenty eight (28) hours of post-licensing training per year. At least 80% of those TFC training hours (i.e., 22.4 hours) are to directly pertain to enhancing the clinical knowledge, skills and expertise of the foster families. At least 12 of those 22.4 hours must be training specific to the clinical presentation and/or diagnosis of the individual child(ren) in the home.

Through pre and post licensing training, foster parents shall receive instruction and professional development in areas including, but not limited to the following:

a. DCF organizational structure and chain of command;
b. mandated reporting;
c. special needs of children in therapeutic foster care (sexual abuse issues, understanding emotional disturbance, medication management, educational and vocational needs);
d. the importance and impact of permanency
e. attachment issues;
f. problem solving;

g. navigating the service system;
h. advocacy;
i. basics of mediation;
j. the family's role in the permanency team;
k. the impact of trauma on children and families
l. working with and supporting birth families;
m. Learning Inventory of Skills Training (LIST);
n. Domestic Minor Sex Trafficking;
o. overview of children's mental and behavioral health (including substance use);
p. separation and loss issues;
q. philosophy and characteristics of a Systems of Care/Wraparound Approach;
r. childhood and adolescent development (including sexuality);
s. crisis prevention, de-escalation, and intervention;
t. unconditional care;
u. behavioral management.

The Contractor shall maintain documentation (e.g., training attendance policy, training topics, training hours, pre and post test results, attendance sheets, name and qualifications/credentials of trainers) evidencing each licensed families' satisfactory completion of all pre and post licensing training requirements. In addition, the Contractor shall regularly review post test results and service provision information (e.g., case notes, DCF Special Investigation Unit reports, Case Review reports, program data and Assessment of Regulatory Compliance reports, etc.); and engage in no less than annual surveying of their foster parents and foster children to assess the types of training that needs to be provided to their families.

The Contractor shall also develop and submit to O'CHYP for approval an annual training plan. This plan shall be informed by the training requirements set forth in this contract and the training needs of their foster care families as identified by the Contractor's review of service provision information, foster parent/child surveying and post test results. Finally, the training plan must be received by July 15 of the preceding state fiscal year (e.g., the SFY 2020 plan shall be submitted to O'CHYP by July 15, 2019).

c. Foster Home Licensing and Re-approval

The Contractor shall license foster homes pursuant to applicable DCF regulations, policies, DCF TFC contract language, and state and federal law. The Contractor will engage in rigorous assessments, including but not limited to development of a thorough home study, using the format prescribed by O'CHYP, and comprehensive criminal, child protection, sexual offender, motor vehicle and other background checks of all foster care applicants, their household members ages 16 and older, and substitute caregivers. The Contractor must receive a waiver from the DCF Commissioner or his/her designee in order to dually license homes (e.g., extend a TFC license to homes that already hold a license as a day care and/or a resource home/family for the Department of Developmental Services).

Foster homes' licenses are to be renewed biennially. In addition to reassessments and reviews related to possible license renewal (e.g., review the entire record, taking note of Careline reports, critical incidences, and the parent(s) participation in training, etc.), the Contractor shall engage in continuous assessment, supervision of and support for the homes it licenses. The Contractor must ensure the timely renewal of all licenses in homes

in which foster children are placed and must ensure a home is fully licensed before a child is placed. The Contractor shall use the DCF identified mechanism(s) and form(s) (e.g., 720 form) for the submission and processing of TFC approved homes into the DCF LINK system. Failure to maintain full, non-lapsed, licensure of TFC homes in which a DCF foster child is placed may result in corrective actions, including potential termination of the contract.

d. Significant Events and Critical Incidences

Extensive documentation of the routine support provided to licensed foster families, and any necessary interventions, will be maintained by the Contractor. The Contractor will also contact the appropriate DCF entities (e.g., Careline, DCF social worker, and O'CHYP) when significant and critical incidents involving their licensed foster families, and/or the DCF children under their care occur.

The Contractor shall also ensure their full cooperation with any DCF investigations. The Contractor will make available any staff and/or records deemed necessary by the Department to aid in their completion of abuse and/or neglect investigations. The Contractor will not notify an involved TFC family with respect to or discuss any open investigations unless expressly authorized by DCF's Special Investigation Unit (SIU).

In addition, the Contractor shall assess and document any identified regulatory concerns, violations, or other significant events (e.g., numerous Careline reports or unsubstantiated allegations) using the Assessment of Regulatory Compliance (ARC) form. The completed ARC shall be submitted by the Contractor to the O'CHYP's TFC Program Development and Oversight Coordinator or designee/s.

The ARC shall comprehensively, thoroughly and accurately set forth the Contractor's assessment of the event, findings, recommendations, and action steps for correction/amelioration or abatement of the issue. The ARC will articulate the persons responsible for completing the identified actions, time-frames for completion, including the mechanisms that that the Contractor will employ to monitor the successful implementation of those steps.

e. Foster Parent, Foster Child and Birth Family Support

The Contractor is to provide comprehensive support to the foster parents that they license. This shall include twenty-four (24) hour support as a means to ensure high quality care and continuity of placements. The Contractor shall ensure that they have 24 hour phone coverage, including the ability to go to the foster home or other settings (e.g., hospital, school, etc.) if a situation requires such in-person outreach. The Contractor shall ensure that its staff, including but not necessarily limited to the care manager, the care manager supervisor and the on-call person(s), proactively engage foster parents ensuring that they have the resources, information and support needed to best serve the foster children in their care. Additional resources for foster parents in the form of support groups and/or peer supports/buddies shall also be provided by the Contractor.

The Contractor shall also develop and implement processes and structures that ensure that the needs and interests of foster children are always maintained and prioritized, yet still provide foster homes with a high level of support. In addition, the Contractor shall provide foster parents, their birth/adoptive children, foster children and their birth families with opportunities for support, growth and education through formal and informal forums such as group meetings, workshops, recognition events, and social activities.

f. Care Planning and Management

The Contractor shall ensure the integration of behavioral, mental health, recreational, cultural and psychosocial interventions and supports that a TFC child needs to succeed in the community using a wraparound/ Systems of Care approach. Children served in TFC are to be placed in homes in or near their birth family or home community, unless contra-indicated.

Children placed in the Contractor's TFC program must be cared for in a culturally and linguistically competent manner. Care must support, respect and uphold each individual child's cultural identity, religious/spiritual ascription, gender identification, physical challenges, cognitive impairments, sexual orientation, and linguistic needs. TFC service provision shall also be tailored to the child's age, diagnosis, developmental level, and educational needs.

Child Placing Agencies must adhere to the Reasonable and Prudent Parent Standard as referenced in: PL 113-183. The term 'reasonable and prudent parent standard' means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities.

The Contractor and their foster parents are required to provide opportunities for children in their care to experience and maintain traditions, including having access to food and activities that are integral to their culture and heritage. In addition, foster parents and TFC staff shall be knowledgeable about and attentive to the daily and routine hair and skin care needs of racially diverse children and youth.

Further, the Contractor will implement their TFC program in a manner that supports children's mastery of the skills necessary to ensure, to the greatest extent possible, their growth into happy, self-sufficient and productive adults. This service will prioritize and better enable children's permanency goals (e.g., reunified with their biological parents, adoption, placed with a relative, or transitioned into independent living.)

Children placed in TFC shall have a comprehensive, holistic, individualized care plan developed and implemented. A child's care plan will, at a minimum, address the following core domains:

i. mental / behavioral health;
ii. social-emotional;
iii. health;
iv. recreational, cultural and spiritual;
v. permanency and life long family ties, including visitation/contact with parents and siblings;
vi. educational / vocational/career;
vii. life skills / daily living.

The child's TFC's care planning and support must address all of these components in a strength-based, outcome oriented manner, congruent with the child's age, developmental level, cultural and gender needs, and other individual factors.

Goals, activities, services, implementation steps, outcome measurements, time-frames and responsible person(s) shall be attached to each domain as a means to guide holistic and integrated care for the children served in the therapeutic foster care program. A robust service/care array for each child must also be created within the construct of the above core domains. All children shall receive a broad range of community-based

programming, supports, interventions, and wraparound services that aid in their increased positive skill development and improved functioning.

The child's TFC care plan shall be concrete and measurable, and serve as a tool for communicating the means by which identified outcomes will be achieved. A preliminary care plan shall be developed within 10 calendar days of a child being placed into TFC. A service plan shall be completed within 30 calendar days of a child's placement. That plan is to be reviewed and updated on at least a quarterly basis. The Contractor is required to convene quarterly child specific treatment/care planning meetings in conjunction with or in addition to the DCF case review process. The Contractor shall invite the child's DCF Social Worker, the foster family, and as appropriate the foster child and their birth family to these meetings.

These plans are to be developed through a teaming approach that includes the TFC foster parent(s) as a key contributor and implementation agent; the child's TFC Care Manager; the child/youth; DCF; birth families, natural supports and other relevant service providers/entities/persons (e.g., clinician, mentor, coach, school, faith institution, etc.). The Contractor must engage the child/youth, DCF, and foster family to determine the persons and entities who are significant to the child's life and who might be integral to the development, review, and implementation of the child's/youth's care plan. Copies of the child's preliminary and quarterly updated plans will be sent to their DCF social worker by the Contractor.

Pursuant to the federal *Fostering Connections to Success and Increasing Adoptions Act of 2008* (H.R. 6893), the Contractor may be required to develop or assist DCF with the creation of personal transition plans for youth aging out of foster care. These plans must be written 90 calendar days before a youth exits from DCF care. These plans must address items including, but not necessarily limited to housing, health, education, mentoring, ongoing support, workforce, employment and, if applicable, Social Security Income (SSI) eligibility.

g. Independent Living / Life Skills Building

The Contractor will ensure that all children in their program, regardless of their age, are incorporated into the daily living of their foster homes and are guided by their foster family and the Contractor in gaining essential life skills. Placed children are to be assigned age and developmentally/cognitively appropriate chores, and provided with an allowance consonant with their age and responsibilities.

The areas of daily living that are to be addressed include, but are not necessarily limited to:

i. food preparation and management;
ii. nutrition;
iii. job skills;
iv. health, safety and well-being;
v. housekeeping;
vi. personal hygiene, grooming and care;
vii. money management;
viii. accessing community resources;
ix. service system navigation;
x. self advocacy.

Children's life and independent living goals are to be monitored at least quarterly as part of the expected care plan review interval.

For youth ages 14 and older, the Contractor will ensure such youth are assessed using the LIST (Assessment Tool) and receive formal life skills training through use of the Learning Inventory of Skills Training (LIST) curriculum. The Contractor shall ensure that all their staff with care management responsibilities receive formal LIST training, and are trained in that curriculum. Data entered into the Provider Information Exchange (PIE) will be required on a quarterly basis congruent with the child's Case Plan. The data will capture the child's progress and needs in the life skill domains based on the LIST assessment tool.

Opportunities for children in TFC to apply acquired life skills in safe, supportive and normative environments/setting must be provided. Children's care plans should set forth the means by which this will be accomplished.

h. Behavioral and Crisis Support

Children placed in TFC must receive guidance, modeling, discipline, and redirection that are consistent with and appropriate to their age and developmental/cognitive level. The Contractor will identify techniques and tools that foster parents can utilize to appropriately manage foster children's behavior, and prevent and/or de-escalate a crisis. As necessary, the Contractor shall use wraparound funds to purchase behavioral support services.

Behavioral support plans and crisis plans shall to be developed for each child served in TFC. They are to be developed in collaboration with a child's clinician. These plans are to be extensive, well articulating the tips, techniques, steps and interventions that may be proactively used to address the presenting or emerging issue. Such plans are to be written at a basic literacy level to ensure that they are easily understood during times of high stress. They also should be written in the preferred language of the foster family.

The Contractor will provide telephonic and, as the situation demands, face to face support (e.g., going out to the home, going to the emergency room, etc.) during times of crisis. TFC families are within the target population to receive EMPS Mobile Crisis Intervention Services (Mobile Crisis), from DCF funded community providers, however the Contractor is expected to also support their foster families and foster children during a crisis. If EMPS is required, the Contractor shall be in communication with that service to ensure the foster child and their foster family are connected to needed supports and that those supports are integrated into the child's TFC care plan.

The Contractor is not to utilize physical intervention on any child unless otherwise authorized by the Department of Children and Families. Prone restraints are not permitted in any circumstance. Expectations must be followed as outlined in the Therapeutic Foster Care Restraint Protocol.

I. Respite Care

Respite is defined as a child's placement outside of their primary foster family for a brief period of time with the expectation and understanding that the child is returning to that primary foster family. The Contractor shall ensure that planned, overnight respite care is extended to all their foster parents. Foster families are to be permitted 18 days of respite, per 12 month period. Those 18 days shall be paid from the child's annual wraparound funding, at the maximum rate of $55.55 per over-night. (i.e., may not exceed $999.90 per 12 month period). The Contractor will be responsible for identifying an appropriate, substitute care giving home when either planned or emergency respite is needed.

A respite plan is to be developed for a child concomitant with the creation of their care plan and crisis plan. This respite plan is required to ensure that children's respite care needs have been formulated in advance and articulate appropriate substitute care-giving options.

Respite, both planned and emergency, is to occur within a family setting. Respite providers shall be persons who are fully licensed and have passed criminal and child protective services background checks. Such individuals shall also receive at least one hour of child specific training to ensure that they have the skills and ability to effectively and appropriately care for the foster child who is to be in their charge. Respite care for children with a co-occurring medical condition may require additional training congruent with the requirements for providing respite care for children who are termed to be medically complex.

Providers are not to use facilities, congregate settings, or TFC personnel's homes for respite placement. In highly exceptional cases (e.g., child's need for skilled and complex medical interventions/care), a facility setting may be used, but will require authorization from the DCF Systems or Clinical Program Director or his/her designee at least 10 business days in advance of the requested planned respite placement date. If a child's needs suggest a skilled facility might be needed in the case of emergency respite, that should be discussed with the DCF Systems or Clinical Program Director or his/her designee and that exception included as part of the child's approved respite plan. The Contractor shall not delegate the responsibility for locating an appropriate respite resource to DCF. In the event that the Contractor is unable to identify an appropriate respite placement for a child on their caseload within their own foster family and respite pool, the Contractor shall outreach to its assigned SALA(s) to identify a respite resource.

Finally, while short term, family-based respite placements can occur without approval by the Department, the Contractor must, however, discuss such arrangements with the child's DCF worker. At a minimum, the child's DCF social worker and/or DCF Careline, in the case of after hours or holidays, must be informed of a child's placement into a respite setting. Emergency respite placements require notification to DCF FASU and the child's CPS chain of command the same business day of placement (if necessary email notification is acceptable with a follow up phone call the following business day). When a respite placement is expected to extend beyond thirty (30) calendar days, a waiver must be submitted to the area office Regional Administrator by the Contractor at least 10 business days before that 30 days mark, setting forth the reason for the prolonged respite and the TFC agency's proposed plans regarding the child's ongoing, stable placement. High numbers of emergency respite placements or respite placements that result in a disruption from the foster home of origin will require corrective action, and could result in loss of contracted capacity or contract termination.

j. Wraparound

The Contractor shall identify and refer TFC children to programming, resources, and a variety of supports and services to maintain their successful care in the foster home and community. Guided by the key care domains and tied to the child's TFC care plan goals, the Contractor is to ensure that children are connected to local behavioral health, rehabilitative, social, recreational, and educational service and activities that are needed for them to attain functional improvements and facilitate positive outcomes.

The Contractor may purchase such aforementioned services that are not reimbursable through the child's insurance and/or obtainable through DCF funded community-services contracts, or other responsible

entities/sources (e.g., Local Educational Authorities). The Contractor shall ensure that each child's wraparound funds are used to purchase therapeutic and structured summer programming (e.g., camp), structured after-school and weekend programming, behavioral management, and 18 days of planned respite. TFC providers will be required to purchase services such as therapeutic support and behavioral management using only persons[1] and agencies that are listed on the DCF Credentialing Services roster, unless explicitly approved by an O'CHYP manager.

Wraparound funds may be used to purchase therapeutic, enrichment, educational and clinical services, supports and programming that cannot otherwise be obtained through other funding sources. Social, cultural and recreational items must be tied to the youth's life skill goals identified in the LIST assessment and congruent with the child's Service Plan. Clothing, furnishings, and gift cards, can only be approved for purchase in the event of an emergency placement or circumstance directly tied to the imminent needs of the child. Cash incentives, allowances, movie passes, amusement park passes, food, cars/vehicles, games/ toys, cellular phones, MP3/AAC devices (e.g., iPod), and repairs/damages are examples of items that are not acceptable use of wrap funds. Exceptions to purchase items such as transportation may be reviewed by the Area/Regional Office Program Manager or designee on a case by case basis. The child's wrap funds must be exhausted prior to the request for utilizing Unique Service Expenditure (USE) funds.

The Contractor will maintain financial records, including receipts, detailing the purchase of wraparound services for the children in their program. The Contractor is required to submit a copy of its wraparound log to O'CHYP detailing the use of these funds for each child on a quarterly basis. An aggravated log shall be submitted annually by July 15th. The Department, however, has the right to request a review of the wraparound log on a more frequent or ad hoc basis. Randomized reviews of this information by the Department may also happen during the course of each fiscal year. Reviews of this financial information will also occur during case reviews and site visits. Such log shall be submitted to DCF in the format determined by the Department.

k. Non-Clinical Sibling and Relative Placements

A "non-clinical" placement includes siblings of a TFC eligible child or a kin-related placement of the foster parent/s. The Contractor will be expected to provide case management services to any foster child placed in one of the Contractor's homes who is deemed to be "non-clinical". The Contractor shall develop and monitor a basic care plan for any such non-clinical child served in their program. The Contractor will ensure that these children are linked to activities in the community and that their routine care, safety, educational, health, recreational/social, and well-being needs are attended to. The Contractor will further ensure (either through themselves or the foster family) children identified as non-clinical are transported and accompanied to medical appointments, and community and educational services/activities/events. The Contractor will also be responsible for identifying a respite placement resource (i.e., planned or emergency respite) when such need arises. At least one face to face visit per month must occur with children determined to be non-clinical.

The administrative rate provided to the Contractor for non-clinical children shall further be used to support such children's participation in activities that the TFC agency may host during the course of the year (e.g., holiday

[1] Persons part of the foster family household (e.g., relatives), even if on the Credentialing Services roster, may not be compensated for providing any clinical, respite, support, or therapeutic services for any foster child(ren) in their home unless authorized by O'CHYP.

parties, picnics, recreation events, amusement park trips, etc.). That rate shall also cover the Contractor's purchase of presents/gifts for the child to mark significant events and occasions (e.g., birthday, holiday, graduation, etc.).

11. Staff Experience and Training

a. The Contractor shall ensure that they have a culturally and linguistically diverse TFC staff pool that is reflective of the foster children and foster families they are to serve. TFC staffing must demonstrate:

i. Child welfare, foster care and home finding experience;
ii. Experience providing direct services to diverse populations;
iii. Multi-lingual capabilities that are relevant to the communities, children and families to be served; and
iv. Knowledge of the cultural, linguistic or experiential backgrounds of the communities, children and families to be served.

b. TFC staff must have the expertise and skills necessary to license, train, coach, supervise, and support foster parents in their care-giving role to foster children from various cultural, ethnic, racial and linguistic backgrounds.

Direct care TFC staff shall complete rigorous pre-service training before they are assigned a caseload. A standard number of pre-service and in-service training hours and/or curriculum for TFC staff may, at a later date, be established by the Department. Ongoing training informed by the needs of the foster children served or to be served and those of the TFC families is also to be provided to the direct care staff, including persons who are responsible for assessment of foster care applicants. Through the combination of pre and in-service training, TFC staff shall receive instruction on the topic areas below. The Contractor is to and may provide additional professional development opportunities as they deem necessary. The minimum topic areas in which direct care TFC staff are to receive training are as follows:

i. DCF organizational structure;
ii. Child Placing Agency regulations;
iii. mandated reporting;
iv. overview of children's mental health, including issues related to suicide and substance abuse;
v. understanding the role of foster families and the importance of achieving positive permanency outcomes for children and youth;
vi. permanency preparation framework;
vii. sexual abuse prevention and intervention;
viii. cultural and linguistic competence and culturally responsive care;
ix. dynamic assessment and evaluation;
x. Learning Inventory of Skills Training (LIST);
xi. crisis prevention, de-escalation, and intervention;
xii. trauma informed care;
xiii. philosophy and characteristics of a Systems of Care/Wraparound Approach;
xiv. overview of community services;
xv. grief, loss and separation issues for children in foster care;
xvi. significance and value of birth families to children placed and supporting their inclusion ;
xvii. meeting facilitation;
xviii. mediation skills;
xix. sexuality;

xx. staff's role in minimizing multiple placements;
xxi. significance of relationship building and connections ;
xxii. Family Systems Approach, including family engagement.

12. Staffing

a. Care Manager

Children placed into TFC shall be assigned a Care Manager (CM). This person will be an employee, or sub-contractor, of the Contractor who serves as the coordinator, broker, and manager of TFC children's care and services. The CM will convene and facilitate team meetings for the purpose of developing, monitoring and updating children's comprehensive care plans.

CMs must possess a least a bachelors' degree in a human services field (e.g., social work, psychology, counseling, child welfare, etc.). They are to have knowledge of or experience providing services to children and/or families who present with serious mental health issues, substance use problems, cognitive limitation, and/or child welfare involvement.

These positions will maintain caseloads, including non-clinical siblings, which do not exceed 14 children. If the Care Manager's caseload is comprised wholly of children identified as requiring TFC, that caseload should not exceed nine (9) children.

The CM must be cognizant that their principle client is the foster child and must engage in activities that support their dedicated focus on the safety, well-being and permanency of such child(ren). While legal, placement, and final decision making responsibility remains with DCF, day-to-day activities of children served through this contract will be managed by the Contractor. The CM is to fulfill duties including, but not necessarily limited to:

i. care planning, coordination, implementation and monitoring;
ii. referral and linkage to community-based supports;
iii. foster family support, guidance, and supervision, including evaluating for parenting and skilled care competencies and the provision of specialized training as needed;
iv. educate foster parents about the trauma inherent in a child's experience of placement Therapeutic engagement and intervention;
v. active participation on the child's permanency team;
vi. conduct family search and engagement through child engagement and case mining in partnership with DCF;
vii. apply permanency preparation framework to assist child in clarification, integration and actualization;
viii. develop and monitor of service contracts/agreements[2];
ix. home safety assessments and monitoring;
x. respite and emergency care planning and placement;
xi. foster child advocacy;
xii. support and maintain relationships between children and their families of origin;

[2] An example of a service contract is an agreement that is drawn up with a foster parent or household member to set forth expectations (e.g., Jane will not be left alone with or in the care of John S. until/unless clear background checks have been received)

xiii. arrange for and/or transport children to appointments and activities, on the rare occasion when foster families are not able;
xiv. ensure that a full and appropriate educational program is provided for and to the children under their caseload;
xv. ensure that the health (medical/physical, dental and mental/behavioral) needs of the children are being met as specified by the child's DCF case plan and health care provider in conjunction with appropriate professionals and the child's foster parents, including, but are not limited to:
    (a) notification to DCF of any changes in the child's physical health status,
    (b) contributing written notes and forms to the child's DCF medical record ,
    (c) regular review with foster caregivers of any prescribed medication, and documentation of such review,
    (d) regular review with foster caregivers of any medical procedure(s) to be provided and managed and/or coordinated by the foster parent, and documentation of such review,
    (e) timely documentation and communication to health care providers regarding any health care concerns;
xvi. safety, behavioral, and crisis planning/development and management;
xvii. supporting and cooperating with announced and un-announced visits by DCF to the TFC homes;
xviii. impart independent living/life skills using the LIST curriculum;
xix. implementation and monitoring of family specific corrective actions;
xx. knowledge of the agency's emergency preparedness plan and accompanying family response;
xxi. child specific training (i.e., provide and/or connect families to such training);
xxii. attend DCF Administrative Case Review (ACR) meetings;
xxiii. educate foster parents about available resources and supports related to adoption (e.g., subsidies, tuition, adoption assistance, tax credit, etc.);
xxiv. discharge planning and implementation;
xxv. aftercare support.

In addition, weekly face to face contact with all children on their caseload must occur. These visits can occur in a variety of settings, as appropriate and non-disruptive, including but not necessarily limited to the foster home, school, agency office, clinical milieu, and other community sites. The CM must regularly meet separately with each child on their caseload, ensuring that there are opportunities for the child to speak privately with them. Case narratives documenting these contacts must be maintained in the child's case file.

Contact with foster families must also occur weekly (e.g., at least 4 contacts during the month). At least two of those contacts during the month must be in person. One of those face to face contacts must occur within the licensed foster home. The two other contacts may be by phone or email In addition, the care manager, or a foster family support person assigned by the Contractor, will be expected to engage in monthly walkthroughs of their assigned foster homes to ensure the ongoing safety of the premises and observe whether there are any new household members or frequent visitors who require background checks. Documentation regarding these weekly contacts and quarterly walkthroughs is to be maintained in the foster families' provider file. The Contractor may be required to monitor and document walkthroughs using forms developed and/or approved by the Department.

Finally, the CM must contact relevant service providers (i.e., the child's DCF social worker, clinician, mentor, school, etc.) at least one time a month. Appropriate releases are to be obtained to support this activity. The CM's communications with service providers are to be thoroughly documented and maintained in the child's or foster parent's care file, as appropriate. Monthly written reports will also be submitted to the child's DCF social worker by the CM outlining, at a minimum, the child's TFC services, activities, issues, and clinical progress.

b. Care Manager Supervisor

The Contractor shall ensure that there is one full-time TFC Supervisor per every six (6) Care Managers. The TFC Supervisor(s) must have at least a master's degree in social work or a closely related field (i.e., marriage and family therapy, counseling or psychology). Persons in this position will have direct behavioral health/mental health experience, proven knowledge of case management, family systems, organizing and coordinating meetings, and exceptional clinical, organizational, communication, and problem solving skills. They must also possess at least two years experience in foster care.

The TFC Supervisor(s) will provide support and consultation to the program CMs. Documentation regarding child and foster family specific related weekly supervision will be maintained in the child and/or family's file. These positions will:

i. oversee the licensing and training of foster parents;
ii. monitor matches;
iii. review and sign-off on all treatment and care plans; and
iv. engage in direct outreach and support to the foster families as needed to ensure high level program outcomes.

The TFC Supervisor(s) shall oversee all aspects of care and service provision within and through the TFC program, including ensuring that children's needs and foster family support occurs in an effective and non-conflictual way. The Contractor must develop a mechanism to ensure that the child is viewed as the primary client while still ensuring that there is distinct support for the TFC family.

Finally, the TFC Supervisor(s) must coordinate and provide back-up to ensure the availability and provision of 24 hour, on-call support.

c. Program Director

A program director shall oversee the agency's TFC program. This program director shall be a full-time employee at the Contractor's agency. For TFC programs serving 15 or more TFC level children, the program director shall be assigned full time to the TFC program. Programs serving 14 or less TFC level children shall have the program director assigned as a .5 FTE exclusively to the TFC service. The person holding this position must meet the educational, training and employment experience requirements consonant with Section 17a-150-58 of the Connecticut Child Placing Agency Licensing and Responsibilities regulations.

The TFC Supervisor shall report to the program director. This managerial position shall ensure the effectiveness of the TFC program. The program director shall review and sign-off on all foster homes licenses. In instances where there is a critical incident, DCF Hotline/protective services investigation or regulatory/policy compliance issue that involves a foster family, the program director shall take a lead role in coordinating activities with DCF, evaluating the impact on practice, and developing and implementing any needed corrective actions steps that

must be undertaken. The program director will further be responsible for ensuring the timely and proper achievement of any follow-up activities that may emanate from a critical event, investigation or compliance complaint.

d. Recruiter

The Contractor shall maintain at least one half time equivalent (. 5 FTE) Recruiter Position per up to 50 slot capacity. Contracted slot capacity above 50 shall require the employment of at least a 1 FTE Recruiter Position.

The Contractor may subcontract with another TFC agency to purchase the requisite full-time equivalent for the Recruiter position. An agreement outlining the terms of that arrangement must be signed by both TFC agencies, and sent to O'CHYP's TFC Program Development and Oversight Coordinator within 7 calendar days of execution. O'CHYP, however, reserves the right to require a refinement of or other changes to that agreement if it is not found to support the express or implied terms of this contract effectively.

The recruiter shall be an individual with a foster care recruitment background, and have a strong knowledge of the local community in which they will be recruiting. This position will be responsible for developing and implementing the Contractor's annual recruitment and retention plan. The recruiter shall work closely with DCF foster care staff, DCF Regional/Area Office staff, SALAs and other TFC provider recruiters to gain a full understanding of the social-emotional behavioral and permanency needs of the children who are to be served in TFC, and to support the attainment of the Contractor's and the Department's recruitment and retention goals. An emphasis on the recruitment of parents to care for adolescents should be of significant priority. This position shall cultivate and maintain relationships with a variety of community organizations, groups and entities (e.g., businesses, faith-based organizations, civic groups, hospitals, colleges/universities) to aid with the recruitment of a sufficient number of qualified and licensed homes to achieve the minimum annual contract service capacity level and the annual local and statewide foster care recruitment and retention goals. The recruiter shall also survey, on at least an annual basis, current TFC parents, and those exiting TFC families in order to identify, develop and implement effective recruitment and retention strategies.

13. Foster Parent Expectations

In addition to ensuring that children are served in a loving, home setting, TFC families are to be supported by the Contractor to serve as key partners in devising and implementing the TFC care plan and the DCF Treatment plan, as appropriate, for the foster children in their home. Foster parents shall have significant input into the treatment/care planning based upon their knowledge and observations of the child in their natural settings. Therapeutic foster parents are expected to implement in-home treatment strategies that support children's increased behavior management, self-regulation, interpersonal skill development, social competence, problem solving and acquisition of independent living skills. Furthermore, therapeutic foster parents are to assist with the achievement of children's permanency goals.

TFC parents shall help children develop social support networks and build healthy, meaningful relationships with caring individuals. They will provide children with a normative experience, embracing their daily care needs in a manner identical to that of any other child who is a member of their family. In support of this, all therapeutic level foster families will:

a. provide appropriate care, nurturing, and affection;

b. implement creative approaches to support pre-placement visits, ensuring that the initial days and weeks of placement are welcoming and engaging for the foster child and, as appropriate, that child's birth family;
c. establish trusting relationships with the children in their care and, as needed, their birth families;
d. model and teach pro-social behavior ,healthy daily living and self care skills;
e. model healthy family roles and decision making ;
f. celebrate and acknowledge the child's achievements (e.g., attend school plays in which the child has a part, watch the child play in sports events, attend award ceremonies, etc.);
g. support opportunities for the child to pursue his or her talents, hobbies, and interests;
h. support educational stability and progress;
i. advocate on behalf of the child(ren) in their care;
j. arrange for and attend medical, mental health, dental appointments and children's other necessary appointments;
k. transport and accompany children to needed appointments and community activities;
l. administer all needed medications consistent with dosage expectations;
m. ensure the child's access to age and developmentally appropriate social, recreational and summer camp opportunities, including systemically setting aside money from the per diem to ensure funds are available;
n. participate in therapeutic foster care treatment team meetings, ACRs, the child's permanency team meetings, and other meetings related to the child's care provision (e.g., education, mental health, etc.);
o. provide a structured home environment;
p. engage in consistent, age appropriate (non-physical) discipline and limit setting;
q. implement therapeutic supports and approaches ;
r. cooperate with announced and unannounced home visits by DCF and the TFC provider;
s. respect and support children's cultural, spiritual, and linguistic needs, including attending to the hair and skin care needs of racially diverse children;
t. reinforce the child's progress;
u. participate in school functions and recreational activities related to the child;
v. become involved with a child's family of origin, serving as a role model and support system;
w. cultivate healthy relationships between the child and their birth family or other significant ties;
x. participate through visitation and involvement in treatment and discharge planning when short-term admissions to alternative levels of care are required;
y. assist with transitions to alternative levels of care and/or reunification;
z. systematically document (e.g., daily logs, progress reports, and records) each child's behavior, progress and areas of challenge.

The Contractor shall ensure that all TFC families have employment schedules that allow them to be available to meet the treatment/clinical and routine care needs of the foster child(ren) in their care. In addition, the Contractor will ensure that the foster family's school, church, community and/or other activities/commitments do not interfere with the TFC family's ability to meet the needs of their foster child(ren).

Finally, the Contractor will develop materials (e.g., manuals, handbooks, policies, guidelines, contracts/agreements, etc.) that comprehensively outline the role, rights, and responsibilities of their licensed foster families. The Contractor will ensure that all licensed foster families are oriented to these materials and acknowledgements signed by the foster parent(s) are maintained in their case file(s) to evidence their review and understanding of their role, rights, and responsibilities.

14. Community Linkages and Key Relationships

The Contractor, its CMs, and TFC families are required to establish and maintain a collaborative relationship with the various service providers that are part of the foster child's treatment/care team. This shall include no less than monthly phone, face to face, or email contacts by the CM with the child's DCF social worker, the child's clinician, school and other key providers. The child's foster parent shall also be expected to communicate regularly with said child's key service providers. Such contacts should include communication about the observations, interventions, progress, goals, plans, and ongoing safety and well-being of the foster child.

The Contractor will work in collaboration with other providers, including DCF's Central Office, DCF Area Offices, Community Collaboratives, Systems of Care, Managed/Integrated Service Systems, and various formal and informal community-based services. The Contractor will be an active participant in statewide meetings of foster care providers, including the TFC Quality Improvement Team.

Finally, the Contractor shall cooperate with the quality assurance and oversight activities that will occur in conjunction with this contract and the ongoing licensing of their agencies. The Contractor shall cooperate with the State's oversight and management activities such as, but not limited to, case reviews, site visits, record reviews, audits, licensing reviews and investigations conducted by the Special Investigation Unit.

15. Birth Family and Significant Connections

The Contractor and their foster families shall assist children with maintaining, or re-establishing meaningfully connections with significant people in their lives. Placement of siblings within the same TFC home, unless counter-indicated, is a priority. When joint placement is not possible, the Contractor and the foster family will assist with visitations and other appropriate ongoing interactions between siblings. Similarly, as clinically appropriate and congruent with protective service stipulations, the Contractor and foster families will be expected to assist with children's visitation with their birth parents, other relatives, and friends. TFC homes shall be included as locations for visits between children and birth families unless there is a DCF agreed upon safety concern. In addition to supporting face to face interactions between TFC children and their significant connections, the Contractor and their foster families must, as appropriate, encourage and support regular contacts such as phone calls, letter writing, emailing, and card exchanges.

The Contractor and foster families will be expected to encourage, facilitate and support birth families' participation, as appropriate, in key aspects of the TFC service. Children's families of origin are to be incorporated into activities such as, but not necessarily limited to, pre-placement visits, treatment/care plan development and implementation, care management meetings, medical, dental and clinical appointments, community-program site visits (e.g., when selecting services for a child), TFC agency trainings, school events, celebrations, and discharge planning and implementation.

The Contractor and their foster parents shall, as appropriate, collaborate with and provide direct support to children's birth parents or other relatives. This may take the form of modeling, coaching or being a "mentor" to the birth families so that they may develop needed skills and techniques, and maintain connections to resources/services necessary to support a successful and sustainable reunification. In addition, as appropriate, the birth family shall be invited to participate in the Contractor's TFC trainings, support groups and social events.

16. Discharge and Aftercare

a. Discharge Decisions and Planning

Discharge planning is to occur coterminous with the development of the TFC care plan. In order to ensure a foster child's coordinated and successful transition following their placement in therapeutic foster care, discharge planning is to minimally address the following:[3]

i. expected duration of treatment/placement;
ii. major treatment recommendations that are likely to facilitate a successful discharge;
iii. most viable and beneficial post-treatment placement for the child.

Early discharge planning is also required to support needed persons (i.e., birth family, kinship, etc.) becoming active participants in the transition plan's creation and implementation from the onset based upon the discharge and permanency goals (e.g., reunification with birth family, open adoption).

Next, the discharge of children from the TFC program will be the result of a plan between DCF and the Contractor. In the event of an emergency hospitalization of the foster child, the Contractor shall immediately contact the child's DCF social worker. Plans for such children to return to the same foster home after hospitalization will be made on a case-by-case basis between DCF, the foster family, and the Contractor. DCF, however, guided by the child's discharge recommendations from the hospital, will be the final determinant as to whether a child continues to be appropriate for a TFC level of care. If it is decided that the child is to remain at a TFC level, but the Contractor is lacking an appropriate resource family, the Contractor shall work with the other TFC providers to identify a TFC home.

b. Aftercare

The Contractor shall provide a comprehensive aftercare component that supports a child's transition into and stabilization within their biological, relative, or an adoptive home. Prior to discharge, the Contractor will provide DCF and the family with an individualized Aftercare Support Services Plan developed in collaboration with DCF. The plan will be flexible and tailored to the needs of the child and family to be served. At a minimum, the Contractor will be available in a "consultative" role as a supportive resource for families/caregivers or subsequent service providers.

The Contractor's Aftercare Support Services Plan will include, but will not be limited to, the following components:

i. aftercare goals and objectives, as outlined in the TFC Care Plan;
ii. menu of aftercare services and referrals provided;
iii. number and frequency of family contacts; detailing family and child transition progress;
iv. behavior management strategies, and crisis support
v. coordination and facilitation with local community services that will further promote successful transitions;
vi. data tracking and performance measures to monitor success of aftercare services.

Aftercare services may be provided to a family for up to 6 months, but must be provided for no less than 4 weeks after discharge, including a minimum of one face to face visit to the child and family and two phone calls. TFC

[3] As taken from the Programs and Standards for Treatment Foster Care, Foster Family-based Treatment Association (1995)

agencies may include a child's foster parent as part of the after-care support team as a means to assist with continuity of care. (e.g., serve as a coach and model to encourage, empower and support the birth or adoptive family or serve as a respite resource to the biological or adoptive family). Aftercare services would also be similarly used to support children who are transitioning from therapeutic foster care to an adoptive or relative home. The Department may, at its discretion, enter into PPSP contracts with the Contractor to support extensive and longer term aftercare services that are congruent with the child's permanency plan.

C. DATA REPORTING, CONTRACT COMPLIANCE, AND OUTCOME MEASURES

1. Data Reporting

a. The Contractor shall develop an annual quality assurance plan that shall be submitted to O'ChYP for review and approval. These plans shall detail the Contractor's strategies, intended actions, and methods to monitor the quality and outcomes of their service. It shall also inform systematic, ongoing improvement to TFC programming. This plan shall be submitted to O'ChYP for review by July 15 of the preceding state fiscal year (e.g., the SFY 2016 plan shall be submitted to O'ChYP by July 15, 2015).

The Contractor shall also develop and submit to the Department an annual plan that outlines the training expectations and curriculum for the TFC staff, and prospective and licensed foster families. The training plan shall, at a minimum, set forth the topics to be provided, brief summary of the training, hours for each training, location, facilitator and their qualifications/credentials.

The Contractor shall also develop a detailed cultural and linguistic competency plan for their TFC program, and participate in the development of a broader, joint, cross TFC provider multiculturalism plan. This plan shall be submitted to O'ChYP for review by July 15 of the preceding state fiscal year (e.g., the SFY 2016 plan shall be submitted to O'ChYP by July 15, 2015).

Data and reports related to the aforementioned plans will be submitted to DCF as requested and in the required format. The Contractor shall expect to send such data and reports to the Department at least twice during each fiscal year.

b. The Contractor shall submit timely and accurate child specific, foster family, and administrative program data comporting with the processes and formats determined by the Department, including the web-based Provider Information Exchange (PIE). Repeated tardy, missing, and/or inaccurate data submissions will result in corrective actions and could result in contract termination. The Contractor shall engage and use data to ensure the quality of their services, including identifying program challenges or barriers, identify potential best practices, and achievement of the program's goals, objectives and outcomes.

The Contractor will also be required to submit other data and reports (e.g., fiscal reports, ad hoc program data). These shall be submitted to DCF within the time-frames and using the processes and formats determined by the Department.

c. The Contractor shall be attentive to the needs of the children and families that they serve. As part of the ongoing quality assurance efforts, the Contractor will to engage in a variety of activities that facilitate the receipt of information concerning children and families' satisfaction with the TFC program. At a minimum, the Contractor shall administer an annual, age appropriate, satisfaction survey to children in their program. An annual survey

to obtain feedback and service improvement input from licensed TFC families will also be administered. The Contractor may be required to utilize a specific satisfaction tools or uniform questions, and engage in standard methodologies for the delivery of said surveys as identified by the Department.

d. DCF licensed child placing agencies are required to develop and maintain an Emergency Preparedness Plan that includes specific procedures related to evacuation, relocation, and power outages maintaining minimum standards of care, and parent and/or guardian notification. Child placing agencies must submit these plans by November 1 each year to DCF's Office of Children and Youth in Placement. If no change in the plan has occurred since the previous submission, the contractor's Executive Director must send a written communication indicating that the plan has been reviewed and no changes are required. Child placing agencies should keep a copy of the agreed upon family-specific emergency plan for each approved home either in a separate file or in the family's case record which will be subject to review during licensing/site audit visits. See appendix X for a sample template.

e. The Contractor will document and report to the appropriate DCF entities (e.g. Risk Management, Careline, DCF social worker) when significant events and critical incidents involving the DCF children under their care occur. This will be accomplished within required timeframes and following established DCF protocols. The Contractor will document and report on an incident report form, atypical events or occurrences that jeopardize the health, safety, treatment or care of children and youth, including but not limited to the following: death, injury, illness, attempted suicide, hospitalization, restraint, seclusion, assault, arrest, or any unauthorized absence. The report will include, but not be limited to: date and time of incident, date of report, child or youth's name, staff involved, summary of incident, actions to prevent the incident, actions taken as a result of the incident, notification of Contractor's administration and or guardian, and signatures of report writer and supervising reviewer. In the event of a critical incident that has potential media involvement, the Central Office Program Development and Oversight Coordinator must be contacted by phone and/or email within 2 hours from the occurrence of the critical incident informing him/her of the incident.

2. Contract Compliance

The Contractor shall comply with the core outcome measures set forth below. Additional or modified indicators may be required over the course of contracting.

In addition to the indicators listed below, the Department shall expect that the Contractor is actively supporting and fostering DCF's goals to place siblings together, preserve or re-establish life long ties for children and achieve permanency for children in their care.

Foster Families

- % completing post-licensing training
- % participating in Care Plan development
- % participating in Care Plan Quarterly Reviews
- % attending ACRs
- % attending Permanency Teaming
- % satisfied with TFC agency

Provider Agencies

- % attending ACRs
- % of placements made in same catchment area of child's DCF case
- % achieving recruitment goals
- % achieving retention goals
- % of timely matches
- % of homes on hold > 2 months
- % of accepted referrals
- % of homes without placements > 2 months
- % of homes requiring a waiver (>1 TFC child in the home)
- % conducting required face to face contacts with the child
- % conducting face to face contacts with the foster parent
- % making weekly contact with foster parent
- % attending Permanency Teamings
- % conducting Quarterly walk-throughs

3. Performance Measures

The Contractor will participate in the implementation and evaluation of client-based outcomes, which will measure the effectiveness of service delivery. Performance measures and outcomes will include but may not be limited to the following:

a. % of children with permanent legal status at discharge
b. % of children discharged to another permanent, kinship placement or home
c. Number of foster homes recruited
d. Number of foster homes retained
e. Number of foster parents trained and/or the number of FP training sessions delivered
f. Number of children who meet criteria (as defined in the TEI) who are accepted
g. Number of children who meet criteria who are placed
h. Number of placements per child
i. Number of case management services/sessions (per child or per case manager or per contractor)(figure in size of caseload), visits, referrals, life skills
j. % of foster homes retained
k. % of foster parents who meet training requirements
l. % of children placed who remain in one placement over the course of treatment
m. % of children placed who do not need a higher level of care, (and remain in foster care)
n. Length of time to place child in a home from time of referral
o. % of significant events that resulted in: EMPS, Police involvement, ED visits, Hospitalizations, AWOL
p. % of positive family satisfaction
q. % of positive youth satisfaction

Approval Date: 12/24/18

Effective Date: 12/28/2018
CONTRACT NUMBER: 19DCF0015
CONTRACT PERIOD: 07/01/2018 through 06/30/2023
ST FISCAL YR (SFY): 2019
PROVIDER: North American Family Institute, Inc. (NAFI Con
Approved by: mpagano

4000 INCOME		Corbin House	Tress Road	MST	MST-PSB	Thomaston	MST-EA-Hartford	MST-EA-Bridgeport	Contract Total	Other Funding	Total Income
Program Funding Period:		07/01/2018 through 06/30/2019	07/01/2018 through 06/30/2019	07/01/2018 through 06/30/2019	07/01/2018 through 06/30/2019	07/01/2018 through 06/30/2019	07/01/2018 through 06/30/2019	07/01/2018 through 06/30/2019			
4100 CONTRACT FUNDING	**SID**	**$ 920,274**	**$ 920,570**	**$ 1,125,239**	**$ 486,043**	**$1,051,369**	**$ 288,750**	**$ 288,750**	**$ 5,080,995**	**$ -**	**$ 5,080,995**
4101 State Funds	16138	$ 920,274	$ 920,570			$1,051,369			$ 2,892,213	$ -	$ 2,892,213
4101 State Funds	16116			$ 687,389					$ 687,389	$ -	$ 687,389
4101 State Funds	16141			$ 437,850	$ 486,043		$ 288,750	$ 288,750	$ 1,501,393	$ -	$ 1,501,393
4300 OTHER INCOME		**$ 0**	**$ -**	**$ 107,994**	**$ 20,511**	**$ -**	**$ -**	**$ -**	**$ 128,505**	**$ 12,467,357**	**$ 12,595,862**
4309 Title XIX (Husky A)				$ 107,994	$ 20,511				$ 128,505	$ 659,125	$ 787,630
4316 Other (specify in narrative)		$ 0							$ 0	$ 7,015,472	$ 7,015,472
TOTAL INCOME		**$ 920,274**	**$ 920,570**	**$ 1,233,233**	**$ 506,554**	**$1,051,369**	**$ 288,750**	**$ 288,750**	**$ 5,209,500**	**$ 22,399,059**	**$ 27,608,559**

5000 DIRECT EXPENSES	Corbin House	Tress Road	MST	MST-PSB	Thomaston	MST-EA-Hartford	MST-EA-Bridgeport	Contract Total		Total Expenses
5100 SALARIES	**$ 495,150**	**$ 517,782**	**$ 661,854**	**$ 274,105**	**$ 590,195**	**$ 146,115**	**$ 146,115**	**$ 2,831,316**	**$ 13,391,210**	**$ 16,222,526**
5101 Staff Salaries & Wages	$ 495,150	$ 517,782	$ 661,854	$ 274,105	$ 590,195	$ 146,115	$ 146,115	$ 2,831,316	$ 13,391,210	$ 16,222,526
5200 FRINGE BENEFITS	**$ 126,263**	**$ 132,034**	**$ 168,773**	**$ 69,897**	**$ 150,500**	**$ 37,259**	**$ 37,259**	**$ 721,985**	**$ 3,481,715**	**$ 4,203,700**
5300 CONTRACTUAL SERVICES	**$ 23,760**	**$ 24,624**	**$ 20,358**	**$ 6,180**	**$ 23,472**	**$ 13,720**	**$ 13,720**	**$ 125,834**	**$ -**	**$ 125,834**
5301 Medical Professional	$ 23,760	$ 24,624	$ 20,358	$ 4,980	$ 23,472			$ 97,194	$ -	$ 97,194
5303 Contracted Workers - Non-Payroll				$ 1,200		$ 13,720	$ 13,720	$ 28,640	$ -	$ 28,640
5400 TRANSPORTATION	**$ 16,361**	**$ 14,224**	**$ 50,658**	**$ 29,434**	**$ 15,331**	**$ 8,167**	**$ 8,167**	**$ 142,342**	**$ -**	**$ 142,342**
5401 Staff Travel Reimbursement	$ 1,800	$ 3,000	$ 19,065	$ 8,100	$ 1,970	$ 8,167	$ 8,167	$ 50,269	$ -	$ 50,269
5402 Vehicle Leases	$ 10,611	$ 5,524	$ 20,778	$ 13,310	$ 7,146			$ 57,369	$ -	$ 57,369
5403 Vehicle Maintenance	$ 3,950	$ 5,700	$ 10,815	$ 8,024	$ 6,215			$ 34,704	$ -	$ 34,704
5500 MATERIALS AND SUPPLIES	**$ 21,894**	**$ 21,979**	**$ 11,096**	**$ 5,997**	**$ 22,945**	**$ 8,637**	**$ 8,637**	**$ 101,185**	**$ -**	**$ 101,185**
5501 Food	$ 15,784	$ 15,784			$ 16,900			$ 48,468	$ -	$ 48,468
5502 Lab & Medical Supplies	$ 200	$ 200			$ 300			$ 700	$ -	$ 700
5503 Equipment (Less than $5,000)	$ 3,500	$ 2,003	$ 3,000	$ 1,200	$ 2,000	$ 3,750	$ 3,750	$ 19,203	$ -	$ 19,203
5504 Other Mtrls and Sppls (specify in narrative)	$ 2,409	$ 3,992	$ 8,096	$ 4,797	$ 3,745	$ 4,887	$ 4,887	$ 32,813	$ -	$ 32,813
5600 FACILITIES	**$ 50,875**	**$ 26,254**	**$ 65,532**	**$ 14,280**	**$ 40,089**	**$ 12,485**	**$ 12,485**	**$ 222,000**	**$ -**	**$ 222,000**
5601 Rent and Real Estate Taxes	$ 25,696	$ 806	$ 55,392	$ 12,000	$ 16,384	$ 8,400	$ 8,400	$ 127,078	$ -	$ 127,078
5603 Maintenance & Repair - Facility and Plant	$ 13,179	$ 16,648	$ 6,540	$ 2,100	$ 12,705	$ 2,860	$ 2,860	$ 56,892	$ -	$ 56,892
5604 Utilities	$ 12,000	$ 8,800	$ 3,600	$ 180	$ 11,000	$ 1,225	$ 1,225	$ 38,030	$ -	$ 38,030
5800 OTHER EXPENSES	**$ 31,910**	**$ 29,573**	**$ 66,288**	**$ 29,318**	**$ 32,488**	**$ 9,738**	**$ 9,738**	**$ 209,052**	**$ 2,937,645**	**$ 3,146,697**
5801 Communications	$ 6,576	$ 5,820	$ 16,908	$ 4,692	$ 7,776	$ 3,850	$ 3,850	$ 49,472	$ -	$ 49,472
5802 Insurance	$ 12,516	$ 11,364	$ 17,863	$ 11,845	$ 11,568	$ 1,571	$ 1,571	$ 68,298	$ -	$ 68,298
5803 Housekeeping	$ 2,604	$ 2,604			$ 3,500			$ 8,708	$ -	$ 8,708
5804 Staff Training and Conferences	$ 6,065	$ 6,000	$ 14,780	$ 5,300	$ 5,405	$ 1,443	$ 1,443	$ 40,436	$ -	$ 40,436
5805 Drug Testing			$ 1,000	$ 200		$ 2,073	$ 2,073	$ 5,346	$ -	$ 5,346
5806 Other (specify in narrative)	$ 4,148	$ 3,785	$ 15,737	$ 7,281	$ 4,239	$ 801	$ 801	$ 36,792	$ 2,937,645	$ 2,974,437
5900 CLIENT SUBSIDIES	**$ 17,000**	**$ 16,992**	**$ 5,000**	**$ 1,900**	**$ 19,764**	**$ 9,625**	**$ 9,625**	**$ 79,906**	**$ -**	**$ 79,906**
5906 Other Client Subsidies (specify in narrative)	$ 17,000	$ 16,992	$ 5,000	$ 1,900	$ 19,764	$ 9,625	$ 9,625	$ 79,906	$ -	$ 79,906
TOTAL DIRECT EXPENSES	**$ 783,213**	**$ 783,461**	**$ 1,049,559**	**$ 431,110**	**$ 894,784**	**$ 245,746**	**$ 245,746**	**$ 4,433,620**	**$ 19,810,570**	**$ 24,244,190**

7000 INDIRECT EXPENSES	Corbin House	Tress Road	MST	MST-PSB	Thomaston	MST-EA-Hartford	MST-EA-Bridgeport	Contract Total		Total Expenses
7100 ADMINISTRATIVE & GENERAL	**$ 137,061**	**$ 137,109**	**$ 183,674**	**$ 75,444**	**$ 156,585**	**$ 43,004**	**$ 43,004**	**$ 775,881**	**$ 3,469,779**	**$ 4,245,660**
7111 Staff Salaries & Wages						$ 43,004	$ 43,004	$ 86,008	$ -	$ 86,008
All Other A&G	$ 137,061	$ 137,109	$ 183,674	$ 75,444	$ 156,585			$ 689,873	$ 3,469,779	$ 4,159,652
TOTAL INDIRECT EXPENSES	**$ 137,061**	**$ 137,109**	**$ 183,674**	**$ 75,444**	**$ 156,585**	**$ 43,004**	**$ 43,004**	**$ 775,881**	**$ 3,469,779**	**$ 4,245,660**
TOTAL EXPENSES	**$ 920,274**	**$ 920,570**	**$ 1,233,233**	**$ 506,554**	**$1,051,369**	**$ 288,750**	**$ 288,750**	**$ 5,209,501**	**$ 23,280,349**	**$ 28,489,850**

INCOME/EXPENSE SUMMARY	Corbin House	Tress Road	MST	MST-PSB	Thomaston	MST-EA-Hartford	MST-EA-Bridgeport	Contract Total		Total
TOTAL INCOME	$ 920,274	$ 920,570	$ 1,233,233	$ 506,554	$1,051,369	$ 288,750	$ 288,750	$ 5,209,500	$ 22,399,059	$ 27,608,559
TOTAL EXPENSES	$ 920,274	$ 920,570	$ 1,233,233	$ 506,554	$1,051,369	$ 288,750	$ 288,750	$ 5,209,501	$ 23,280,349	$ 28,489,850
EXCESS/(SHORTAGE)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**(0)**	**$ (881,290)**	**$ (881,290)**

[ ] Original Contract # 19DCF0015
[X] Amendment # 2 of 2
(*For Internal Use Only*)

SIGNATURES AND APPROVAL

The Contractor ☒ IS or ☐ IS NOT a Business Associate under the Health Insurance Portability and Accountability Act of 1996, as amended.

Contractor

North American Family Institute, Inc. (NAFI Connecticut, Inc.)
Contractor (Corporate/Legal Name of Contractor)

DocuSigned by:
Lynn Bishop
A8978...

1/11/2019 | 9:43 AM EST

Signature (Authorized Official) Date

Lynn Bishop Executive Director

(Typed/Printed Name and Title of Authorized Official)

Agency

Department of Children and Families
Agency Name

DocuSigned by:
Deborah Ennis
E17CBCC7E27947B...

1/11/2019 | 11:23 AM EST

Signature (Authorized Official) Date

Deborah Ennis Chief Fiscal Officer

(Typed/Printed Name and Title of Authorized Official)

Office of the Attorney General

X Part I of this Contract having been reviewed and approved by the OAG, it is exempt from review pursuant a Memorandum of Agreement between the Agency and the OAG dated **October 24, 2017**.

Signature Date

Assistant / Associate Attorney General