

SERVICE STANDARD

INDIANA DEPARTMENT OF CHILD SERVICES

HOME BASED FAMILY CENTERED CASEWORK SERVICES

I. Service Description

- A. Provision of home based casework services for families involved with DCS/Probation.
- B. Home based casework is also available for pre-adoption and post-adoption services for adoptive families at risk or in crisis.
- C. These in-home services should be high quality, family centered, and culturally competent.
- D. They should be effective in reducing maltreatment, improving caretaking and coping skills, enhancing family resilience, supporting healthy and nurturing relationships, and children's physical, mental, emotional, and educational well-being.
- E. Home based casework services should help to safely maintain children in their home (or foster home), prevent children's initial placement or re-entry into foster care, preserve, support, and stabilize families, and promote the well-being of children, youth, and families.
- F. Home based casework services provide any combination of the following kinds of services to the families as approved by DCS/Probation.
 - 1. Home visits
 - 2. Participation in DCS Case Planning
 - 3. Supervised visitation
 - a) Supervised visits will be billed separately from other services within the standard and will consist of work within the scope of this service standard.
 - b) The Individual and Monthly Visitation Reports must be used to document the supervised visitation portion of the services provided.
 - c) The Monthly Progress Report will be used to document other services provided within this service standard.
 - d) Further instructions on how to facilitate, document, and bill for visitation is outlined in the Visitation Facilitation Service Standards:
 - (1) Section II (Service Delivery Referral Process)
 - (2) Service VII (Billable Units)
 - (3) Section XIII (Training)

4. Coordination of Services
5. Conflict management
6. Emergency/crisis services
7. Child development education
8. Domestic violence education
9. Parent Education
 - a) Approved evidence-based programs are outlined below. Other Parent Education Programs may be used, including Promising Practices, but they first require written approval from the DCS Central Office.
 - (1) Requests should be submitted to the Child Welfare Plan Inbox- childwelfareplan@dcs.in.gov
 - b) The California Evidence: www.cebc4cw.org
 - c) Substance Abuse and Mental Health Services Administration (SAMHSA): www.nrepp.samhsa.gov
 - d) The Office of Juvenile Justice and Delinquency Prevention: <http://ojjdp.ncjrs.gov>
10. Family communication
11. Facilitate transportation
 - a) Home based casework transportation is limited to client goal-directed, face to face as approved/specific as part of the case plan or goals/objectives identified at the Child and Family Team Meeting (e.g. housing/apartment search, etc.)
12. Participation in Child and Family Team Meetings
13. Family Reunification/Preservation
14. Reactive Attachment Disorder (RAD) Support
15. Foster family support
16. Advocacy
17. Family Assessment
18. Community referrals and follow-up
19. Develop structure/time management
20. Behavior modification
21. Budgeting/money management
22. Meal planning/preparation
23. Parent training with children present
24. Monitor progress of parenting skills
25. Community services information

26. Develop long and short term goals
27. Life skills training

II. Service Delivery

- A. Service provision must occur with face-to-face contact with the family within 48 hours of the referral.
- B. Services must include 24 hour crisis intake, intervention, and consultation seven days a week and must be provided primarily in the family's home.
 1. Limited services may also be provided at a community site.
- C. **EFFECTIVE OCTOBER 15, 2018:** Within the first 30 days, an assessment must be completed, with the family and input of other team members, to determine the family's needs.
 1. The provider should include the following domains in the assessment:
 - a) Life Domain
 - (1) Education level
 - (2) Employment history and current status
 - (3) Financial status
 - (4) Housing history and current arrangement
 - (5) Criminal history
 - b) Health Domain
 - (1) Current physical and mental diagnoses
 - (2) Current symptoms
 - (3) Current prescribed medications
 - (4) Substance Use Screening Tool
 - (a) UNCOPE or CAGE
 - (b) Substance Abuse and Mental Health Services Administration (SAMHSA):
www.nrepp.samhsa.gov
 - c) Trauma Domain
 - (1) Parental history of childhood trauma
 - (2) Child history of trauma
 - (3) How trauma has impacted life functioning
 - (4) Prior child welfare involvement

- d) Family Domain
 - (1) Family safety and well-being
 - (2) Domestic violence risk indicators
 - (3) Parental capabilities
 - (4) Family structure and customs
 - (5) Functional strengths
 - (6) Family functioning and stability
- e) Community Domain
 - (1) Utilization and access to resources
 - (2) Access to transportation
 - (3) Essential connections

- 2. The assessment shall guide the recommendations for treatment and/or services.
- 3. Recommendations regarding the family's needs including service needs, risks, and goals should be included in the treatment/service plan.
- 4. A copy of the assessment must be retained in the service provider's case file for the client.
 - a) The DCS Local Office and/or Court may request the full assessment at any time, and it shall be provided.

D. Services must include ongoing risk assessment and monitoring family/parental progress.

- 1. A re-assessment of the family's risks, needs, and goals shall be completed at a minimum of every 90 days, while updating the treatment/service plan as appropriate.
 - a) The agency shall provide DCS with a copy of the updated treatment/service plan every 90 days.
 - b) The treatment/service plan shall be reviewed with the client at a minimum of every 30 days.

E. The family will be the focus of service, and services will focus on the strengths of the family and build upon these strengths.

- 1. Members of the client's family, which may include foster parents, are to be defined in consultation with the family and approved by DCS/Probation.
- 2. This may include persons not legally defined as part of the family.

3. Approved family members will be documented as those listed on the authorizing DCS/Probation referral and subsequent written documents.
- F. Services will be time-limited and focused on limited objectives derived directly from the established DCS/Probation Case Plan or informal Adjustment.
 - G. Services must include development of short and long term family goals with measurable outcomes that are consistent with the DCS Case Plan.
 - H. Services must be family centered and child focused.
 - I. Services may include intensive rehabilitation, mental health skills building, and in-home skill building and must include after-care linkage.
 - J. Parent/caregiver should be incorporated into the children/youth life skills training and development to facilitate a transfer of learning.
 - K. Services include:
 1. Providing monthly progress reports, due by the 10th day of each month following the month of service.
 2. Providing requested supportive documentation such as case notes, social summaries, etc.
 3. Requested testimony and/or court appearances including hearings and/or appeals, Case Conference, staffing.
 - L. Staff must respect confidentiality.
 1. Failure to maintain confidentiality may result in immediate termination of the service agreement.
 - M. Services will be conducted with behavior and language that demonstrates respect for socio-cultural values, personal goals, lifestyle choices, and complex family interactions.
 1. Services must be delivered in a neutral-valued culturally-competent manner.
 - N. The caseload of the home based caseworker will include no more than 12 active families at any one time.
 - O. Services will be provided within the context of the DCS Practice Model or Probation Plan with involvement in Child and Family Team Meetings, if invited.
 1. A treatment plan will be developed based on the assessment by the provider and agreements reached in the Child and Family Team Meetings and/or documented in the authorized referral.
 - P. Each family receives comprehensive services through a single home based caseworker acting within a team, with team back up and agency availability 24 hours a day, 7 days a week.

- Q. If a family member is receiving services of a Recovery Coach, as part of substance abuse treatment, a referral may not be needed for Home Based Casework.
 - 1. If both services are deemed necessary, collaboration shall occur between the providers to ensure services are not duplicated.
- R. DCS may choose to select a standardized tool for evaluating family functioning.
 - 1. Services will include administration of this tool at the initiation of services as well as periodically during service provision.

III. Target Population

- A. Services must be restricted to the following eligibility categories:
 - 1. Children and families who have substantiated cases of abuse and/or neglect and will likely develop into an open case with Informal Adjustment (IA) or CHINs status.
 - 2. Children and their families which have an Informal Adjustment or the children have the status of CHINS or JD/JS.
 - 3. Children with the status of CHINS or JD/JS and their Foster/Kinship families with whom they are placed.
 - 4. All adopted children and adoptive families.

IV. Crisis Service

- A. “Safely Home Families First” is the Indiana Department of Child Services (DCS) Initiative for 2011.
 - 1. Our goal is to keep as many children “Safely Home” with their caretakers when possible.
 - 2. When removal of a child is necessary, then placement should be with “Families First”.
 - 3. Placing children with relatives is the next healthiest action to take, regarding meeting a child’s safety needs as well as their emotional needs.
 - 4. Crisis services may be necessary to prevent the removal of the child(ren). The family centered practice of the home based services is the best avenue to provide crisis services.
- B. These crisis services are for families who have children at imminent risk of removal.
 - 1. Imminent risk if defined as: Immediate threat of injury or harm to a child when no interventions have occurred to protect the child.
 - 2. The goal is to resolve the immediate crisis, prevent removal of the child, and to transition and/or link the family to needed services.

- C. Criteria for service:
1. The crisis intervention provider must be available for contact 24/7.
 2. The provider must have a crisis intervention telephone number.
 3. The FCM will notify the provider of a crisis situation and require a 1 hour response on the part of the provider.
 4. One (1) hour response time is required.
 - a) No more than 1 hour from phone call to provider to a face to face contact with the family by the provider.
 5. Referrals will be for families who are not currently receiving home based services (Home Based Casework, Home Based Therapy, Homemaker, or Homebuilders).
 - a) Crisis intervention services for existing clients in Home Based Services are already included as part of the service standards.
 6. Crisis intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis. Most interventions are expected to be in the home.
 7. Crisis payment is for the “incident only”. The “incident” for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends.
 8. A Crisis Report shall be electronically sent to the FCM within 24 hours.
 - a) This report should document the start time and end time of the intervention.
 - b) It shall report the assessment of the situation and recommendations for services, if any.
 9. The referral for this service will be after the incident and will include ongoing services if deemed necessary.

V. Goals and Outcomes

- A. Goal #1: Maintain timely intervention with the family and regular and timely communication with the referring worker.
1. Objective: HBCW or back-up is available for consultation to the family 24/7 by phone or in person.
 - a) Outcome Measure: 95% of all families that are referred will have face-to-face contact with the client within 48 hours of receipt of the referral or inform the current FCM/PO if the client does not respond to requests to meet.

- b) Outcome Measure: 95% of families will have a written treatment/service plan prepared and sent to the FCM/PO following receipt of the referral within 30 days of contact with the client.
 - (1) The treatment/service plan should include the family's service needs, risks, and goals.
 - c) Outcome Measure: 95% of families will be re-assessed and have their treatment/service plan updated at a minimum of every 90 days for the life of the referral.
 - d) Outcome Measure: 100% of all families will have monthly written summary reports prepared and sent to the current FCM/PO by the 10th day of the month following the month of service.
- B. Goal #2: Client will achieve improved family functioning.
- 1. Objective: Goal setting and service planning are mutually established with the client and Home Based Caseworker within 30 days of the initial face-to-face intake and a written report signed by the Home Based Caseworker and the client is submitted to the current FCM/PO.
 - a) Outcome Measure: 67% of the families that have a child in substitute care prior to the initiation of service will be reunited by closure of the service provision period.
 - b) Outcome Measure: 90% of the individuals/families will not be the subjects of a new investigation resulting in the assignment of a status of "substantiated" abuse or neglect throughout the service provision period. To be measured by DCS/PO staff.
 - c) Outcome Measure: 90% of the individuals/families that were intact prior to the initiation of service will remain intact throughout the service provision period.
 - d) If DCS elects to implement a standardized tool for evaluating family functioning, a related outcome measure will be added.
- C. Goal #3: DCS/Probation and client will report satisfaction with services.
- 1. Outcome Measure: DCS/Probation satisfaction will be rated 4 and above on the Service Satisfaction Report.
 - 2. Outcome Measure: 90% of clients will rate the services "satisfactory" or above on a satisfaction survey developed by the service provider, unless one is distributed by DCS/Probation to providers for their use with clients. Providers are to survey a minimum of 12 clients or 20% of their caseload (whichever results in a larger number) randomly selected from each county served.

VI. Minimum Qualifications

- A. Direct Worker

1. Direct workers under this standard must meet one of the following minimum qualifications:
 - a) Bachelor's degree in Psychology or Sociology, or licensed Bachelor Degree Social Worker or licensed Social Worker with a Baccalaureate Degree
 - (1) A license is required unless a statutory licensure exemption in IC 25-23.6-4-2(a) is met.
 - b) Master's degree with a Temporary Permit in Social Work
 - c) Bachelor's or Master's degree in a directly related human services field. The individual must also:
 - (1) Complete a minimum of 39 semester/58 quarter hours in the following coursework:
 - (a) Human Growth and Development
 - (b) Social and Cultural Foundations
 - (c) Lifestyle and Career Development
 - (d) Sexuality
 - (e) Gender and Sexual Orientation
 - (f) Ethnicity, Race, Status, and Culture
 - (g) Psychology
 - (h) Sociology
 - (i) Social Work
 - (j) Criminology
 - (k) Ethics and Philosophy
 - (l) Physical and Behavioral Health
 - (m) Family Relationships
 - (n) Advocacy and Mediation
 - (o) Case Management
 - (p) Resources and Systems
 - (q) Social Policy
 - (r) Community Planning and Relations
 - (s) Crisis Intervention
 - (t) Substance Use
 - (u) Counseling and Guidance
 - (v) Educational Studies
 - (2) The individual must complete the Human Service Related Degree Course Worksheet.
 - (a) For auditing purposes, the worksheet should be completed and placed in the individual's personnel file.

- (b) Transcripts must be attached to the worksheet.
 - (c) Other Bachelor's degrees will be accepted in combination with a minimum of two years-experience providing a service to families that need assistance in the protection and care of their children and/or providing skills training, development, and habilitation.
 - (i) Experience gained by an employee in which the employee was not qualified to complete the work at the current or previous employer does not count toward the required two (2) year experience in combination with a Bachelor's degree.
 - (3) Coursework must be completed at a satisfactory level, no less than a C- for any quarter or semester grade in applicable coursework.
 - (a) Applicable coursework listed above
 - d) Individuals who hold a Master or Doctorate degree that is applicable toward licensure, must become licensed as indicated in 1. a) and 1. b) above.
2. The individual must possess a valid driver's license and the ability to use a private car to transport self and others, and must comply with the state policy concerning minimum car insurance coverage.
3. In addition to the above:
 - a) Knowledge of child abuse and neglect, and child and adult development
 - b) Knowledge of community resources and ability to work as a team member
 - c) Belief in helping clients change their circumstances, not just adapt to them
 - d) Belief in adoption as a viable means to build families
 - e) Understanding regarding issues that are specific and unique to adoptions such as loss, mismatched expectations and flexibility, loss of familiar surroundings, customs and traditions of the child's culture, entitlement, gratification delaying, flexible parental roles, and humor.

B. Supervisor

- 1. Supervisors under this standard must meet one of the following minimum qualifications:

- a) Master's or Doctorate degree in Social Work, Psychology, or directly related human services field from an accredited college and completion of DCS Supervision Qualification Training requirements specified for Masters level supervisors.
- b) Master's Degree in Social Work, Psychology, Marriage and Family Therapy, or related human services field, and two (2) years related clinical experience with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist, or Mental Health Counselor Board, as one of the following:
 - (1) Clinical Social Worker
 - (2) Marriage and Family Therapist
 - (3) Mental Health Counselor
- c) A Bachelor's Degree in Social Work, Psychology, or directly related human services field from an accredited college with five years-experience delivering home based child welfare or home based probation services with one year experience under the DCS Home Based Casework Service Standards (Community Partners, Father Engagement, or Home Based Family Centered Casework) and completion of DCS Supervisor Qualification Training requirements specified for Bachelor's level supervisors.
 - (1) The individual must have a minimum of 6 months of experience with the current agency or must have provided supervision under the service standard for at least 1 year at a different agency.
 - (2) All staff who are supervised by a bachelor's level supervisor must have clinical consultation a minimum of quarterly.
 - (a) This supervision can be provided in a group format.
 - (b) Supervisors should be present during clinical consultation, as this time can apply towards the minimum staffing requirements required for supervision.

2. Supervision Training Criteria:

- a) All providers providing supervision must adhere to the DCS Supervisor Qualification Training.
- b) The DCS Supervisor Qualification Training outlines a training criteria.
- c) These trainings can be completed by the agencies own training program if it meets the competencies or utilizes DCS resources to train staff.

- d) The link for the DCS Supervisor Qualification Training can be found at <http://www.in.gov/dcs/3493.htm>

3. Supervision:

- a) Supervisors must respond to the ongoing individual needs of staff by providing them with the appropriate combination of training and supervision.
- b) The frequency and intensity of training and supervision are to be consistent with “best practices” and comply with the requirements of each provider’s accreditation body.
- c) Supervision should include individual, group, and direct observation modalities and can utilize teleconference technologies.
- d) Under no circumstance is one-on-one supervision to be less than one (1) hour of supervision per 25 hours of face-to-face direct client services provided, nor occur less than every two (2) weeks.

4. Shadowing:

- a) All agencies must have policies that require regular shadowing (by supervisor) of all staff at established intervals based on staff experience and need.
- b) Shadowing must be provided in accordance with the policy.
- c) The agency must provide clear documentation that shadowing has occurred.

C. Clinical Consultation

1. Applicable when the supervisor meets the requirements at a Bachelor’s Degree level, as described above. The individual providing Clinical Consultation under this standard must meet one of the following minimum qualifications:

- a) Master’s Degree in Social Work, Psychology, Marriage and Family Therapy, or related human services field, and two (2) years related clinical experience with a clinical license issued by the Indiana Social Worker, Marriage and Family Therapist, or Mental Health Counselor Board, as one of the following:
 - (1) Clinical Social Worker
 - (2) Marriage and Family Therapist
 - (3) Mental Health Counselor
- b) All staff who are supervised by a Bachelor’s level supervisor must have a minimum of quarterly clinical supervision.
 - (1) The consultation can be provided in a group or individual setting.
 - (2) Bachelor’s level Supervisor should be present during clinical consultation with direct staff.

- (3) This time is applicable to minimum supervision requirements only if conducted one-on-one with staff.

VII. Billable Units

A. Medicaid:

1. Services through the Medicaid Rehabilitation Option (MRO) may be Case Management and/or Skills Training and Development. Medicaid shall be billed when appropriate.
 - a) Medically necessary behavioral health care Skills Training and Development services for the MRO will be paid per 15 minute unit for Individual and Family per 15 minute unit for group.
 - b) Medically necessary behavioral health care Case Management for the MRO child will be paid per 15 minute unit. Case Management services should not exceed those included in the MRO package.

Billing Code	Description
T1016 HW	Case Management, each 15 minutes
H2014 HW	Skills Training and Development , per 15 minutes
H2014 HW HR	Skills Training and Development, per 15 minutes (family/couple, consumer present)
H2014 HW HS	Skills Training and Development, per 15 minutes (family/couple, without consumer present)
H2014 HW U1	Skills Training and Development , per 15 minutes (group setting)
H2014 HW HR U1	Skills Training and Development , per 15 minutes (group setting, family/couple, with consumer present)
H2014 HW HS U1	Skills Training and Development , per 15 minutes (group setting, family/couple, without consumer present)

2. DCS hold overall Case Management responsibility. In order to assist DCS with the coordination of medically necessary behavioral health care needs of the MRO client, CMHCs may provide case management services with this specific focus.

B. DCS Funding:

1. Those services not deemed medically necessary for the Medicaid eligible client, including services to other referred members of the family that are not related to the behavior health care needs of the eligible client, will be paid to DCS per face-to-face hour as outlined below.
 - a) These billable units will also be utilized for services to referred clients who are not Medicaid eligible and for those providers who are unable to bill Medicaid.
2. Face to Face
 - a) Members of the client family are to be defined in consultation with the family and approved by DCS.
 - (1) This may include persons not legally defined as part of the family.
 - b) Includes client specific face-to-face contact with the identified client/family during which services as defined in the applicable Service Standard are performed.
 - c) Includes Child and Family Team Meetings or case conferences initiated or approved by the DCS for the purposes of goal directed communication regarding the services to be provided to the client/family.
 - d) Provider meetings initiated by the FCM for the purpose of goal directed communication regarding the client family.
 - e) Includes in-vehicle (or in-transport) time with the client provided it is identified as goal-directed, face-to-face, and approved/specified as part of the client's intervention plan (e.g. housing/apartment search, etc.).
 - (1) Travel time is only billable when the client is in the vehicle.
 - f) Includes crisis intervention via telephone with the identified client family.
 - (1) Best practice would include a follow up face to face visit with the client family.
 - (2) Crisis over the phone is for extraordinary circumstances and should not be the mode to which ongoing services are provided.
 - g) Includes time spent completing any DCS approved standardized tool to assess family functioning.
 - h) Groups shall not be facilitated within this service standard.
 - i) Reminder: Not included are routine report writing and scheduling of appointments, collateral contacts, travel time, and no shows.
 - (1) These activities are built into the cost of the face to face rate and shall not be billed separately.

3. Supervised Visitation
 - a) Time spent supervising visits will be billed separately from other services within this standard and will consist of work within the scope of this service standard.
 - b) The rate will be the same as the face-to-face rate, but will include only time spent face-to-face supervising the visit.
 - c) Any other billable time as defined in the face-to-face rate should be billed under the face-to-face rate.
4. Services may be billed in 15 minute increments; partial units are rounded to the nearest quarter hour using the following guidelines:
 - a) 0 to 7 minutes – Do not bill (0.00 hour)
 - b) 8 to 22 minutes – 1 fifteen minute unit (0.25 hour)
 - c) 23 to 37 minutes -- 2 fifteen minute units (0.50 hour)
 - d) 38 to 52 minutes – 3 fifteen minute units (0.75 hour)
 - e) 53 to 60 minutes – 4 fifteen minute units (1.00 hour)
 - f) **Note on Intermittent supervised visitation:** when DCS requests the provider to check in intermittently - at least once per hour - , the provider can bill in increments of 30 minutes for each check-in, provided that the total amount of time billed should not exceed the total length of the visit.
5. Interpretation, Translation, and Sign Language Services
 - a) The location of and cost of Interpretation, Translation, and Sign Language Services are the responsibility of the Service Provider.
 - b) If the service is needed in the delivery of services referred, DCS will reimburse the Provider for the cost of the Interpretation, Translation, or Sign Language service at the actual cost of the service to the provider.
 - c) The referral from DCS must include the request for Interpretation services and the agencies' invoice for this service must be provided when billing DCS for the service.
 - d) Providers can use DCS contracted agencies and request that they be given the DCS contracted rate but this is not required.
 - e) The Service Provider Agency is free to use an agency or persons of their choosing as long as the service is provided in an accurate and competent manner and billed at a fair market rate.
 - f) If the agency utilizes their own staff to provide interpretation, they can only bill for the interpretation services. The agency cannot bill for performing two services at one time.
6. Court
 - a) The provider of this service may be requested to testify in court.

- b) A Court Appearance is defined as appearing for a court hearing after receiving a written or email request or subpoena from DCS to appear in court, and can be billed per appearance.
 - c) If the provider appeared in court two different days, they could bill for 2 court appearances.
 - (1) Maximum of 1 court appearance per day.
 - d) The Rate of the Court Appearance includes all cost associated with the court appearance, therefore additional costs associated with the appearance cannot be billed separately.
7. Reports
- a) If the services provided are not funded by DCS, the 'Reports' hourly rate will be paid.
 - b) A referral for 'Reports' must be issued by DCS in order to bill.
8. Crisis Intervention/Response
- a) Crisis Intervention includes, but is not limited to, crisis assessment, planning and counseling specific to the crisis.
 - b) Most interventions are expected to be in the home. Crisis payment is for the "incident only".
 - c) The "incident for payment purposes for the provider will start at the time of a face to face contact with the client and end when that face to face contact ends. An hourly rate will be paid.

VIII. Case Record Documentation

- A. Case record documentation for service eligibility must include:
- 1. A completed, and dated DCS/ Probation referral form authorizing services
 - 2. Copy of DCS/Probation case plan, informal adjustment documentation, or documentation of requests for these documents from referral source.
 - 3. Safety issues and Safety Plan Documentation
 - 4. Documentation of Termination/Transition/Discharge Plans
 - 5. Treatment/Service Plan
 - a) Must incorporate DCS Case Plan Goals and Child Safety goals.
 - b) Must use Specific, Measurable, Attainable, Relevant, and Time Sensitive goal language
 - c) Must include initial and ongoing assessments of needs including service needs, risks, and goals.
 - (1) Must be provided within the first 30 days and should be reassessed and submitted at least every 90 days for the life of the referral.
6. Monthly reports are due by the 10th of each month following the month of service, case documentation shall show when report is sent.

- d) Provider recommendations to modify the service/ treatment plan
- e) Discuss overall progress related to treatment plan goals including specific examples to illustrate progress
- 3. Progress/Case Notes Must Document: Date, Start Time, End Time, Participants, Individual providing service, and location
- 4. When applicable Progress/Case notes may also include:
 - a) Service/Treatment plan goal addressed (if applicable-
 - b) Description of Intervention/Activity used towards treatment plan goal
 - c) Progress related to treatment plan goal including demonstration of learned skills
 - d) Barriers: lack of progress related to goals
 - e) Clinical impressions regarding diagnosis and or symptoms (if applicable)
 - f) Collaboration with other professionals
 - g) Consultations/Supervision staffing
 - h) Crisis interventions/emergencies
 - i) Attempts of contact with clients, FCMs, foster parents, other professionals, etc.
 - j) Communication with client, significant others, other professionals, school, foster parents, etc.
 - k) Summary of Child and Family Team Meetings, case conferences, staffing
- 5. Supervision Notes must include:
 - a) Date and time of supervision and individuals present
 - b) Summary of Supervision discussion including presenting issues and guidance given.

IX. Service Access

- A. All services must be accessed and pre-approved through a referral form from the referring DCS staff.
- B. In the event a service provider receives verbal or email authorization to provide services from DCS/Probation an approved referral will still be required.
- C. Referrals are valid for a maximum of six (6) months unless otherwise specified by the DCS.
- D. Providers must initiate a re-authorization for services to continue beyond the approved period.

X. Adherence to DCS Practice Model

- A. Services must be provided according to the Indiana Practice Model, providers will build trust-based relationships with families and partners by exhibiting empathy, professionalism, genuineness and respect.
- B. Providers will use the skills of engaging, teaming, assessing, planning and intervening to partner with families and the community to achieve better outcomes for children.

XI. Interpretation, Translation, and Sign Language Services

- A. All Services provided on behalf of the Department of Child Services must include Interpretation, Translation, or Sign Language for families who are non-English language speakers or who are hearing-impaired.
- B. Interpretation is done by an Interpreter who is fluent in English and the non-English language and is the spoken exchange from one language to another.
- C. Certification of the interpreter is not required; however, the interpreter should have passed a proficiency test in both the spoken and the written language in which they are interpreting.
- D. Interpreters can assist in translating a document for a non-English speaking client on an individual basis, (i.e., An interpreter may be able to explain what a document says to the non-English speaking client).
- E. Sign Language should be done in the language familiar to the family.
- F. These services must be provided by a non-family member of the client, be conducted with respect for the socio-cultural values, life style choices, and complex family interactions of the clients, and be delivered in a neutral-valued culturally-competent manner.
- G. The Interpreters are to be competent in both English and the non-English Language (and dialect) that is being requested and are to refrain from adding or deleting any of the information given or received during an interpretation session.
- H. No side comments or conversations between the Interpreters and the clients should occur.

XII. Trauma Informed Care

- A. Provider must develop a core competency in Trauma Informed Care as defined by the National Center for Trauma Informed Care—SAMHSA (<http://www.samhsa.gov/nctic/>):
 - 1. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.
 - 2. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance

use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

3. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.
 4. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization
- B. Trauma Specific Interventions: (modified from the SAMHSA definition)
1. The services will be delivered in such a way that the clients/families feel respected, informed, connected, and hopeful regarding their own future.
 2. The provider must demonstrate an understanding, through the services provided, of the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
 3. The provider will work in a collaborative way with child/family, extended family and friends, and other human services agencies in a manner that will empower child/family.

XIII. Training

- A. Service provider employees are required to complete general training competencies at various levels.
- B. Levels are labeled in Modules (I-IV), and requirements for each employee are based on the employee's level of work with DCS clients.
- C. Training requirements, documents, and resources are outlined at:
<http://www.in.gov/dcs/3493.htm>
 1. Review the **Resource Guide for Training Requirements** to understand Training Modules, expectations, and Agency responsibility.
 2. Review **Training Competencies, Curricula, and Resources** to learn more about the training topics.
 3. Review the **Training Requirement Checklist** and **Shadowing Checklist** for expectations within each module.

XIV. Cultural and Religious Competence

- A. Provider must respect the culture of the children and families with which it provides services.
- B. All staff persons who come in contact with the family must be aware of and sensitive to the child's cultural, ethnic, and linguistic differences.
- C. All staff also must be aware of and sensitive to the sexual and/or gender orientation of the child, including lesbian, gay, bisexual, transgender or questioning children/youth.
 - 1. Services to youth who identify as LGBTQ must also be provided in accordance with the principles in the Indiana LGBTQ Practice Guidebook.
 - 2. Staff will use neutral language, facilitate a trust based environment for disclosure, and will maintain appropriate confidentiality for LGBTQ youth.
 - 3. The guidebook can be found at:
<http://www.in.gov/dcs/files/GuidebookforBestPracticeswithLGBTQYouth.pdf>
- D. Efforts must be made to employ or have access to staff and/or volunteers who are representative of the community served in order to minimize any barriers that may exist.
- E. Contractor must have a plan for developing and maintaining the cultural competence of their programs, including the recruitment, development, and training of staff, volunteers, and others as appropriate to the program or service type; treatment approaches and models; and the use of appropriate community resources and informal networks that support cultural connections.

XV. Child Safety

- A. Services must be provided in accordance with the Principles of Child Welfare Services.
- B. All services (even individual services) are provided through the lens of child safety.
 - 1. As part of service provision, it is the responsibility of the service provider to understand the child safety concerns and protective factors that exist within the family.
 - 2. Continual assessment of child safety and communication with the Local DCS Office is required. It is the responsibility of the service provider to report any safety concerns, per state statute, IC 31-33-5-1.
- C. All service plans should include goals that address issues of child safety and the family's protective factors. The monthly reports must outline progress towards goals identified in the service plans.

