Michigan Department of Health and Human Services
Bureau of Grants and Purchasing (BGP)
PO Box 30037, Lansing, MI 48909
Or
235 S. Grand Avenue, Suite 1201, Lansing, MI 48933

CONTRACT NUMBER: RFCAN xxx
Between
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
And

CONTRACTOR	PRIMARY CONTACT	EMAIL
xxx	xxx	xxx
CONTRACTOR ADDRESS		TELEPHONE
xxx		- -

STATE CONTACT	NAME	TELEPHONE	EMAIL
Contract Administrator		- -	xxx@Michigan.gov
BGP Analyst	xxx	- -	xxx@Michigan.gov

AGREEMENT SUMMARY			
SERVICE DESCRIPTION	Residential Foster Care Abuse Neglect		
GEOGRAPHIC AREA	Statewide		
INITIAL TERM	EFFECTIVE DATE*	EXPIRATION DATE	AVAILABLE OPTION YEARS
3 years	October 1, 2024	September 30,2027	2
MISCELLANEOUS INFORMATION			
ESTIMATED CONTRACT VALUE AT TIME OF EXECUTION	$xxx		
CONTRACT TYPE	Per Diem		

*The effective date of the contract is the date listed in the “Effective Date” box above.

The undersigned have the lawful authority to bind the Contractor and MDHHS to the terms set forth in this Contract. The Contractor’s signature certifies that the Contractor is not an Iran linked business as defined in MCL 129.312.

FOR THE CONTRACTOR:

Contractor

Signature of Director or Authorized Designee

Print Name

Date

FOR THE STATE:

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Signature of Director or Authorized Designee

Christine H. Sanches

Print Name

Date

Anticipated Total Contract Value: $XX

This Contract will be in effect from October 1, 2024, through September 30, 2027. No service will be provided and no costs to the state will be incurred before October 1, 2024.

At the discretion of MDHHS this Contract may be renewed by an amendment not less than 30 days before its expiration. This Contract may be renewed for up to two additional one-year periods.

1 PROGRAM REQUIREMENTS

1.1 Client Eligibility Criteria

a. Eligible Clients

Services provided by the Contractor under this Contract are limited to those youth and families for whom Michigan Department of Health and Human Services (MDHHS) can legally provide care and services and for whom MDHHS makes a State payment.

b. Determination of Eligibility

MDHHS must determine the youth and families' eligibility and document this in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) or Comprehensive Child Welfare Information System (CCWIS).

1.2 Referrals

All referrals for residential intervention services for MDHHS supervised children must come from the Regional Placement Unit (RPU), or West Michigan Partnership for Children (WMPC) for Kent County. RPU must provide to the Contractor referral materials as outlined in FOM-912 *Residential Intervention: MDHHS Responsibilities*.

A court order is required to place an adjudicated delinquent youth in a specific contracted abuse/neglect program. With a court order, placement exception request approval is required from Division of Child Welfare Licensing (DCWL).

a. Regional Placement Unit (RPU):

When considering a placement, a youth’s demographics (age, sex, gender identity, gender expression and geographic home) and indicated need(s) must align with the Contractors service description, in addition to the Regional

Placement Unit (RPU) and the Contractors reporting that there is a current vacancy or vacancy expected that aligns with projected admission date.

The importance of maintaining youth and family connection must be considered when identifying a residential intervention location.

The RPU must refer youth to a Contractor consistent with FOM Policy, Michigan Child Caring Administrative Rules, and applicable federal and state law(s).

Based on the recommendation from the independent assessment, a child will be referred for placement in one of the following residential foster care program types:

1) Mental Health Behavior Stabilization
2) Developmentally Disabled and Cognitively Impaired
3) Substance Abuse Treatment
4) Youth with Problematic Sexual Behavior
5) Parent/Baby
6) Specialized Developmentally Disabled
7) Intensive Stabilization
8) Human Trafficking Survivor

Definitions, symptomology, and program specific services which the Contractor must make available to each youth in its care are listed in Attachment A.

b. Referral Packet

At the time of referral, the primary caseworker/agency must provide the contractor with a complete referral packet as outlined in FOM 912.

1.3 Admission Criteria

a. The Contractor must submit program information to DCWL, RPU, Residential Collaboration and Technical Assistance Unit (RCTAU), and the Foster Care Program Office. The criteria as outlined in the Contractor's submitted program information must identify the behaviors and characteristics of children for whom the Contractor can provide services. It is understood by both parties to this Contract that the youth's needs must be met by the Contractor upon acceptance.

b. The Contractor must accept all children referred by the RPU that match the behaviors and characteristics of children as outlined in the Contractor's program information. If exceptional circumstances exist and the child does not fit current program conditions, the Contractor must contact the RPU. A Contractor that provides services under this contract may indicate they cannot admit the child if circumstances exist in the specific residential intervention program that would place the child, other children or staff safety at risk. The Contractor must provide a detailed explanation to the RPU and

the Foster Care Program Office Manager or designee, if safety or appropriate treatment concerns exist in the program that prevents the Contractor from admitting the child to determine if the concerns can be mitigated. Refusal cannot be based on the youth's diagnosis, acuity, criminal or sexual offender status, race, color, religion, national origins, sexual orientation, gender identity, linguistic or cultural needs, or previous negative outcomes or residential experiences of the child, if the child's characteristics and needs align with the Contractor's identified characteristics and needs served.

Should Foster Care Program Office disagree with the explanation preventing acceptance, a review meeting shall be held within 48 hours to include the Contractor, CSA Senior Deputy Director or designee, Foster Care Program Office Manager or designee and other parties determined necessary to evaluate the appropriateness of referral acceptance.

If the Foster Care Program Office does not agree with the Contractor's decision to deny a placement, the Contractor will not receive an incentive payment for the month the denial occurred.

c. For all youth placed with the Contractor on or after April 1, 2021, acceptance must be based on a recommendation from an independent assessor that a residential intervention program is the least restrictive setting in which the youth can be served. In emergency situations, if an assessment has not been conducted prior to placement, the Contractor must cooperate with the independent assessor and the primary caseworker/agency responsible for placement to ensure the youth receives the required independent placement assessment within 20 days of placement.

1.4 Service Planning and Delivery

All children entering a residential intervention program must be assessed by a contracted qualified independent assessor selected and contracted by MDHHS. Whenever possible this will occur prior to referral to any residential intervention program. In some emergency situations a child may be referred to a residential intervention program prior to the completion of the assessment. The Contractor is not responsible for conducting or securing these assessments; the referral will be made by the RPU, and the assessment will be conducted by a qualified independent assessor.

1.5 Legal or Court Related

a. MDHHS must not transfer legal responsibility for any child(ren) to the Contractor except as provided herein.

b. MDHHS must involve the Contractor, to the extent allowed by law, in matters relating to any legal or court activities concerning the youth while in the Contractor's care.

c. The Contractor must ensure all directives and services ordered by the court are completed to the satisfaction of the court within the timeframes ordered.

2 CONTRACTOR RESPONSIBILITIES

2.1 Email Address

The Contractor authorizes MDHHS to use the contact information below to send contract related notifications/information. The Contractor must provide MDHHS with updated contact information if it changes.

Contact email address:

2.2 Requests for Information

The Contractor may be required to meet and communicate with MDHHS representatives and MDHHS may require that the Contractor create reports or fulfill requests for information as necessary to fulfill the MDHHS' obligations under statute and/or Dwayne B. v. Whitmer, et al., 2:06-cv-13548, herein referred to as the Modified Implementation, Sustainability, and Exit Plan (MISEP).

2.3 Geographic Area

The Contractor must provide services described herein in the following geographic area: Statewide

2.4 Licensing Requirements and Number of Children in Care

a. The MDHHS Division of Child Welfare Licensing (DCWL) is the licensing agency for Child Caring Institutions (CCI). A license is issued to a certain person or organization at a specific location, is non-transferable, and remains the property of the Department. Therefore, an CCI must be established at a specific location.

b. The Contractor must ensure that, for the duration of this contract, it must maintain a license for those program areas and services that are provided under this Contract. If the Contractor fails to comply with this section, MDHHS shall terminate this Contract for default.

c. The Contractor is licensed to provide service under this contract under the following license number: xxx

d. At no time must the number of youth in care exceed the licensed capacity of the facility specified in the Contractor's license. On no day during this Contract period, must there be more youth than the number of contracted beds listed in Schedule B Pricing Matrix for whom MDHHS has the responsibility to make a State payment. If the Contractor can admit more than the contracted number of youth (but not more than the licensed capacity), a bed cap exception must be obtained through the Foster Care Program Office prior to placement.

2.5 Location of Facilities

The Contractor must provide services described herein at the following location(s):

xxx

2.6 Program Statement

a. The Contractor must provide the Foster Care Program Office with a copy of the program statement for each program covered under this Contract. The program statement must comply with the requirements of MDHHS DCWL standards specific to the license listed in Section 2.4 above and with all federal laws related to the separation of abuse/neglect and juvenile justice programs.

b. The Contractor must inform MDHHS of any programmatic changes that would require a revised program statement at any point during the term of this Contract and provide a copy of the revised program statement to MDHHS.

2.7 Reserved

2.8 Credentials

a. The Contractor must ensure that appropriately credentialed or trained staff under its control, including Contractor employees and/or subcontractors, must perform functions under this contract.

b. The Contractor must include persons with residential foster care program lived experience (e.g., young adult, family members) on their Executive Board, and/or committees, and/or in programmatic decision making where appropriate.

2.9 Compliance Requirements

a. The Contractor must comply with requirements of MDHHS policy Children's Foster Care Manual (FOM 912-1) and MDHHS policy amendments, including interim policy bulletins.

b. Throughout the term of this contract, the Contractor must ensure that it provides all applicable MDHHS policy and MDHHS policy amendments

(including interim policy bulletins) and applicable Michigan Child Caring Institution Administrative Rules to social service staff. The Contractor must ensure that social service staff complies with all applicable requirements.

MDHHS policies, amendments, and policy bulletins, are published on the following internet link: https://dhhs.michigan.gov/olmweb/ex/html/. Michigan Child Caring Institution Administrative Rules are published on the following internet link:
ARS Public - MI Admin Code for Health and Human Services - Children's Services Agency (state.mi.us)

c. The Michigan Department of Health and Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sex or gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to a beneficiary's eligibility or a person's ability to perform the duties of a particular job. The statement is supported by MDHHS policy bulletins APB 2020-013/APB 2020-20, Elliott-Larsen Civil Rights Act (ELCRA) and Executive Directive 2019-09. The policy and directive highlight staff and affiliates expectation of being proactive in identifying and eliminating barriers to our customers specific needs, ensuring there is no inequitable impact on any individual or group, so we may all achieve our highest potential.

   The above statement applies to all MDHHS supervised children, and to all licensed and unlicensed caregivers and families that could potentially provide care or are currently providing care for MDHHS supervised children, including MDHHS supervised children receiving services in a MDHHS contracted residential intervention program.

d. The Contractor must provide services within the framework of Michigan's child welfare practice model, MiTEAM. The Contractor must utilize the skills of engagement, assessment, teaming and mentoring in partnering and building trust-based relationships with families and children by exhibiting empathy, professionalism, genuineness, and respect. Treatment planning must be from the family driven, youth guided perspective clearly articulated and identified in the treatment plan. For youth without an identified permanent family, treatment planning must engage supportive adults involved with the youth.

e. The Contractor must comply with the provisions of 2015 PA 53 once an assignment from MDHHS is accepted by:

   1) Submitting a written service agreement (DHS-3600) to perform the services related to the youth or individuals MDHHS referred to the Contractor; or

2) Engaging in any activity that results in MDHHS being obligated to pay the Contractor for services related to youth MDHHS referred to the Contractor.

The Contractor acknowledges that it has waived any legal protections under MCL 722.124e, MCL 722.124f, and/or MCL 710.23g to decline to provide any services that conflict with, or under circumstances that conflict with, the child placing agency's sincerely held religious beliefs unless those beliefs are contained in a written policy, statement of faith, or other document adhered to by the Contractor.

f. The Contractor must ensure compliance with all applicable provisions and requirements of the Dwayne B. v. Whitmer, et al., 2:06-cv-13548, Modified Implementation, Sustainability, and Exit Plan.

g. Throughout the term of this Contract the Contractor must maintain the capability to provide services 24 hours a day, 365 days a year as specified in the treatment plan for each child and child's family accepted for care.

h. The Contractor must ensure compliance with all provisions of the Family First Prevention Services Act (FFPSA) of 2018 (H.R. 1892) and all requirements of the Qualified Residential Treatment Program (QRTP) established within the Act, MCL 722.111, and MCL 722.123(a).

i. To be certified as a QRTP, the Contractor must be accredited by one or more of the following for the duration of the Contract:

1) Council on Accreditation (COA)
2) Commission on Accreditation of Rehabilitation Facilities (CARF)
3) Joint Commission on Accreditation of Health Care Organizations (JCAHO)
4) Education Assessment Guidelines Leading Towards Excellence (EAGLE)
5) Teaching Family Association (TFA)
6) Other non-profit accreditation organization approved by the US Department of Health and Human Services QRTP listing.

j. The Contractor must submit the Chief Administrator Annual Assessment CWL-4607-CCI annually to MDHHS.

k. The Contractor must implement a MDHHS approved trauma informed practice model. The trauma informed practice model must be re-certified annually.

l. The Contractor must be certified as QRTP compliant annually using the MDHHS-5999, Residential Foster Care Abuse and Neglect and Residential Foster Care Juvenile Justice Contract Qualified Residential Treatment Program (QRTP) Re-Certification.

m. The following individuals must be provided, without prior notice, access at any time to the Contractor's property to meet privately with youth:

   1) MDHHS Children's Services Administration director or designee
   2) MDHHS case workers
   3) MDHHS child welfare licensing consultants
   4) The youth's attorney or guardian ad litem
   5) Disability Rights Michigan advocate

   The Contractor must provide these individuals access to the Contractor's property, building(s) or part thereof, including the youth's sleeping room.

n. A lack of MDHHS conducting contract performance monitoring and evaluation or failure of MDHHS to bring to the attention of the Contractor, a lack of compliance in fulfilling its obligations under this Contract, does not relieve the Contractor from its past, current, or future obligations, nor penalty for failure to comply with this contract.

o. The Contractor must have a minimum of 15 video surveillance cameras in operation at the facility. The Contractor must maintain video surveillance of all common areas and utilize video surveillance to reduce blind spots in their facility. Common areas are defined as any area the residents may routinely occupy on facility grounds excluding sleeping areas, bathrooms, or areas where youth may receive individual medical, dental, or mental health treatment.

   Facilities will be required to maintain access to existing video surveillance footage for a minimum of 30 days. Constant rolling and motion triggered surveillance systems are both acceptable formats.

   If the minimum video requirements are not met MDHHS reserves the right to move all MDHHS youth out of the program and terminate the contract.

   The Mental Health Code Act 258 0f 1974 (Rights of Recipients of Mental Health Services) prohibits the use of video surveillance in facilities that serve mental health recipients. The Mental Health Code defines a recipient as "an individual who receives mental health services from the department, or a community mental health service program or a facility or from a provider that is under contract with the community mental health service program." MCL 330.1100c(13). Therefore, facilities that have any mental health recipients are exempt from the video surveillance contract requirements in this section.

p. The Contractor will uphold high ethical standards and is prohibited from:
   1) holding or acquiring an interest that would conflict with this Contract,
   2) doing anything that creates an appearance of impropriety with respect to the award or performance of the Contract,

3) attempting to influence or appearing to influence any State employee by the direct or indirect offer of anything of value,
4) paying or agreeing to pay any person, other than employees and consultants working for Contractor,
5) any consideration contingent upon the award of the Contract.

Contractor must immediately notify MDHHS of any violation or potential violation of these standards. This Section applies to Contractor, any parent, affiliate, or subsidiary organization of Contractor, and any subcontractor that performs Contract Activities in connection with this Contract.

q. The contractor must comply with the provisions of:

1) 1984 Public Act, 114, as amended being M.C.L. 3.711 *et seq*., Interstate Compact on the Placement of Children.
2) 1975 Public Act 238, as amended, being M.C.L. 722.621 *et seq*., Child Protection Law.
3) 1982 Public Act 162, as amended, being M.C.L. 450.2101 *et seq.,* Michigan Nonprofit Corporation Act.
4) 1994 Public Act 204, as amended, being M.C.L. 722.921 *et seq.,* Michigan Children's Ombudsman Act.
5) 1973 Public Act 116, as amended, being M.C.L. 722.111 *et seq.,* Michigan Child Care Organization Act.
6) 1939 Public Act 288, Chapter X and XIIA, being M.C.L. 710.1 *et seq.,* Michigan Adoption Code and Michigan Juvenile Code.
7) 1984 Public Act 203, as amended, being M.C.L. 722.951 *et seq.,* Michigan Foster Care and Adoption Services Act.
8) The Social Security Act as amended by the Multiethnic Placement Act of 1994 (MEPA); Public Law 103-382, and as amended by Section 1808 of the Small Business Job Protection, the Interethnic Adoption Provision (IEAP).
9) The Indian Child Welfare Act (ICWA); Public Law 95-608 being 25 U.S.C. 1901 *et seq.*
10) The Michigan Indian Family Preservation Act (MFPA), 2012 PA 565.
11) 1976 Public Act 453, as amended, being M.C.L 37.2101 *et seq.,* Elliott-Larsen Civil Rights Act.
12) Fostering Connections to Success Act of 2008
13) Preventing Sex Trafficking and Strengthening Families Act, Federal PL113-183
14) Social Security Act, 42 USC 671(a)(20)
15) 2017 Public Acts 246 through 255, Michigan Opioid Laws
16) Rehabilitation Act of 1973, Section 504 Protecting Students with Disabilities
17) Free Appropriate Public Education (FAPE) as per the Rehabilitation Act of 1973
18) Individuals with Disabilities Act (IDEA)

2.10 Services to be Provided

a. Trauma Informed Practice Model

1) Services provided under this Contract must be trauma informed, evidence-based, evidence-informed or identified as a promising practice to effect optimal outcomes.

a) A child welfare trauma-informed approach understands and recognizes that youth in foster care may have experienced complex trauma, which can significantly harm individual and familial development.

b) The Contractor must educate parents and caregivers on the potential developmental impact of trauma.

c) The Contractor must screen youth and families for trauma based on requirements in this contract if trauma screening and/or trauma assessment has not been completed.

d) The Contractor must refer or provide clinical trauma assessments as necessary, collaborate with mental health providers to link youth to evidence-based and supported trauma services, develop resiliency-based case plans and recognize the necessity of building workforce resiliency both at the individual staff and organizational levels.

b. Primary Focus – Inclusion and Involvement

1) The Contractor must ensure the primary focus of residential intervention is to engage and support family members, caregivers, and identified permanent connections to ensure youth can live in the community successfully. The Contractor must build a workforce committed to the importance of permanency and the value of youth residing with family.

2) The Contractor must be responsible for collaborating in establishing permanence for the child. Contractors must collaborate with the primary assigned case manager to identify and engage appropriate family members, caregivers, and permanent connections unless doing so would be harmful in the treatment of the child. Contractors must demonstrate practices that ensure youth and family permanency connections.

3) For youth with no identified permanent family, the primary focus will be on permanency.

4) Services must be delivered according to each child and family's assessed needs. Interventions must be aligned with the identified needs and

desirable outcomes; particularly those identified by the youth and by the family.

5) Resources for evidence-based, evidence-informed interventions and promising practices for engaging and supporting families and supporting youth can be found on the websites listed below, and in other best practice overviews.

   a) Building Bridges Initiative (BBI); www.buildingbridges4youth.org
   b) American Academy of Pediatrics; Mental Health Practice Tools and Resources (aap.org)
   c) SAMHSA's Evidence-Based Practices Resource Center; www.samhsa.gov/ebp-resource-center
   d) California Evidence-Based Clearinghouse for Child Welfare; https://www.cebc4cw.org/
   e) The National Child Traumatic Stress Network; www.NCTSN.org
   f) American Academy of Child and Adolescent Psychiatry (AACAP); www.aacap.org.
   g) Washington State Institute for Public Policy; http://www.wsipp.wa.gov/BenefitCost?topicId=1

c. Residential Intervention

1) The Contractor must ensure that each child in their care must be provided with the elements of residential intervention outlined in the MDHHS DCWL Child Caring Institution standards specific to the license listed in Section 2.4. of this Contract.

2) The Contractor must incorporate normalcy activities into residential programing such as activities that a youth/family in a community setting would have the ability to participate in. These activities must comply with the Reasonable and Prudent Parent Standard to help youth and families develop skills essential for positive development.

   The Reasonable and Prudent Parent Standard is characterized by careful and sensible parental decisions that maintain a youth's health, safety, and best interests while at the same time encouraging the youth's emotional and developmental growth. The contractor must use the standard when determining whether to allow a youth in foster care including those participating in residential intervention to participate in extracurricular, enrichment, cultural, and social activities. The Contractor must reference DHS-5331 to assist in determining the appropriate level of approval for such activities.

   A youth must not be moved from one residential treatment program or facility to another without going through the RPU placement process. The assigned provider is responsible for continuing residential treatment services for the

youth and the youth's family until MDHHS assigns a new placement. Disruption of, or non-cooperation in the program is not a sufficient reason for replacement of a youth.

d. Standardized On-Going Assessment Tools:

1) The Contractor must utilize the following assessment tools unless otherwise specified in Attachment A to assess the youth's needs and strengths while in the residential program:

a) Child Assessment of Needs and Strengths (CANS), Child and Adolescent Needs and Strengths (CANS), or Child and Adolescent Functional Assessment Scale (CAFAS), and

b) Casey Life Skills Assessment (CLSA) or Daniel Memorial Assessment (for youth 14 years of age and older).

2) The Contractor may utilize additional standardized and reliable assessment tools to assess overall progress in functioning.

Additional program specific assessment tools are identified within each residential foster care program type in Attachment A. The Contractor must administer the assessment tool(s) at the interval indicated by each tool until planned discharge.

3) The contractor must utilize information from visits with the youth and family, treatment team and treatment plans to assess whether the youth is benefitting from treatment

4) The range of services specified within each residential intervention program type establishes a range and number of services to be provided. Services provided to each child must be individually determined based on the assessment, and must be documented in the child's treatment plan.

e. Referral and Intake Process

The Contractor must not admit any MDHHS supervised abuse neglect youth who are not assigned by the RPU, or WMPC for Kent County.

Co-Location of Residential Intervention Program Youth must not be moved from one residential placement or program to another, even within the same campus/area until the RPU or primary caseworker/agency has completed the re-placement process.

A new referral must be completed when the youth would be best served in a different program with the Contractor. This includes a change of programming (*e.g.*, Mental Health Behavior Stabilization to Substance Abuse) or security level.

1) Referral

a) The Contractor must accept and act on referrals from RPU upon receipt of a complete referral packet. The referring primary caseworker/agency must not be required to complete an application or other Contractor forms for inclusion in the agency case record or agency files or for any other purpose.

b) The RPU must be notified, within five working days of receipt of a complete referral packet, see Section 1.2, of:
   i) the desire to set up an initial telephone or face-to-face interview with the youth/family.
   ii) the rejection (and reason for rejection) or acceptance of the youth for placement, and if accepted,
   iii) the admission date or status on a waiting list.
   iv) youth/family or current provider outreach and engagement activities to be offered while they are waiting for placement.

c) The Contractor must not admit a child prior to a fully executed Individual Service Agreement (DHS-3600). In event of an emergency placement, the DHS-3600 must be fully executed no later than the first working day following placement.

2) Intake

The Contractor must develop an assessment-based treatment plan within 30 calendar days of placement. The treatment plan must be consistent with the short and long-term treatment goals identified in the recommendation from the independent assessor.

The Contractor must document the assessment-based treatment plan on the identified Children's Foster Care Residential Intervention Case Plan.

The Contractor must ensure that licensed/limited licensed clinical personnel (see requirements in Section 2.10.e.2 conduct a bio-psychosocial evaluation or review a recent bio-psychosocial evaluation (within the past year) as outlined in FOM 912.

f. <u>Staffing</u>

The Contractor must provide sufficient staff who are trained to provide and consistently demonstrate effective youth engagement that encourages youth to be empowered, educated, and given a decision-making role in the care of their

own lives while creating a safe environment to adequately fulfill the terms of this Contract.

1) Diversity, Equity, Inclusion

The Contractor will recruit and employ a diverse staff reflective of the Contractor's client population.

2) Normalcy

The Contractor must designate individual(s) trained in making decisions using the reasonable and prudent parent standard and who are authorized to consent to the youth's participation in activities. A designated individual(s) is to be onsite to exercise the reasonable and prudent parent standard. The designated individual must take reasonable steps to determine the appropriateness of the activity in consideration of the youth's age, maturity, and developmental level. The designated individual(s) is to consult with social work or treatment staff members who are most familiar with the youth at the residential program in applying and using the reasonable and prudent parent standard.

3) Youth Care

Youth care is defined as those activities necessary to meet the daily physical, social and emotional needs of the youth. Specific direct care staffing ratios are defined within each residential foster care program category within Attachment A and Schedule B Pricing Matrix.

The contractor must:

a) Provide a minimum of a .5 full-time equivalent (FTE) Educational Specialist position for every eight youth.

The Educational Specialist must have a bachelor's degree in human services or education.

b) Assure the availability, within 10 minutes of on-call Contractor support staff or contracted staff for emergency assistance at all times.

4) Staff Education and Experience Qualifications

a.) All program staff must possess the minimum qualifications prior to working with youth outlined in Michigan Child Caring Institution Administrative Rules and FOM 912.

b.) Therapy must be provided by one of the following who is trained/certified in evidence-based trauma informed treatment:
   i. Michigan Licensed mental health clinician or limited licensed mental health clinician with appropriate supervision (licensed master's level social worker, limited licensed master's level social worker, doctorate level licensed psychologist, limited licensed psychologist, licensed counselor, limited licensed counselor, or licensed professional trained in the assessment and treatment of trauma in children and adolescents)
   ii. Psychiatrist trained to work with youth and families; Board Certified in Child/Adolescent Psychiatry is preferred.

   If therapy services are subcontracted, the Contractor must ensure the subcontracted provider has the appropriate credentials outlined in this Contract in addition to training, experience and a conceptual approach to youth and families consistent with the intent of this contracted service.

5) The Contractor must employ, at a minimum, one FTE staff member dedicated to continuous quality improvement and the implementation of quality assurance processes. The Foster Care Program Office may approve a partial FTE on an individual contract basis. The designated individual(s) must have a bachelor's degree and experience with collection, reporting, analysis, of data, systems and process review and improvement. The continuous quality improvement position will focus on using data to evaluate the Contractor's progress on Program Performance Objectives as described in Section 2.2.

6) <u>One-to-One Supervision</u>
If a youth requires short-term, one-to-one supervision to stabilize behaviors and ensure safety, the Contractor must submit a request in writing on letterhead. The request must describe the youth's behavior which warrants one-to-one supervision, the steps taken to stabilize behavior within the contracted direct care staffing ratio, and the number of one-to-one supervision hours requested. See FOM 903-09 Case Service Payments.

7) <u>Staff Training Requirements</u>

The Contractor must choose a training practice model that fully operationalizes the values of family-driven, youth-guided, trauma-informed, permanency, strong involvement with the home communities, and culturally and linguistically competent care.

The training model must have an urgent focus on permanency practices and engaging and working with families in their homes and communities towards successful and sustained reunification.

The Contractor must provide 50 hours of training during a new hire's first year of employment.

The Contractor must provide a minimum of 40 hours within the first 30 calendar days of employment. Sixteen of the 40 hours must occur prior to direct care staff having contact with children. The remaining hours must be completed prior to the end of the first year of employment.

a) Orientation must include topics identified in Michigan Child Caring Institutions Administrative Rule R400.4128, as well as the Child Protection Law, Mandated Reporting Requirements, Family/Child/Youth Engagement, interpersonal-communication, appropriate discipline, crisis intervention, effects of trauma, secondary trauma, MiTEAM Case Practice Model Overview, youth handling and de-escalation techniques and basic group dynamics.

b) A minimum of 25 hours per year of staff development training must be provided to direct care staff following the first year of employment.

c) All program staff must be provided with training on the topic of engaging youth and family to ensure ongoing development and support of knowledge and skills in this area. This does not have to be accomplished solely through traditional classroom or online training methods.

d) All program staff must be provided with trauma-focused program training to maintain a trauma-informed milieu and treatment environment. Trauma-focused programming must be based on an evidence-based, evidence-informed, or promising practice treatment model.

e) Based on the assessment of a staff persons identified training needs, annual training topics must be selected from, but not limited to, the areas identified in Michigan Child Caring Institutions Administrative Rule, R 400.4128 and FOM 912:

f) All program staff must be trained to serve as a role model to youth for appropriate social skills, prioritizing needs, negotiation skills, accessing local resources, hygiene and grooming preparation, food preparation and anger management.

g) All staff that have direct contact with youth shall complete Sexual Orientation, Gender Identity and Expression (SOGIE) training listed on the MDHHS CCI Training Resources webpage: https://www.michigan.gov/mdhhs/doing-business/contractor/training/cci-training-resources

These courses include:

- Building Safety for Youth and Families: Recognizing and Affirming SOGIE – Introduction
- Building Safety for Youth and Families: Recognizing and Affirming SOGIE – Part 1
- Building Safety for Youth and Families: Recognizing and Affirming SOGIE – Part 2
- Building Safety for Youth and Families: Recognizing and Affirming SOGIE- Part 3
- Building Safety for Youth and Families: Recognizing and Affirming SOGIE – Post Test

SOGIE Training shall be required by existing staff within 90 days of contract inception and annually thereafter. All staff hired on or after 10/1/24 shall be compliant with SOGIE Training within 90 days of hire and annually thereafter.

g. Reporting

1) The Contractor must develop and submit to the primary caseworker/agency responsible for placement: all service plans, case summaries, incident reports, arrests, death notifications and other reports as required in FOM 912 and the MDHHS DCWL standards specific to the Contractor's license specified in Section 2.4 of this Contract. Service Plans must be completed for the age-appropriate treatment plan.

2) The Contractor must submit a photo of the child to the primary caseworker/agency responsible for placement taken at the time of placement. A copy of the photo must be maintained in the child's file and replaced with a new photo annually or sooner with any significant physical changes.

3) A transitional discharge plan must be established within 30 days of placement and submitted to the primary caseworker/agency responsible for placement. Efforts toward discharge, including updated action steps, must be discussed during quarterly Family Team Meetings (FTMs) at a minimum.

4) Census
The Contractor shall submit census data daily that includes contracted available beds and waitlists, in a format and manner prescribed by the Foster Care Program Office.

h. Restraint and Seclusion

1) The Contractor must implement strategies to eliminate the use of restraint and seclusion and promote cultures of care that are family-driven, youth-

guided, trauma informed and responsive, and culturally and linguistically competent.

2) The Contractor must follow restrictions, debriefing requirements, and reporting requirements as outlined below as well as in FOM 722-02B.

3) The Contractor must report the use of restraint and seclusion/isolation within 24 hours to MDHHS and 12 hours to the child's parent or legal guardian. The Contractor must follow the incident reporting requirements outlined in FOM 722-02B.

i. Critical Incidents

1) The Contractor must document any incidents required by Michigan Child Caring Institution Administrative Rule, R 400.4150 and MDHHS policies in MiSACWIS/CCWIS, including, but not limited to:
   a) Death or suicide.
   b) Attempted suicide.
   c) Serious injury or illness requiring inpatient hospitalization.
   d) Behavior resulting in contact with law enforcement.
   e) Corporal punishment.
   f) Physical restraint.
   g) Mechanical restraint.
   h) Seclusion.
   i) AWOL/Escape.
   j) Allegations of sexual abuse or sexual harassment.

2) The Contractor must notify all appropriate parties as required by Michigan Child Caring Institution Administrative Rule, R 400.4150 that are not notified electronically through the MiSACWIS/CCWIS:
   a) Licensing consultant.
   b) MDHHS juvenile justice specialist.
   c) Non-MDHHS state or local governmental agency.
   d) Parent(s)/Legal Guardian(s).
   e) Law Enforcement.

j. Family Team Meetings

Family team meetings are an essential component of Michigan's Practice Model, MiTEAM and serve as the primary forum for collaborative case planning for the youth and family. The overall goals of the family team meetings are used to plan and review for the youth ensuring the youth receives an appropriate array and quantity of services necessary to stabilize him/her clinically and behaviorally and to prepare him/her to succeed in less restrictive community-based settings after discharge. The Contractor and youth must participate in quarterly family team meetings.

1) The Contractor must incorporate relevant planning goals/action steps regarding the child from previous family team meetings into the Contractor developed initial case plan due 30 days from admission.

2) The Contractor must coordinate with the primary worker/agency, a Pre-Meeting Discussion with the youth at least 24 hours prior to the family team meeting. The Contractor must participate with the youth in person or via phone conference for all family team meetings when appropriate for the youth to participate.

3) The Contractor must work with the youth, family, treatment team, primary caseworker/agency, and local Community Mental Health (CMH) provider to assist the youth in developing meaningful connections to the youth's family, community, and other non-family resources. These ties will provide assistance and connections with caregivers to help meet the youth's relationship needs.

k. Legal or Court Related

1) The Contractor must cooperate with the primary caseworker/agency responsible for placement of the youth in matters relating to any legal or court activities concerning the youth. These activities may include, but are not limited to:

2) Transportation of the youth to and from court hearings.

a) Supervision of the youth during transport or while present at the hearing.
b) Court testimony, recommendations, and reports to the court as requested by the court.

3) Safety of the youth must always be a priority concern when considering the youth's transportation needs. If determined that a youth is presenting safety concerns and is unable to be safely transported to a court hearing, the Contractor must immediately notify the youth's Legal Guardian Ad Litem (LGAL) and the primary caseworker/agency responsible for the youth's placement.

l. Absent Without Legal Permission

1) The Contractor must have a clearly defined process for determining when a youth is absent without legal permission (AWOLP) from the placement. The process must delineate how the facility and grounds are searched, what personnel will be involved in the search, and how the determination will be made that the youth is AWOLP from the placement.

Once determined that a youth is AWOLP from the placement, the Contractor must:

a) **Immediately** notify law enforcement agencies that the ward under their care has failed to return at the expected time.
b) **Immediately** file a missing person report with law enforcement.
c) **Immediately** notify the local office the primary caseworker/agency responsible for placement or designee of the child's AWOLP status.

2) The Contractor and primary caseworker/agency are expected to discuss the factors that led to the youth leaving placement, the plan to alleviate these factors, and the activities of the youth while AWOLP, including if the youth was a victim of trafficking so that appropriate services and treatment can be implemented. It is imperative that the Contractor and primary caseworker/agency communicate regarding any service needs subsequent to an AWOLP youth being trafficked consistent with SRM 300 Human Trafficking of Children and the MDHHS Human Trafficking of Children Protocol.

m. Independent Living Preparation

Independent living preparation is defined as a comprehensive and coordinated set of activities that will assist all youth in preparing for a state of independence or self-sufficiency in areas of housing, employment, financial and personal care.

1) The Contractor must provide independent living activities for all youth aged 14 and older which must include but are not limited to: budgeting and money management; employment seeking skills; communication skills; relationship building; establishing health and hygiene; household maintenance and upkeep; educational assistance; preventive health services; parenting skills and accessing community services.

2) The Contractor must identify independent living activities following the child's 14th birthday, according to the FOM 722-03C, Older Youth: Preparation, Placement, and Discharge. For youth with developmental disabilities that will challenge independence, the Contractor must provide relevant adult self-care, daily living skills, community engagement and mobility skills within the domains.

n. Individual or Group Therapy

The Contractor must provide at a minimum weekly direct therapy services for each youth individually; group therapy can be used as an adjunct treatment. Individual and/or group therapy must be provided in accordance with the youth's treatment needs as identified in the youth's service plan.

o. Inclusion and Involvement of parents, other family members, or caregivers

Families (including incarcerated parents) and placement caregiver(s) must be included as extensively as possible from the beginning of the admission process through discharge, transition, and aftercare. Families and caregiver(s) must be supported and involved in all aspects of the youth's/family's treatment and transitional/discharge planning. Family and caregiver(s) involvement must remain the center of the youth's programming. All services must be provided in a manner that ensures youth, families and placement caregiver(s) receive comprehensive, culturally competent interventions.

The Contractor must, in accordance with each youth's individual treatment plan:

1) Include the family (birth, relative, identified adult support and/or permanent caregiver) in the development of the treatment plan and specifically document the family's involvement in the service plan.
2) Provide a method to ensure the opportunity for daily contact between family and youth, when safe and therapeutically indicated for the youth to have contact with their family.
3) Provide family therapy to include children, parents, caregivers, or other supportive adults when appropriate and not already occurring through another provider. Provision of family therapy should be based on the child and family permanency goals and treatment plans developed by the foster care caseworker.
4) Provide transportation and flexible hours to meet the family's time schedule to facilitate the family's accomplishment of the treatment goals. Transportation is defined as any travel, including travel for family visitation, required by the youth or family for treatment purposes which occurs in the Contractor's geographic area to be served, that may not reasonably be provided by the parents or other funding source. The Contractor must coordinate/collaborate with the primary caseworker/agency responsible for placement to resolve transportation and location barriers. If the distance of a family from the agency is identified as a barrier, describe the agency's plan to reduce the barrier to ensure ongoing family contact as outlined in the FOM 722-06I, Maintaining Connections Through Visitation and Contact. The primary emphasis should be working with the family in their home and community.
5) Provide an identifiable area for family visits which offer privacy and comfort when it is safe and in the best interest of the youth to do so.
6) In collaboration with the primary caseworker/agency responsible for placement, ensure weekly sibling involvement and visitation and other required sibling interaction as outlined in FOM 722-06I, Maintaining Connections through Visitation and Contact. Provide supported intervention, based on the youth's treatment needs, to encourage and strengthen sibling relationships unless the primary caseworker/agency indicates it should not occur.

7) Include a specific plan to address the family's needs, to assist the family in meeting the needs of the youth in placement, and to attain the family goals, as well as delineation of roles of the Contractor, assigned caseworkers, and family to accomplish these goals. The Contractor must coordinate with the primary caseworker/agency responsible for placement to identify, recruit and prepare any identified family for eventual placement or involvement with the youth.
8) Not withhold family contact (in any form) as a method of discipline
9) Ensure the child is present for identified special recruitment activities for youth available for adoption without an identified permanent family. If age appropriate, the youth must also be involved in adoption recruitment and planning activities. If there are safety concerns or other identified treatment concerns, the Contractor must consult with the assigned primary caseworker/agency responsible for placement.

p. Religion and Cultural

1) The Contractor must respect the religious preference of the youth and the child's parent(s) or legal guardian and allow for participation in compliance with FOM 722 and Michigan Child Caring Institution Administrative Rules.

2) The Contractor must ensure each youth is afforded opportunities to attend religious services or activities in the child's religious faith of choice. The Contractor must arrange for or ensure reasonable means are provided for transportation of a youth to services or activities on or off site. Safety of the youth must always be a priority concern when transporting and supervising youth.

3) The Contractor must not require or coerce a youth to participate in religious services or activities, must not discipline, discriminate against, or deny privileges to any youth who chooses not to participate. The Contractor must recognize and take into consideration the racial, cultural, ethnic, and religious backgrounds of a youth when planning various activities or religious activities.

q. Education

The Contractor must ensure every youth is provided with appropriate educational services. Such services must be provided in accordance with the requirements set forth in the FOM and MDHHS Division of Child Welfare Licensing standards for the license specified in Section 2.4 of this Contract, and as detailed in the MISEP.

If educational services are subcontracted, the Contractor shall require the subcontractor comply with the provisions of:

1) Rehabilitation Act of 1973, Section 504 Protecting Students with Disabilities.
2) Free Appropriate Public Education (FAPE) as per the Rehabilitation Act of 1973.
3) Individuals with Disabilities Education Act (IDEA).

In addition, the contractor must:

a) Collaborate with the youth's identified school to screen for possible educational disabilities; and if a disability is suspected, refer the youth for an Individual Education Program Team (IEPT) evaluation within the first 30 calendar days to assess, plan and place the youth in the most appropriate educational/vocational program.
b) Request prior educational assessments within 30 calendar days of placement to assist in assessing the current educational needs. Documentation of diligence in requesting records must be included in the youth's file.
c) Initiate an exit review of the educational plan, outlining educational needs, at least 30 calendar days prior to discharge and forwarded to the primary caseworker/agency responsible for placement.
d) Assure that program staff is available for the school to contact in crisis situations to assist in managing the crisis or to call for assistance.
e) Provide or arrange structured educational and/or vocational activities for youth suspended from or expelled from school, or who have passed their General Education Development (GED) test, (i.e., structured homework time, additional reading or writing activities, online educational programming, independent study assignments and independent living skills). This must include Free Appropriate Public Education (FAPE) to all students with disabilities.
f) Take an active role in monitoring and maintaining school progress (including documenting a minimum of weekly contact with the school monitoring the youth progress) for youth whether they attend a structured school program or not. Interventions may include, but are not limited to, obtaining school assignments, monitoring completion of homework, supporting test preparation, capturing, and reporting grades and test scores when and where available, and additional tutoring.
g) Provide tutorial services to a youth, as necessary, based on the youth's Individualized Education Plan (IEP) or treatment plan. Tutorial staff must have appropriate educational credentials to provide tutorial services. Appropriate educational credentials are determined by the Contractor's educational specialist. Tutorial services must not be a substitute for special education and related services.
h) Provide advocacy and service planning for youth that are expelled or suspended including actively engaging the youth's family in the advocacy and planning process.

i) Comply with Michigan's Department of Education rules and requirements if they operate a school on the Contractor's grounds.
j) Whenever possible, maintain enrollment in the youth's school of origin.
k) Assess the family's educational background and capacity to support the youth's education service needs and coordinate with the primary caseworker/agency to refer family members to relevant adult education programming as indicated, when appropriate.

r. Medical and Dental Care

1) The Contractor must assure that each youth receives routine and non-routine medical and dental care as required in the FOM 801, Health Services for Foster Children and the MDHHS DCWL standards for the license specified in Section 2.4 of this contract and as detailed in the MISEP. The Contractor must provide all medical and dental information to the assigned primary caseworker/agency responsible for placement to facilitate maintenance of the Medical Passport (DHS-221). In addition, the Contractor must assure that specific health care is provided, including:

a) Rehabilitative, physical, or dental procedures by medical personnel, as necessary.
b) Utilization of enrolled Medicaid providers or a board-certified physician or dentist volunteering their time for health procedures.
c) Provision of medication as prescribed by a treating physician. The contractor must have a Standard Operating Procedure for dispensing and storage of medication.
d) Special diets provided as needed and regularly reassessed utilizing appropriate specialized personnel. Any child who is determined to be obese/underweight must have a plan to address their weight, health, and well-being.
e) Registered or licensed nursing staff on-site and/or available 24 hours a day, 7 days a week. The nursing staff must always be available within 60 minutes to the Contractor at all times. The Contractor may sub-contract the nursing services required in this Contract.

2) The Contractor must forward the above required examination reports and assessments to the primary caseworker/agency within five working days of completion.

s. Wardrobe/Personal Possessions

The Contractor must assure that each youth has an adequate wardrobe as defined by and documented on the Clothing Inventory Checklist (DHS-3377) while in placement and upon leaving placement. When the youth is absent or at the conclusion of the placement, the Contractor must have a process in place to keep the youth's wardrobe and possessions safe until claimed by the youth or primary

caseworker/agency. If the possessions are not claimed within 90 calendar days, the Contractor may dispose of the items at its discretion.

t. Recreation Activities

The Contractor must provide daily access to appropriate recreation activities as defined by MDHHS DCWL standards for the license specified in Section 2.4 of this Contract.

u. Behavioral Health Services

The clinical staff must be on-site and/or available 24 hours a day, 7 days a week. The clinical staff must be available within 60 minutes to the Contractor at all times. The Contractor must provide the following in accordance with the treatment plan for each individual youth. The costs of these elements may be billed to the youth's medical insurance provider if the service is covered. If not, the costs are to be covered by the per diem reimbursement rate:

1) Psychological Services

Psychological services are defined as various professional activities or methods, provided by a licensed Masters Social Worker, licensed Professional Counselor, licensed psychologist or a limited licensed psychologist, including therapy with youth individually or in groups, consultation with staff, administering and interpreting psychological tests and work with families.

a) The Contractor must provide psychological services to an individual youth on an as needed basis, per the youth's Residential Initial Treatment Plan or Residential Updated Treatment Plan.

b) The Contractor must provide psychological testing as necessary for assessment and treatment planning. Only professionals trained to administer and interpret psychological tests and whose license includes psychological testing in the scope of practice must be allowed to provide this service.

c) The Contractor must provide psychological consultation to staff as necessary to assist staff in understanding the youth's background or needs, test results, implications for treatment and interventions most appropriate for the youth/family.

2) Psychiatric Services

Psychiatric services are defined as various professional activities or methods, performed by a licensed physician with expertise in mental/behavioral health care as evidenced by:

a) Certification in Child and Adolescent Psychiatry by the American Board of Psychiatry and Neurology (ABPN), or

b) Certification in general psychiatry by the ABPN and clinical experience with children and adolescents.

c) Services may include diagnostic assessment, individual psychotherapy with evaluation and management, medication review with minimal psychotherapy, individual or group therapy with the resident(s) and consultation with agency staff. Telehealth may be used when a local psychiatrist is not available. If telehealth is utilized the provider must follow general clinical guidelines for this technology. All services (in-person or telehealth) must be HIPAA compliant.

i. The Contractor must provide psychiatric services to an individual youth, on an as needed basis, according to the youth's treatment plan. The Contractor must engage the parent(s), medical and educational staff and any other relevant individuals involved in the youth's treatment in the initial and ongoing evaluation process.

ii. The Contractor must provide psychiatric consultation or supervision of Contractor staff as necessary to assist staff in understanding the results of the psychiatric evaluation(s), implications for the child's treatment and identification of treatment interventions most appropriate for the child.

iii. Psychotropic Medication must be prescribed or adjusted by a youth's psychiatrist or a psychiatrist with experience working with the children or the youth's primary care physician if a psychiatrist is not available via telehealth. For temporary wards, the youth's parents must be engaged in the consultation either in person or by phone conference. For state wards, the child's caseworker must be engaged in the consultation either in person or by phone conference**.** Both consultations must be witnessed by the Foster Care Psychotropic Medication Oversight Unit (FC-PMOU). Appropriate consent must be obtained for administration of each psychotropic medication to a youth. The Contractor must follow FOM 802-1, Psychotropic Medication in Foster Care.

iv. Within 15 calendar days of the youth's admission, if necessary, from the youth's treatment plan, the psychiatrist must assess the youth and coordinate with the licensed clinical personnel completing the psychosocial assessment. The psychiatrist must review the youth's medication history, current needs, and

prescriptions. This includes adjustment of medications and dosage, as necessary.

v. After the first 45 calendar days of a youth's placement, the psychiatrist must review the youth's current medical and psychiatric needs and prescription or adjustment of medications and dosage, as necessary.

vi. Within 24 hours of admission, a telephone call between the nursing staff of the accepting and referring programs (residential or hospital) at a minimum is to be held. The conversation must include:

a. A review and reconciliation of all medications.
b. The supply of medication that is accompanying the youth, including medications, prescriptions, or refills available to fill or transfer.
c. The overall health status of the youth, including current treatment and any diagnostic work up that will not be complete at the time of transition.
d. A list of any ongoing laboratory or other monitoring required because of current treatment; for example, complete blood counts required for individuals taking clozapine.

i. The nurse from the receiving program will document the call as a nursing note that will be kept in the youth's record.

ii. Within 24 hours of the youth's entry to the receiving program, the nurse from the receiving program will reconcile the information documented during the nursing call and the transmission packet supplied when the youth come to the program, contracting the referring program nurse to resolve any discrepant information. The reconciliation process will be documented in a nursing note.

iii. When a youth is admitted from a community placement, the nurse from the receiving program will review the transmission packet supplied on admission and resolve any discrepant information or questions with the nursing staff from the transferring program(s) by the first business day following admission. Any conversation/correspondence will be documented as a nursing note that will be kept in the youth's record.

d) The Contractor must have a protocol in place if a youth has attempted suicide or has known suicidal ideation. The protocol must include, but is not limited to:

i. Immediate determination of the youth's need for hospitalization or onsite safety planning.
ii. If the youth is admitted for inpatient psychiatric care, the youth must be seen within 7 days of inpatient psychiatric services discharge.
iii. Ongoing consultation with a psychiatric provider per youth's treatment plan.

v. Transitional Service Following Discharge

Transition and discharge planning must begin at the time of admission. The Contractor must develop an initial transition/discharge plan within 30 days of placement. A review of the transition/discharge plan must be completed within 30 days of intervention and every quarter thereafter. These plans must be created in collaboration with the child, parent or guardian, agency with placement responsibility, foster parents, relative caregiver, local community mental health providers, permanency resource monitor and the assigned residential staff responsible for the creation and review (the Family Transition Coordinator (FTC) if assigned). Discussions relating to the development of the plan will include services the youth identify for themselves, needed supports identified by the family, consideration regarding a referral to CMH for wraparound services up to 180 days prior to discharge, and formal and natural community supports to link the youth and family to prior to discharge. The youth's transition/discharge plan along with a projected date for discharge must be included in each youth's/family's service plan. The youth's/family's transition/discharge plan will include the level of care projected to be needed at discharge. The plan will include recommended services, transfer of information (e.g., medical records, mental health records) and a graduated visitation schedule; an extended plan to spend time together as a family or with supportive adults.

The Contractor must ensure the child's/family's transition/discharge plan is reviewed and updated during quarterly team meetings. The child will be engaged with their Lawyer Guardian ad Litem (LGAL) and/or other supportive adult should be included during all subsequent family team meetings following admission.

1) Medical and Mental Health Instructions at Discharge

When a youth is transitioning out of the Contractor's residential facility, the contractor must provide a health packet 5 days prior to transition to the youth's new treatment team including the residential/shelter facility (if applicable), psychiatric, and primary care providers. The health packet must include:

a) A complete list of the youth's medications including those used routinely and on an as needed basis. This list must be generated from the medication administration record used to administer medications and must

be reviewed and reconciled by the Contractor's nurse. This list must be generated and reconciled no more than 48 hours before discharge.

b) A list of the medications supplied on discharge including (as applicable):

   i. Prescriptions for medications sent with the youth (minimum 30-day supply).
   ii. Prescription refills (minimum 30-day supply) available for transfer from the pharmacy at discharge.
   iii. Medications supplied in packaging (minimum 30-day supply).
   iv. If a youth is taking Clozapine and the pharmacy will not dispense a 30-day supply, the prescription should include refills sufficient to provide a 30-day supply once Clozapine Risk Evaluation and Mitigation Strategy (REMS) - required lab work is obtained/documented.

c) Copies of psychiatric care documentation including the initial psychiatric evaluation, all medication review documents and any related documents (e.g., documented correspondence about psychiatric care).

d) Copies of medical examinations including comprehensive (annual) health examinations, and acute care visits.

e) Copies of laboratory and all other diagnostic studies conducted while the youth was in the Contractor's care.

f) Assessment documents including those conducted as part of the intake process, and any assessments conducted for the purposes of treatment planning.

g) Initial and two most recent updated treatment planning documents from the residential intervention program.

h) A statement for each youth receiving psychotropic medication, including the name of the youth's next treating psychiatrist/primary care physician, date of last medication review, date of last signed informed consent, date of medication review following discharge (within five days of discharge), and date the psychiatric information was provided to the next psychiatrist/primary care physician.

i) The packet may be sent by fax to the appropriate recipients, or paper copies may be transferred by the caseworker or other person transporting the youth to the next placement. Document the transmission of the packet.

J) When any youth is transitioning from one residential intervention program to another, within 24 hours of discharge, a telephone call

between the nursing staff of the accepting and referring programs (residential or hospital) at a minimum is to be held to discuss the items as listed in section 2.10, u,2), c), vi. Psychiatric Services.

k) When a youth transitions from the Contractor's residential program to a hospital (general medical or psychiatric), the Contractor's nurse will contact the hospital nursing staff (emergency department or floor/unit to which the youth is admitted) to coordinate care. This conversation must include:

   i. A review and reconciliation of all medications.
   ii. The overall health status of the youth, including current treatment and any diagnostic work up in progress at the time of transition.
   iii. A list of ongoing laboratory or other monitoring required because of current treatment; for example, complete blood counts required for individuals taking clozapine.

l) The Contractor's nursing staff will communicate with consulting physicians/health care providers (general health and psychiatric) within one business day of any of the following transition events:

   i. From inpatient medical or psychiatric care to the residential program.
   ii. From the residential program to an emergency department for potential admission for medical or inpatient psychiatric care.
   iii. From another clinical site to the residential program.

m) The communication between the Contractor's nursing staff and consulting physician/health care provider must include:

   i. A summary of the nurse-to-nurse consultation.
   ii. Status of the youth, including any concerns, e.g., level of alertness, side effects, ongoing diagnosis or treatment that will need attention/orders prior to psychiatric evaluation.
   iii. Review of current medication supply/needs prior to scheduled psychiatric evaluation.

n) The Contractor's nurse to consulting physician/health care provider communication can occur via direct phone call, voicemail to the consulting physician/health care provider, fax, or HIPAA-compliant email. The manner of communication will be documented in the nursing note, as will any subsequent communication between the Contractor's nurse and the consulting physician/health care provider.

o) The contractor must ensure the communication is documented as a nursing note and will be co-signed by the physician/health care provider within five business days, either by fax transmission of a paper health

record, or by electronic signature within an electronic health record. The document must be kept in the youth's health record.

Note: If the youth is hospitalized in a psychiatric hospital, once stabilized it is expected that the youth would return to their residential intervention program unless there is documentation as to why this cannot occur.

2) Planned Discharge

In addition to aftercare requirements outlined in Section 2.11, and medical and mental health requirements outlined above, the Contractor must provide the following transitional services to children discharged from the program in a planned discharge:

a) Submit a discharge service plan to the RPU or primary caseworker/agency responsible for placement, which complies with the requirements of the MDHHS DCWL standards specific to the Contractor's license specified in Section 2.4 and also contains a summary of services provided during care.

b) Maintain communication and coordination with CMH (if involved) or coordinate with the primary caseworker/agency at least 180 days prior to discharge to make a referral to Community Mental Health (CMH) for assessment and case management/wraparound services and continue coordination with CMH until discharge. If the child does not meet eligibility requirements for CMH services, maintain transitional psychosocial services as outlined in section 2.11 until the youth is scheduled to attend an initial appointment with a community based psychosocial service provider. Document services needed to continue to meet the youth's needs and identified providers for such services to provide continuity of services.

3) Unplanned Discharge

An unplanned discharge must be defined as occurring when the Contractor requests removal of the child from placement, within 30 days, prior to the child successfully achieving the treatment goals due to one of the following:

a) Maximum Benefit Reached

A contractor may request a discharge when a youth does not benefit from or has reached maximum benefit of the specific residential's programming.

If the contractor is considering **or** has decided to request removal of a youth due to the youth reaching maximum benefit, the Contractor **must**

notify the youth's caseworker and submit an email to the MDHHS-Residential-Contracts@michigan.gov mailbox. The notification must include the following information:

1) Youth's identifying information.
2) A detailed explanation of the safety concerns and youth's behaviors.
3) A detailed explanation of the circumstances that exist that prevents the residential service provider from meeting the youth's needs.
4) Actions taken by the residential service provider to address youth's treatment needs.
5) Evidence that a FTM/TDM was held with the assigned case manager, supervisor, and parent or involved family member within 30 days of the request to explore alternatives to replacement which might include:
   a) Options to change milieu (unit, peers).
   b) Changes in staffing ratio (including request for 1:1 – dependent on staff availability and expedited approval from DCWL).
   c) Modifications of the treatment/behavior plan or program structure.
   d) Additional psychiatric consults/screening.
   e) Access to additional outside services if indicated which might include inpatient or partial hospitalization, occupational therapy, Primary Care Physician (PCP) or dietician consults, speech, and language services.
   f) Exploration of IEP amendments for additional services or change in school setting.
   g) Exploration of reunification or placement with a fit and willing relative or another appropriate community-based placement.
   h) Other suggestions from the FTM/TDM.

If the Foster Care Program Office does not agree with the Contractor's decision to remove youth, the Contractor shall not receive an incentive payment for the month youth were removed.

b) Safety Concerns for Youth, Peers, and/or Staff

A Contractor may request a change in placement due to documented incidents of risk or serious harm to youth, peers, or staff and efforts to reduce the risk have been exhausted.

1. Contractor Responsibilities

   a. When a Contractor is requesting the unplanned discharge of a youth in their program due to one of the outlined reasons, a request for discharge within 30 days must be submitted in

writing to the primary foster care caseworker and RPU and must include the following:

I. Youth identifying information.
II. A detailed explanation of the youth's behaviors.
III. A detailed explanation as to the circumstances that exist at the facility that prevents the Contractor from continuing care of the youth.
IV. History of actions taken to address youth's treatment needs.
V. Evidence that a FTM was held with the foster care caseworker, Supervisor, RPU, and parent or involved family member within 30 days of the request to explore alternatives to replacement which might include:
    - Explore options to change milieu (unit, peers).
    - Changes in staffing ratio (including request for 1:1 – dependent on staff availability and expedited approval from DCWL).
    - Modifications of the treatment/behavior plan or program structure.
    - Additional psychiatric consults/screening.
    - Access to additional outside services if indicated which might include inpatient or partial hospitalization, occupational therapy, Primary Care Physician (PCP) or dietician consults, speech, and language services.
    - Exploration of IEP amendments for additional services or change in school setting.
    - Exploration of reunification or placement with a fit and willing relative.
    - Other suggestions surfaced from the FTM.

b. The Contractor must continue services to the child for up to 30 calendar days following written request to the primary foster care caseworker and RPU to discharge the child from placement. A youth must not be moved to another program or facility without going through the RPU placement process.

c. The contractor will provide RPU with all documents necessary for referral to the independent assessor.

d. If the Foster Care Program Office does not agree with the Contractor's decision to remove youth, the Contractor shall not receive an incentive payment for the month youth were removed.

2. MDHHS Responsibilities

Following the receipt of a request from a Contractor for unplanned discharge of a youth within 30 days, MDHHS must do the following:

a. Respond acknowledging receipt of the request for new placement within 2 business days to ensure the health and safety of the youth and the well-being of other youth in the program.
b. Schedule a meeting with the Contractor, foster care caseworker and/or supervisor, and RPU staff to review documentation submitted to determine if the concerns can be mitigated, identify the specific treatment needs of the child, and if mitigation is not possible identify alternative placement needs.
c. RPU will make a referral to the independent assessor within 1 business day of decision to move youth.
d. Arrangements will be made with the contractor to move the child within 30 days.
e. When unplanned discharge is being requested because the youth pose a threat of harm to self or others, the Contractor may be approved to provide 1:1 staffing ratio. The approval for 1:1 staffing must be requested in writing on agency letterhead and emailed to the local DHHS Office and the DCWL Departmental Analyst. The emailed request must be secured and encrypted to protect the child's personal information.

2.11 Aftercare Services

a. Aftercare services must be provided for each youth who received residential services contracted by MDHHS.

Aftercare services must continue for a duration of 12 months post discharge, or until the court ends jurisdiction, whichever occurs first, and must be provided to youth who are discharged into a community setting; this excludes discharge to another CCI, adult foster care, shelter, hospital (for mental health services), detention, or jail.

Aftercare services are not required if the youth was in the contractor's care for 14 days or less, or if the independent initial assessment determines that the youth should be serviced in the community and that youth is discharged from the contractor's care within 30 days of entry.

b. For families living outside a 90-mile radius from the facility, the Contractor may subcontract or partner with another agency in the family's community. If the family is outside of the 90-mile radius and services are subcontracted, the

Contractor must ensure the required services are provided and the MDHHS-5391 Residential Aftercare Report is completed and submitted in MiSACWIS/CCWIS.

c. The contractor may employ a Families Transition Coordinator (FTC) that would be assigned to a youth's case prior to the youth exiting the program. The FTC may be the "designated individual" to exercise the Reasonable and Prudent Parent Standard and work in partnership with the family during the intervention.

   At a minimum, the FTC must have a bachelor's degree in a human services field from an accredited university. The FTC must receive supervision from a clinical supervisor with demonstrated commitment to permanency and children living with families in their homes and communities, who incorporates family-driven care in practice and staff skills, and who has, or obtains advanced clinical skills in a specific evidence-based, evidence-informed family engagement practice such as Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), or Motivational Interviewing (MI).

d. In order to facilitate quality aftercare services, the Contractor must maintain community involvement and active participation in transition/permanency planning. The Contractor must demonstrate a strong commitment to achieving permanent connections for every youth to ensure permanency and a broad family/community support network is in place for each child served. Permanancy planning ensures regular contact between youth, families, siblings, and significant adults.

   The Contractor must collaborate with CMH, MDHHS, community providers, family members, RPU staff and the primary worker case manager and supervising agency to partner in activitites such as Family Team Meetings (FTM) and Team Decision Meetings (TDM), ongoing relative search efforts, and identifing mentors for the youth and the family.

e. Service Levels

   1) Level 1: Level 1 aftercare services to be provided when the youth have services being provided in the home by Community Mental Health (CMH), a Prepaid Inpatient Health Plan (PIHP), or other services approved by the Foster Care Program Office.

      The Contractor must:

      a) Collaborate with the youth, parent/legal guardian and/or community caregivers, the youth's CMH or other mental health providers, the primary case manager, and others as necessary to create a plan of

safety and structure for the youth's successful transition to the community. The plan must include:

i. Specific safety concerns related to the youth's return to a community placement.
ii. Proactive strategies to reduce the likelihood of the safety concerns.
iii. Reactive strategies to support the youth and community's safety if the identified concerns arise.
iv. A plan for a gradual reduction of structure in the youth's community placement to support a successful transition from the level of structure provided in the residential program.

b) Assess the youth and family for needs that are not being met by community-based services and coordinate with the foster care case manager and supervising agency to ensure the appropriate referrals are made.
c) Participate in CMH wraparound services meetings, FTMs, TDMs, or other treatment team meetings, if appropriate.
d) Assist with identification, facilitation, and support of positive, normative, age-appropriate pro-social relationships and activities within the youth's community. Pro-social activities can include any number of activities that are meaningful to the youth and contribute to positive and pro-social behaviors including, but not limited to, sports, volunteering, employment, extra-curricular and school activities.
e) Maintain a minimum of monthly contact with the youth's service providers, including but not limited to CMH or other mental health service providers for updates on the youth. Contacts may be made by a variety of methods, including face-to-face, phone, video conference, email, text message, or mail.
f) Maintain consistent and ongoing engagement with youth and families with a minimum of four contacts per month to solicit the youth and family's preferences and feedback related to provision of aftercare services. Contacts may be made by a variety of methods, including face-to-face, phone, video conference, email, text message, or mail.
    i. Ensure initial contact with the youth/family is completed within five business days of discharge from the facility.

2) Level 2: Level 2 aftercare services must be provided when the youth does not have services provided by CMH, a Prepaid Inpatient Health Plan (PIHP), another provider, or a service approved by the Foster Care Program office.

The Contractor must:

a) Collaborate with the youth, parent/legal guardian and/or community caregivers, the primary case manager, and others as necessary to

create a plan of safety and structure for the youth's successful transition to the community. The plan must include:

i. Specific safety concerns related to the youth's return to a community placement.
ii. Proactive strategies to reduce the likelihood of the safety concerns.
iii. Reactive strategies to support the youth and community's safety if the identified concerns arise.
iv. A plan for a gradual reduction of structure in the youth's community placement to support a successful transition from the level of structure provided in the residential program.

b) Provide therapeutic and psychiatric services as identified in the youth's treatment plan. Telehealth may be utilized for this service.
c) Organize and facilitate the transition of medical and mental health services, including therapeutic and psychiatric services, from the residential program to providers in the youth's community.
d) Assess the youth and family for additional needs that are not being met by community-based services and coordinate with the foster care case manager to ensure the appropriate referrals are made.
    i. Assist with identification, facilitation, and support of positive, normative, age-appropriate pro-social relationships and activities within the youth's community. Pro-social activities can include any number of activities that are meaningful to the youth and contribute to positive and pro-social behaviors including, but not limited to, sports, volunteering, employment, extra-curricular and school activities.
    ii. Assess and support the needs of the youth's community caregivers related to meeting the child's needs. Supports may include, but are not limited to, parenting skills development related to the youth's specific needs and family therapy.
e) Participate in FTM, TDM, or other treatment team meetings, as appropriate.
f) Provide crisis on-call services with 24/7 availability. The Contractor must provide the youth and family with an on-call number. The Contractor must return any crisis calls within 20 minutes and provide direct services or referral to another provider in order to maintain safety and diffuse the crisis. Crisis intervention services must be tailored to the youth's current behaviors and needs.
g) Maintain a minimum of four contacts per month with youth and families to solicit the youth and family's preferences and feedback related to provision of aftercare services.
    i. Contacts may be made by a variety of methods, including but not limited to face-to-face, phone, video conference, email, text message, or mail, except as otherwise specified below.
    ii. Initial face-to-face contact with the youth and family must be completed within five business days of discharge from the facility.

iii. Face to face contact must be made weekly for the first 30 days post discharge.
iv. Face to face contact must be made twice per month for the second- and third-month post discharge.
v. Face to face contact must be made once per month for the remaining months.
vi. Face to face contacts may be made by the FTC or therapist.

f. Assessments and Reports

The Contractor must complete the MDHHS-5931, Residential Aftercare Report every 30days after a youth's discharge from the facility. All reports must include any clinical assessments and treatment goals. The reports are due to the primary case manager/supervising agency no more than 15 days after completion.

2.12 Program Performance Objectives

During the contract period, the Contractor will be responsible for tracking performance objectives using the CCI Dashboard as a data source. In addition to the performance objectives below, other performance objectives may be developed by MDHHS in collaboration with the Contactor.

Performance Indicators:
To track progress toward achieving our goals for supporting youth to live in the community successfully and assess success of services, MDHHS will monitor a set of performance indicators, as they become available through the CCI Dashboard, that may include, but are not limited to:

a. Safety indicators:
   i. Percentage of youth in care experiencing physical restraints each month.
   ii. Number of physical restraint incidents per month.
   iii. Number of MIC investigations in last 12 months (currently open plus substantiated over previous 12 months).
b. Well-being indicators:
   i. Number of youth in care with greater than 6 months stay in current facility.
   ii. Percentage of youth discharged to a community placement within 182 days.
   iii. Number of youth exiting to a community placement last month.
c. Permanency & Stability:
   i. Number of youth moving to another residential program last month.
   ii. Number of youth who have moved from a non-secure to a secure placement or hospitalization.

iii. Percentage of youth re-entering residential programs within 6 months of exiting to community-based setting.
iv. Number of youth remaining in a community placement following aftercare services.

d. Entries and Exits:
   i. Number of new intakes (including entries from another residential program) each month.
   ii. Number of exits (all exits, including community-based settings, other residential intervention, hospitalizations, AWOLPs, age outs).

MDHHS will work with the Contractor to further develop this measurement framework to ensure appropriate metrics are tracked for specific programs and sub-populations. MDHHS is especially interested in monitoring trends in performance over time, with the goal of continuous improvement against these metrics.

MDHHS reserves the right to request/collect other key data and metrics from the Contractor, including client-level demographic, performance, and service data. The Contractor shall make reasonable efforts to collect additional data related to performance as requested by MDHHS and shall be expected to collect and share data with MDHHS according to the format, frequency, and submission protocol specified by MDHHS.

Requested data may include but not be limited to aggregate and individual-level information on:

a) Youth referred for services, enrolled in services, and discharged from services.
b) Activities undertaken by the Contractor to provide high-quality treatment to meet youth needs (including youth participation in treatment, findings of assessments completed during services, provision of or referrals to aftercare services).
c) Activities undertaken by the Contractor to support youth & family engagement (including youth contacts with family and other supportive individuals, family participation in youth-related treatment and other activities, staff attendance at FTMs).
d) Youth outcomes during service delivery and following discharge.
e) Utilization and spending against contract value.

MDHHS reserves the right to revise the scope and array of requested data and metrics to be collected by the Contractors.

Meetings:
Regular reviews of and conversations around program performance, program results and program data, particularly related to the goals outlined in this Contract, will be held between MDHHS and the Contractor to employ real-time

information to track performance, identify good practice, and address any challenges experienced on the ground.

At such meetings, the Contractor shall work with MDHHS in good faith on planning and executing improvement strategies reviewed and discussed in areas that may include but not be limited those described below. The Contractor and MDHHS shall review data and reports to:

a. Monitor progress, highlight accomplishments, and identify concerns.
b. Share effective practices for continuously improving processes and outcomes.
c. Develop strategies to improve service delivery and coordination between services.

Periodic meetings may take place according to a schedule to be established by MDHHS, with reasonable notice provided for the Contractor.

Meetings shall include, at least, the MDHHS Director of the Bureau of Out-of-Home Services, or designee, and the contracted agency's chief executive officer, or designee. Each party may be represented by additional representatives as such party deems appropriate. MDHHS may request the attendance of additional parties as it deems appropriate. Representatives from the Contractor will attend all meetings as requested by MDHHS. Meetings may take place individually or jointly with other contractors.

2.13 Audit Requirements

Contractor/Vendor Relationship

This Contract constitutes a contractor/vendor relationship with MDHHS. The Contractor must immediately report to the MDHHS Bureau of Audit any audit findings of fraud, ongoing concern, financial statement misstatement, or accounting irregularities, including noncompliance with provisions of this Contract.

2.14 Financial Audit Requirements

a. Required Audit or Audit Exemption Notice
Contractors must submit to MDHHS either a Single Audit, Financial Statement Audit, or Audit Exception Notice as described below. If submitting a Single Audit or Financial Statement Audit, Contractors must also submit a Corrective Action Plan for any audit findings that impact MDHHS-funded programs, and management letter (if issued) with a response.
    1) Single Audit
    Contractors that are a non-profit organization and that expend $1,000,000.00 or more in federal awards during the Contractor's fiscal year, must submit a Single Audit to MDHHS, regardless of the amount of funding received from

MDHHS. The Single Audit must comply with the requirements of Title 2 Code of Federal Regulations, Subpart F.

2) Financial Statement Audit
Contractors exempt from the Single Audit requirements with fiscal years that receive $1,000,000.00 or more in total funding from MDHHS in State and Federal grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS).

3) Audit Exemption Notice
Contractors exempt from the Single Audit and Financial Statement Audit requirements (1 and 2 above) must submit an Audit Exemption Notice that certifies these exemptions. The template Audit Exemption Notice and further instructions are available at http://www.michigan.gov/mdhhs by selecting Inside MDHHS menu, then MDHHS Audit, then Audit Reporting.

b. Due Date and Where to Send
The required audit and any other required submissions (i.e. Corrective Action Plan and management letter with a response), or Audit Exemption Notice must be submitted to MDHHS within nine months after the end of the Contractor's fiscal year by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required submissions must be in PDF files and compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the audit materials if for any reason the electronic submission process is not successful.

c. Penalty

1) If the Contractor does not submit the required Single Audit or Financial Statement Audit, including any management letter and applicable corrective action plans within nine months after the end of the Contractor's fiscal year, MDHHS may withhold from the current funding an amount equal to five percent of the audit year's contract funding (not to exceed $200,000) until the required filing is received by MDHHS. may retain the amount withheld as a penalty if delinquency reached 120 days past due. MDHHS may terminate the contract if the Contractor is 180 days delinquent in meeting the audit requirements.
2) Failure to submit the Audit Exemption Notice, when required, may result in withholding from the current funding an amount equal to one percent of the audit year's funding until the Audit Exemption Notice is received.

d. Other Audits

MDHHS or federal agencies may also conduct or arrange for "agreed upon procedures" or additional audits to meet their needs.

2.15 Cost Reporting

The Contractor must submit annual financial cost reports based on the state's fiscal year which begins October 1 and ends September 30 in the following calendar year. The reports must contain the actual costs incurred by providers in delivering services required in this contract to MDHHS clients for the reporting period. Costs for non-MDHHS youth are not to be included. Reports will be submitted using a template provided by MDHHS. The financial reports must be submitted annually, and will be due December 15th of each fiscal year. The Contractor must comply with all other program and fiscal reporting procedures as are or may hereinafter be established by MDHHS. Reports must be submitted electronically to MDHHS-Foster-Care-Audits@michigan.gov with the subject line: RFCAN Cost Report.

Failure to meet reporting responsibilities as identified in this contract may result in MDHHS withholding payments until receipt of annual financial cost report. MDHHS may withhold from current payments an amount equal to five percent of the Contractor's reporting year MDHHS revenue (not to exceed $60,000) until the required filing is received by MDHHS. MDHHS may retain withheld funds as a penalty if delinquency reaches sixty (60) days past due. MDHHS may terminate the contract if the Contractor is ninety (90) days delinquent in submitting the required annual financial cost report.

2.16 Service Documentation

The Contractor agrees to maintain program records required by MDHHS, program statistical records required by MDHHS, and to produce program narrative and statistical data at times prescribed by, and on forms furnished by, MDHHS.

2.17 Private Agency MiSACWIS/CCWIS

The Contractor must ensure that residential payment staff has access to the MiSACWIS/CCWIS through a web-based interface, henceforth referred to as the "MiSACWIS/CCWIS application." Requirements for MiSACWIS/CCWIS for CCI contracts may be found at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_7199---,00.html

2.18 Billing

The Contractor must submit through the MiSACWIS/CCWIS system the bi-weekly roster for any youth in the Contractors care per the instructions within the MiSACWIS/CCWIS system. For unfilled bed payments, the Contractor must bill MDHHS in accordance with section 2.18.a. Unfilled Bed Procedure, below.

For filled bed payments, see section 2.18.c. Filled Bed Procedure, below.

Original payment requests submitted 180 days or more after the end of the billing period will not be considered for payment.

When the Contractor's financial records reveal that payment for a youth has not been provided by MDHHS within 30 days of receiving all necessary documentation, the Contractor will seek payment resolution by contacting the direct supervisor of the assigned MDHHS worker in writing. Any concerns over a payment authorization or issuance that cannot be resolved within 30 days of the written notice must be reported to the MDHHS County Director for immediate resolution. The Contractor will apprise MDHHS Federal Compliance Division at MDHHS-FederalComplianceDivision@michigan.gov of any ongoing, unresolved payment concerns.

a. Unfilled Bed Procedure
Unfilled Beds are contracted beds in which a youth is not placed.

Unfilled Bed Payments
The Contractor must submit the monthly unfilled bed invoice and MDHHS provided spreadsheet within 30 days from the end of the billing period. A reconciliation of placement days of care will occur by MDHHS to verify the unfilled bed payment. All undisputed amounts are payable within 45 days of receipt. The State has the right to withhold payment of any disputed amounts until the parties agree as to the validity of the disputed amount. The State will notify the contractor of any dispute within a reasonable time.

The invoice and completed spreadsheet must be submitted electronically to MDHHS-FederalComplianceDivision@michigan.gov. The subject line shall read: AN Unfilled Bed Payment. The Contractor shall receive the applicable unfilled bed per diem rate listed in Pricing Matrix.

b. Placement Caps and Suspensions
The Contractor shall not receive the full unfilled bed payment while a placement cap or suspension is being implemented.

1) Placement Cap
A placement cap is an adverse action when the Contractor has been provided notice by MDHHS that the number of beds that can be filled is less than the contracted number of beds for safety reasons. The contractor shall receive unfilled bed payments in accordance with the placement cap.
2) Placement Suspension
A placement suspension is an adverse action when the Contractor has been provided notice by MDHHS that no additional placements can be made into unfilled beds for safety reasons. The contractor will not receive unfilled bed payments during the period of placement suspension.

When a placement suspension is lifted by MDHHS to resume admissions, the Contractor must provide an admissions plan. The After

Placement Suspension Admissions Plan (APSAP) is due to the Foster Care Program Office no later than five (5) business days after the placement suspension is lifted. The Contractor shall receive unfilled bed payments in accordance with the APSAP once the placement suspension is lifted and the APSAP is approved by MDHHS.

The APSAP must describe:

a) A detailed admission plan to ramp up the facility to full contracted capacity within a specific timeframe and the Contractor's manager responsible for implementation. The MDHHS Program Office must have immediate and unlimited access to the Contractor's Implementation Manager.
b) All tasks, duties, or responsibilities associated with implementation and complete contract administration.
c) Methods, tools, and processes intended for oversight and completion of the implementation.
d) How issues impacting the ability to admit according to the approved plan will be conveyed to the Foster Care Program Office and include suggested resolution or risk mitigation strategies to the issue(s).
e) A detailed protocol and escalation communication process; the plan must also provide escalation procedures and contact information for issues that may need to be escalated above the Contractor's manager responsible for implementation.
f) Any additional information or considerations for services to begin by the After Placement Suspension Admission Plan date and continue thereafter for the Contract term.

MDHHS will approve/deny all APSAP within three (3) business days of APSAP submission.

c. Filled Bed Procedure

Filled beds are the number of contracted beds in which a youth is placed.

Filled Bed Payments

The Contractor must submit through the MiSACWIS/CCWIS system, the bi-weekly roster for all youth in the Contractors care per the instructions within the MiSACWIS/CCWIS system. The billing must only indicate the units of service provided by the Contractor and must be submitted to MDHHS within 30 days from the end of the billing period.

Youth placed in a contracted bed by a court directly, that are not under the care and supervision of MDHHS, shall not be verified in MiSACWIS/CCWIS roster for payment; however, all youth placed in a contracted bed, regardless of the supervising agency, shall be reported to MDHHS by the Contractor.

d. Incentive Per Diem Payments

Incentive per diem payments will be issued to RFCAN facilities by MDHHS if all "not accepted" exceptions and "maximum benefit" exceptions are approved. Incentive per diem payments will be paid through MiSACWIS/CCWIS system monthly.

Incentive per diem payments are based on accepting all referrals and maintaining all placements as validated by MDHHS until the youth's planned discharge unless MDHHS or courts remove the youth in a given month (not including MDHHS approved absences, temporary breaks or court ordered placement changes). Incentive per diem payments will be processed in MiSACWIS/CCWIS by MDHHS when a Contractor is eligible. The Contractor shall receive the applicable incentive payments at the rate listed in Schedule B Pricing Matrix.

e. One-to-One Supervision Procedure
The Contractor shall submit monthly payment requests in accordance with FOM 903-09 policy.

f. Aftercare Procedure
The Contractor shall invoice the youth's assigned case manager on agency letterhead. The invoice shall contain the following:
1) Youth's first and last name.
2) Youth's MiSACWIS person ID (PID).
3) Dates that the aftercare services were provided.
4) Level of aftercare provided. If aftercare levels change during a billing period, the dates for each specific level must be clearly indicated.

2.19 Fees and Other Sources of Funding

a. The Contractor guarantees that any claims made to MDHHS under this Contract must not be financed by any source other than MDHHS under the terms of this Contract. If funding is received through any other source, the Contractor agrees to deduct from the amount billed to MDHHS the greater of either the fee amounts, or the actual costs of the services provided.

b. The Contractor may not accept reimbursement from a client unless the Contract specifically authorizes such reimbursement in the "Contractor Responsibility" Section. In such case, a detailed fee scale and criteria for charging the fee must be included. If the Contractor accepts reimbursement from a client in accordance with the terms of the Contract, the Contractor must deduct these fees from billings to MDHHS.

c. Other third-party funding sources, e.g., insurance companies, may be billed for contracted client services. Third party reimbursement must be considered payment in full unless the third-party fund source requires a co-pay, in which case

MDHHS may be billed for the amount of the co-pay. No supplemental billing is allowed.

2.20 Repayment

If an overpayment occurs, MDHHS will contact the Contractor by letter with details regarding the overpayment. The letter will provide instructions for remitting payment as well as contact information for disputes. If the Contractor fails to remit payment or make payment arrangements in accordance with the overpayment letter, such failure may constitute grounds to terminate immediately any or all of MDHHS' contracts with the Contractor.

2.21 Child Protection Law Reporting Requirements

a. The Contractor must ensure that all employees who have reasonable cause to suspect child abuse or neglect must report any suspected abuse or neglect of a youth in care to MDHHS for investigation as required by the Child Protection Law, 1975 PA 238, MCL 722.622 et seq.
b. Failure of the Contractor or its employees to report suspected abuse or neglect of a youth to MDHHS must result in an immediate investigation to determine the appropriate corrective action up to and including termination of the contract.
c. Failure of the Contractor or its employees to report suspected child abuse or neglect two or more times within a one-year period must result in a review of the contract agency's violations by a designated Administrative Review Team, which must include the Director of CSA or designee and the Director of DCWL or designee or its successor agency, that must consider mitigating and aggravating circumstances to determine the appropriate corrective action up to and included license revocation and contract termination.

2.22 Corrective Action Requirements

Corrective Action shall mean any plan of action developed to address and remedy an area of program or service noncompliance based on licensing or other written standards. If a program review by MDHHS reveals a lack of compliance with the requirements of this Contract, the Contractor must:

a. Meet with MDHHS to discuss the noncompliance and develop an Agency Focus Plan.

b. Address and correct any identified Corrective Action within the timeframes identified in the Corrective Action Plan and Agency Focus Plan.

c. Upon request of either party, the Contractor and MDHHS may schedule monthly meetings to review operating performance, related matters, and any Corrective Action Plan.

d. MDHHS may terminate the contract pursuant to Section 4.24 if Contractor does not comply with the Agency Focus Plan and/or Corrective Action Plan or if an Agency Focus Plan and/or Corrective Action Plan cannot be agreed to by the parties.

2.23 Criminal and Children's Protective Services Background Checks

As a condition of this Contract, the Contractor certifies that the Contractor shall, prior to any individual performing work under this Contract, conduct or cause to be conducted for each new employee, employee, subcontractor, subcontractor employee or volunteer who works directly with Clients and/or children under this Contract, or who has access to client information:

a. An Internet Criminal History Access Tool (ICHAT) check and a National and State Sex Offender Registry check.

   Information about ICHAT can be found at http://www.michigan.gov/ichat.

   The Michigan Public Sex Offender Registry web address is http://www.mipsor.state.mi.us.

   The National Sex Offender Public Website address is http://www.nsopw.gov.

b. A Central Registry (CR) check.

   Information about CR can be found at http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_48330-180331--,00.html

c. A Children's Protective Services confirmed case background check.

   A clearance shall be completed prior to the hiring of an individual to provide services within this contract. Prior to hire, the Contractor shall submit a request to clear any new employee, subcontractor, subcontractor employee utilizing the CWL-4624 form. This form must be submitted to MDHHS-LASO-DCWL@michigan.gov. The results of the clearance will be returned to the Contractor.

   The Contractor must have a written policy that requires employees to notify the Contractor when the employee has a Children's Protective Services' investigation in which the employee was found to have a confirmed case of child abuse or neglect, regardless of whether the employee's name was placed on the Central Registry. The Contractor shall notify MDHHS, in writing, of the confirmed case within one business day.

The Contractor shall ensure the policies are implemented for the agency pertaining to adherence to the Central Registry changes. The policies at minimum shall include the following provisions:

1. All applicants are required to disclose CPS case history where the applicant was found responsible for the abuse or neglect of a child regardless of whether the case resulted in placement on CR. The applicant must provide a written narrative describing case/s as well as explanation of changes the individual has made to mitigate their previous actions.

2. All employees are required to disclose CPS cases where the employee was found responsible for the abuse or neglect of a child regardless of whether the case resulted in placement on CR immediately but no later than the beginning of the next business day after receiving notice. It is the employee's responsibility to immediately communicate this information to their immediate supervisor and the applicable Human Resources (HR) department. The employee must provide a written narrative describing the case details as well as an explanation of changes the individual has made to mitigate their previous actions.

   A staff member or unsupervised volunteer who has been confirmed by the department as a perpetrator of abuse or neglect that does not result in a central registry placement, shall not have contact with children until the appropriate entity has reviewed the CPS history, in addition to the current confirmation, and determines the staff member or unsupervised volunteer does not pose a substantial risk to children.

d. The Contractor shall require each employee, subcontractor, subcontractor employee or volunteer who works directly with clients or who has access to client information, under this Contract to timely notify the Contractor in writing of criminal convictions (felony or misdemeanor) and/or pending felony charges or placement on the Central Registry as a perpetrator.

   Additionally, the Contractor shall require each new employee, employee, subcontractor, subcontractor employee or volunteer who works directly with clients under this Contract or who has access to client information and who has not resided or lived in Michigan for each of the previous ten (10) years to sign a waiver attesting to the fact that they have never been convicted of a felony or identified as a perpetrator, or if they have, the nature and recency of the felony.

e. The Contractor further certifies that the Contractor shall not submit claims for or assign to duties under this Contract, any employee, subcontractor, subcontractor employee, or volunteer based on a determination by the Contractor that the results of a positive ICHAT and/or a CR response or

reported criminal felony conviction or perpetrator identification make the individual ineligible to provide the services.

f. If MDHHS determines that an individual provided services under this Contract for any period prior to completion of the required checks as described above, MDHHS may require repayment of that individual's salary, fringe benefits, and all related costs of employment for the period that the required checks had not been completed.

g. Upon request, Contractor must perform criminal and CPS background checks on all employees and subcontractors and its employees prior to their assignment. The scope is at the discretion of the State and documentation must be provided as requested. Contractor is responsible for all costs associated with the requested background checks. The State, in its sole discretion, may also perform background checks.

2.24 Ordering

The appropriate authorizing document for the Contract will be the executed Master Agreement.

2.25 Service Level Agreements (SLA)

SLA
Unfilled Bed Requirements
Guarantee
100% of the Contracted beds, identified in Schedule B, must be available for use by the MDHHS throughout the term of the Contract regardless of availability of staffing or services, except in unanticipated emergency situations. The Contractor is expected to meet 100% capacity absent lack of assignments from the Regional Placement Unit that meet the Service Description set forth in Attachment A. This SLA will be measured using daily census reporting by Contractor.
Credit
If a youth was not accepted or was removed from the program and MDHHS did not agree with the Contractor's objection to accepting a youth or disagrees that a youth has not reached maximum benefit, the Contractor will not receive the monthly incentive payment.

3 MDHHS RESPONSIBILITIES

3.1 Maximum Amount of Contract

MDHHS agrees to pay the Contractor an amount not to exceed the total contract amount identified in Schedule B Pricing Matrix. Refer to the Schedule B Pricing Matrix for established pricing.

3.2 Performance Evaluation and Monitoring

a. The services provided by the Contractor under this Contract must be evaluated and assessed at least annually by MDHHS based on the criteria outlined below.

   MDHHS must perform contract monitoring through activities such as:

   1) Review auditing expenditure reports.
   2) Interim or Renewal Licensing Studies and reports.
   3) Review of written plans and reports.
   4) Review compliance with the contract and court orders via Annual Compliance Review (ACR) and Special Investigations.
   5) Review of licensing violations, contract violations, Maltreatment in Care (MIC) substantiations, Prison Rape Elimination Act (PREA) compliance, and overall safety of youth served.

b. The Contractor shall participate in an annual contract evaluation to assess contract compliance and overall service provision. The participation shall include, but is not limited to, the following:

   1) Provide quantitative and qualitative data as requested by MDHHS
   2) Attend and engage in meetings as requested
   3) Develop and implement an Agency Focus Plan with CSPC staff to address all areas of non-compliance.

3.3 Residential Collaboration and Technical Assistance Unit (RCTAU)

RCTAU shall be responsible for review of the Contractor's compliance with the Contract via Annual Contract Evaluation. RCTAU may review, analyze and comment on all activities covered within the terms of the Contract. If the Annual Contract Evaluation reveals that the Contractor has not complied with the requirements of this Contract, the following procedures shall be implemented:

a. RCTAU shall notify the Contractor of the Contract noncompliance. This notification shall occur through a written report of the findings. The Contractor may request a meeting to discuss and examine the identified Contract noncompliance.
b. Upon completion of the Annual Contract Evaluation, RCTAU will complete an interim report outlining areas of non-compliance. The Contractor will have 60 days to come into compliance with contract requirements and provide documentation

of compliance. At that time, the final Annual Contract Evaluation report will be completed by RCTAU.

c. Following the completion of the final Annual Contract Evaluation report, RCTAU will meet with the Contractor to develop an Annual Agency Focus Plan to within 14 days of the Contractor receiving the final written report of findings.
d. Based on the severity or repeated nature of cited violations, a recommendation may be made by the Foster Care Program Office or RCTAU at any time to place a moratorium on new placements with the contractor or to cancel the contract. This recommendation will include consultation with the RCTAU, MIC, and DCWL, at a minimum. The recommendation will be submitted to the MDHHS Executive Governance Committee for review and approval prior to final decision being made. If either recommendation is made and approved by the Executive Governance Committee, a meeting will be convened with the director of the contracted agency, the Foster Care Program Office, RCTAU, MIC and DCWL.
e. If a moratorium on new placements is put into place, it shall be for a minimum of 90 days to allow the contractor to remedy cited violations and comply with any agreed on corrective actions. If the cited violations are not corrected during the period of the moratorium or additional serious violations are cited, consideration shall be given to cancellation of the agency's contract. Final decisions regarding the cancellation of a contract shall be made by the Executive Governance Committee.

4. INSERT Standard Contract Terms

2. INSERT FEDERAL TERMS

Attachment A: Residential Foster Care Program Types

REMOVE ALL PROGRAM TYPES BELOW EXCEPT FOR THE PROGRAM TYPE IDENTIFIED IN THE CONTRACT.

The Contractor must ensure access to the elements of residential intervention outlined in the MDHHS DCWL standards specific to the license listed in Section 2.4. Additionally, the Contractor must ensure access to those services outlined in Section 2.10 of this Contract for each residential program type.

1. Mental Health and Behavior Stabilization

Definition

The Mental Health and Behavior Stabilization (MHBS) Residential Intervention Program type provides intensive and frequent services and has a lower staff to youth ratio than General Residential. The staffing, structure, and environment make more intensive youth supervision possible. The Mental Health and Behavior Stabilization Program provides for the application of a comprehensive array of services that include psychiatric and clinical assessments and evaluations and corresponding interventions designed to stabilize and treat the conditions of mental health/behavioral instability. Level of service intensity is tailored to and based on the needs of the youth and the youth's diagnosis at the time of intake and ongoing progress in the program.

The Mental Health and Behavior Stabilization program provides intensive youth supervision via staffing, structure, environment, and treatment intervention.

Behaviors of a youth currently experiencing or with a history of MHBS may include among others: aggressive behavior towards self and others, psychotic symptoms (delusions, hallucinations, suicidal/homicidal ideations), sexually aggressive behavior, and/or frequent severe emotional instability. Additionally, the youth may have a history of refusing medication and/or medication may not result in behavior stability. The Contractors Program Statement should align with the Definition and Symptomology listed here.

Symptomology

A youth currently experiencing or with a history of active unstable symptoms which may include severely aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations, suicidal/homicidal ideations), and/or frequent severe emotional episodes. The youth is non-compliant with and/or not stabilized on medication. The youth have a high risk of serious self-harm and aggression. Lack of intact thought process.

Standardized Assessment Tool

The contractor must utilize assessment tools identified in Section 2.10.d., to assess the youth's overall progress in functioning while in the residential program.

The Contractor must administer the assessment tools within timeframes outlined in section 2.10.d. and quarterly thereafter until planned discharge as defined in Section 2.10.v.2).

Services

The youth must have a psychiatric consultation within seven calendar days of the youth's admission to the program. The consultation will include a conference (telephone or video) between the prescribing clinician, nursing, and designated clinical staff from the program. The consultation must include discussion of the youth's presenting circumstances, summary of prior history, current reconciled medication list, active problems, and concerns (health and mental health) and needs prior to the comprehensive psychiatric evaluation. The consultation, including date and time, will be documented in a nursing note, co-signed by the prescribing clinician within 7 calendar days of the consultation and included within the youth's health file. This seven-day consultation may be provided by a Physician's Assistant (PA) who has a valid MI license and has an existing practice agreement with the physician with whom they work or a nurse practitioner who has a valid MI license and has a collaborative agreement with a physician. If there is a recommendation for medication change, there must be a comprehensive psychiatric examination within 15 calendar days of admission.

The youth must have a comprehensive psychiatric examination within 15 calendar days of the youth's admission into the program. The evaluation must include the following elements:

- Vital signs (obtained by staff on site)
- Full medication list (psychotropic and general)
- History of present illness
- Past Psychiatric History
- Review of Systems
- Medical History
- Family History
- Social History
- Mental Status Examination
- Diagnosis
- Treatment recommendations

The evaluation must be conducted face to face or via telehealth technology. If telehealth is utilized the provider must follow general clinical guidelines for this technology. All services (in-person or telehealth) must be HIPAA compliant.

If a program's prescribing clinician conducts the comprehensive psychiatric examination within seven calendar days of admission, then the psychiatric consultation will not be required.

a. Nurse oversight of physical interaction with psychotropic medication.

b. Within 24 hours of admission, a telephone call between the nursing staff and consulting psychiatrist, at a minimum, is to be held to review medications, including both description and supply, current status, and to address any urgent needs.
c. Self-help groups as needed.
d. Family activity programs.
e. Individual, Group and Family Therapy
    i. Both individual and group therapy are requirements of this Contract. At least two times per week, the Contractor must provide direct therapeutic interventions for each youth individually and/or in group sessions. At least one session per week must be an individual therapy session. Individual and/or group therapy must be provided in accordance with the youth's treatment needs as identified in the youth's service plan.

    ii. Parents, family members and pertinent supportive adults should be engaged in therapy with the youth. Family therapy, when safe for the youth, should be provided no less than one time per month.

    iii. The Contractor must describe its plan for supporting each youth to build, strengthen and/or repair primary attachments with parents, family members, and pertinent supportive adults in the youth's life.

Staffing Ratio

The Contractor must:

a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix
b. The awake ratio will be for non-school hours. School hours are not included in this requirement.
c. For sleeping ratio, all the staff must be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Program Performance Objectives

During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

2. Youth with Problematic Sexual Behaviors

Definition

A program for youth with problematic sexual behaviors uses treatment modalities aligned with the Association for the Treatment of Sexual Abusers, Practice Guidelines for Assessment, Treatment, and Intervention with Adolescents who Have Engaged in Sexually Abusive Behavior. Services are individualized based on the trained expert assessment. The Contractor must provide individualized treatment plans based on risk-need-responsivity.

The Contractors Program Statement should align with the Definition and Symptomology listed here.

Symptomology

A youth with sexual behavior that has impacted daily life functional areas, including relationships, school, family, or other domain to the extent that continued services in the community do not provide sufficient support. A trained expert using an evidence-based assessment has identified residential treatment is the level of care necessary.

Youth with problematic sexual behaviors have a diverse set of needs and should not be treated as a homogenous group. The determination of whether to provide specific treatment for a youth with problematic sexual behaviors must occur through assessment of risk(s), need(s), protective factors, and available resources.

Standardized Assessment Tool

The assessment process should identify the youth's treatment needs and recommended level of service/care.

In addition to the assessment tools outlined in Section 2.10.d., the contractor must utilize the CANS-Sexually Aggressive Behavior Module (CANS-SAB) to identify the youth's preliminary risk factors and the PROFESOR for dynamic factors to assess the youth's overall progress while in the residential program.

The Contractor must administer the assessment tools as required by JRM policy thereafter until planned discharge/release as defined in Section 2.10.v.2).

The tool must be utilized by a professional trained in the utilization of the identified tool.

Services

a. Individual, group, and family therapy must be established consistent with the trained expert assessment and aligned with the Association for the Treatment of Sexual Abusers, Practice Guidelines for Assessment, Treatment, and Intervention with Adolescents who Have Engaged in Sexually Abusive Behavior.
b. Interventions focusing on and treating any history of trauma as well as any problematic sexual behavior is required.
c. Additional life skills interventions, including relationship building, sexual education, and healthy sexuality.

Service Delivery

a. The Contractor must not have a phased approach to service delivery.
b. Risk factors identified in the assessments should drive group and individual therapy.
c. Skills and education must be used to lessen risk factors and should be the focus of treatment sessions.
d. The Contractor must be equipped to address each youth's own trauma history as part of the youth's treatment.
e. Plethysmography and polygraph must not be used in the treatment for the youth.

f. The contractor must ensure that the caregiver is supported and engaged in treatment.
g. Risk assessment results need to be transparent and shared with the youth receiving treatment, the youth's caregiver, and the youth's primary caseworker with the goal of reducing risk and increasing protective factors.
h. The Contractor must deliver services in a manner that ensures re-entry to the community at the earliest possible date based on reduction of risk and/or increased protective factors.

Service Provider Qualifications

All programs must be:

- Equipped with knowledge of normative childhood sexual development.
- Equipped with knowledge of current treatment practices for children with problematic sexual behaviors.
- Programming should not be Relapse Prevention-focused, but rather a strength-based approach (Good Lives Model for youth with sexual behavior problems) (https://www.goodlivesmodel.com/information.shtml) (Workbook: https://safersocietypress.org/store/good-lives-model-adolescents/).

Therapists must be persons that meet the qualifications outlined Section 2.10. f. 4) b). and have experience working with youth who have displayed problematic sexual behavior or be supervised by a therapist with the experience and qualifications outlines in Section 2.10. f. 4) b).

Staffing Ratios/Room Assignments

The Contractor must:

a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix
b. The awake ratio will be for non-school hours. School hours are not included in this requirement.
c. For the sleeping ratio, all staff must be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Single occupancy rooms are highly recommended.

Program Performance Objectives

During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

3. Developmentally Disabled and Cognitively Impaired Program

Definition

Services for youth with developmental disabilities consists of individualized services that include structure and support in mastering activities of daily living, developing positive self-protective skills, community integration, behavior plans and interventions, including mental health treatment as needed. Services are designed and delivered to

engage the client at his or her level of functioning. Residential providers support youth in their treatment, school programs, adult transition planning, transition planning to a less restrictive placement and, when it is a part of the youth's individual plan, preserving connection with their families.

Intellectually disabled is defined as mild to moderate (IQs 45 to 69), intellectually impaired youth, with or without substance use or dependence symptoms. This also includes youth with severely or profound cognitive impairments (IQ below 45), can include those with classic autism spectrum disorder that exhibit severely restricted functioning levels, and severely multiply impaired, which includes those with a combination of cognitive and physical impairments, and may also include mental and/or emotional impairments.

Developmentally disabled is defined as an individual diagnosed with a mental disorder which significantly impacts their adaptive functioning and ability to care for themselves and generally is considered a lifelong condition.

The Contractors Program Statement should align with the Definition and Symptomology listed here.

Symptomology

Youth experiencing significant adjustment problems at home, in school, and/or in the community as a result of serious emotional disturbance (SED) with or without substance use or dependence symptoms, concurrent with cognitive impairments.

Youth experiencing significant adjustment problems at home, in school, or in the community concurrent with cognitive impairment or developmental disability, emotional impairment and behavioral concerns that cannot be addressed in a less restrictive placement.

Youth may be currently experiencing or have a history of active unstable symptoms which may include severely aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations, suicidal/homicidal ideations), and/or frequent severe emotional episodes. The youth is non-compliant with and/or not stabilized on medication. The youth have a high risk of serious self-harm and aggression. Lack of intact thought process.

Standardized Assessment Tool

The Contractor must utilize a standardized assessment tool as defined in the Contractor's program statement to assess the youth's overall progress in functioning while in the residential program. The Contractor may utilize a tool other than the Casey Life Skills Assessment, listed in section 2.10 of this contract, to assess independent living skills for youth with developmental/cognitive delays.

The Contractor must administer the assessment tools within timeframes outlined in section 2.10.d. and quarterly thereafter until planned discharge as defined in Section 2.10.v.2).

The tool must be utilized by a professional trained in the utilization of the identified tool.

Staffing Ratio

The Contractor must:

a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix
b. The awake ratio will be for non-school hours. School hours are not included in this requirement.
c. For the sleeping ratio all staff must be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services

a. Nurse oversight of side effects with psychotropic medications
b. Intensive activity-based individual or specialized group therapy.
c. Self-help groups as needed.
d. Family therapy and/or family activity programs.
e. Independent living skills assessment/preparation and community reintegration.
f. Adjunctive therapy, provided either on site or in the community, including recreational therapy, occupational therapy, music therapy, art therapy, speech therapy, physical therapy, and respiratory therapy when these or any other interventions are prescribed by a treating physician or required by an IEP.
g. Peer support groups that focus on social norms, learning how to interpret social cues and problem solve responses that are acceptable.
h. Family therapy directed toward the establishment and utilization of positive behavioral management and strengthening family relationships.
i. Aftercare service planning, connecting the youth with services that include coordinating a referral and initial appointment with a local Community Mental Health center for casework services for persons with developmental delays.

Program Performance Objectives

During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

4. Substance Abuse Rehabilitation

Definition

A comprehensive array of services to address substance abuse, prevent substance use, and support recovery. Interventions are co-occurring, capable, and address the full range of related issues including:

a. recognizing the harmful effects of chemicals on the youth.
b. develop skills to avoid chemical use.
c. identify alternate methods of meeting the needs previously met by chemical use.
d. achievement and maintenance of sobriety or abstinence
e. health and mental health needs
f. counseling and/or psychotherapy

g. education
h. improved social, emotional, psychological, cognitive, and vocational functioning.

The Contractors Program Statement should align with the Definition and Symptomology listed here.

Symptomology
Youth experiencing substance use disorders with a significant impairment in an area of functioning.

Standardized Assessment Tool
In addition to the assessment tools outlined in Section 2.10.d. the Contractor must utilize a published standardized assessment tool as defined in the Contractor's program statement to assess the youth's overall progress in functioning while in the residential program.

The Contractor must administer the assessment tools within timeframes outlined in section 2.10.d. and quarterly thereafter until planned discharge as defined in Section 2.10.v.2).

The tool must be utilized by a professional trained in administering the identified tool.

Staffing Qualifications
Therapists must have appropriate certifications as outlined in the Michigan Certification Board for Addiction Professionals.

Staffing Ratio
The Contractor must:
a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix
b. The awake ratio will be for non-school hours. School hours are not included in this requirement.
c. For the sleeping ratio, all staff must be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services
a. Individual therapy at least one time weekly.
b. Specialized group, multi-family or didactic group therapy as identified in the youth's treatment plan.
c. Self-help groups and/or sober leisure skill development.
d. Family therapy and/or family activity programs.
e. Level appropriate community or campus-based education.
f. Intensive school supports services e.g., testing, monitoring, tutoring.

Program Performance Objectives
During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

5. Parent/Baby

Definition

The Parent/Baby Residential Program provides a discharge-focused, interdisciplinary, psycho-educational, and therapeutic 24-hour-a-day structured program with community linkages, provided through non-coercive, coordinated, individualized care, and interventions with the aim of moving individuals toward a stable, less intensive level of care or independence. Interventions should be evidence-based and include trauma-focused interventions.

The Parent/Baby Program must offer an intensive array of services to meet the short term and longer-term needs of pregnant and parenting youth in the Michigan child welfare system. Research has shown that successful programs incorporate three elements that offer a pregnant and parenting youth the supports needed to succeed: socialization, nurturing and support, structure, and discipline. To best support pregnant and parenting youth in Michigan, the program must be designed as a continuum of care approach. The continuum may consist of three levels. Level 1 is highly structured with 24-hour supervision. Level 2, a step down to a less restrictive living situation where the level of supervision is decreased, and the youth obtains more responsibility for managing his/her own money. Level 3 includes a step to a less restrictive non-residential setting. The tiered level approach encourages youth participation and investment in the program while working on their long-term goal of being self-sufficient.

The Parent/Baby Program service delivery can be offered in several different modalities. Ideally, the program should provide a continuum of services to allow the youth to transition from a residential/group home setting to a non-residential setting. The approach should include supervision, staffing, home settings, and basic program standards.

The objectives of Parent/Baby Residential Program type are:

a. Youth will acquire skills necessary to successfully maintain placement in a less restrictive home setting.
b. The youth will engage in educational or vocational programming while participating in the program.
c. Youth and infants/toddlers will be monitored and assessed for special health and/or mental health care needs and developmental delays.
d. Pregnant and/or parenting youth will demonstrate appropriate expectations of their infants/toddler's behavior and needs.
e. The youth will understand typical child development.
f. The youth will have a supportive adult connection upon discharge to assist with transitioning from the program into independence or to next placement.
g. Children of parenting youth will remain with the parent without substantiated reports of abuse or neglect.
h. The youth will demonstrate an ability to prioritize the child's needs above their own.

i. The youth will have the ability to reflect on their own parenting strengths and challenges.

   The Contractors Program Statement should align with the Definition and Symptomology listed here.

Eligibility
The Parent/Baby Program is available to youth ages 13 and older who are pregnant and/or parenting and the youth's infants/toddlers. The Contractor must have the ability to serve both pregnant and parenting youth and the youth's infant/toddler(s).

Symptomology
The youth present risk in school, home and/or community. The youth has presented risk to self, others, and property. The youth has exhibited a behavior(s) that has interfered with his/her ability to function adequately in a less restrictive setting. Such behaviors could include, but may not be limited to aggressive episodes, stealing or petty theft; vandalism; inappropriate social interactions (threatening behavior, inappropriate language, disruptive school behavior, consistent failure to adhere to rules, incorrigibility in not following adult directives), and/or reactions to past trauma, which results in maladaptive behaviors.

Standardized Assessment Tool
In addition to the assessment tools outlined in Section 2.10.d., the Contractor must utilize the Adult-Adolescent Parenting Inventory (AAPI) to assess parenting skills progress.

The Contractor must administer the assessment tools within timeframes outlined in section 2.10.d. and quarterly thereafter until planned discharge as defined in Section 2.10.v.2).

The tool must be utilized by a professional trained in the utilization of the identified tool.

Services
For a youth in the Parent/Baby Residential Program, the Contractor must ensure access to the elements of residential intervention outlined in DCWL standards specific to the license listed in Section 2.4. Additionally, the Contractor must ensure access to those services outlined in Section 2.10 of this Contract in addition to the following:

a. Interventions through infant mental health or Early On must be provided as needed and/or recommended for at-risk infants/toddlers.
b. Intensive school supports services e.g., testing, monitoring, tutoring.
c. Transportation Assistance - Assist the parenting youth in accessing necessary transportation to obtain or maintain employment, attend school or vocational training, attend medical appointments and therapy appointments.
d. Access to Mentors - Encourage and develop opportunities for pregnant and parenting youth to be matched with mentors in the community that will provide additional support and a potential long-term connection.

e. Recreational Activities - Provide recreation activities defined as a planned, age appropriate, regular, and recurring set of staff-supervised leisure time events designed to support the youth's treatment plan. These recreational activities must be supported by appropriate supplies and equipment that are well maintained and in useable condition.

The Contractor must:

a. Provide activities which must contain a variety of physical, intellectual, social and cultural opportunities indoors and outdoors.
b. Assign a minimum of one staff for every eight youth/infants to directly supervise the activities.
c. Parenting Skills Training - Parenting Skills Training and interactive training activities must be utilized in accordance with the outcomes specified in the case service and treatment plan, including youth development, improvement and reinforcing of age appropriate social, communication and behavioral skills. Classes and referrals must address issues which include, but are not limited to:

(i) Infant care/early infant brain development.
(ii) Stages of growth in infants.
(iii) Safe Sleep.
(iv) Infant/toddler safety.
(v) Parenting preparation.
(vi) Child development.
(vii) Child health care.
(viii) Infant/toddler emotional and social needs.
(ix) Child management skills and positive discipline.
(x) Parent/child roles and communication.
(xi) Responsible fatherhood.
(xii) Developing secure attachment.
(xiii) Securing appropriate childcare.
(xiv) Stress management and coping skills.
(xv) Domestic violence.
(xvi) Changes in parent mood and awareness of surroundings under the influence of recreational drugs or alcohol.
(xvii) How to access community resources.

In addition to parenting classes, programming must address specialized bonding and attachment sessions and activities to promote secure attachments between the parent and infant. Research indicates early attachments lay the foundation for social, emotional, and academic skills. Interactive parenting activities must include opportunities to capitalize on teachable moments with the adolescent parent, promote the value of family literacy with teaching nursery rhymes, songs, etc. and offer various interactive play activities that engage both the youth and baby.

a. Community Referrals - Referrals must be made to community resources such as Early Head Start, Early On, Parent Infant Program, Infant Mental Health or other

in-home programs and documented in the service plan. Research has shown that participation in this type of programming is linked to several positive impacts on parenting, child development, and economic self-sufficiency.

b. Child Care Assistance - The youth must be provided assistance in obtaining appropriate childcare while they are participating in programming to enhance their self-sufficiency. Childcare can be provided on site or off site by a licensed childcare provider.

   The Contractor must ensure the infant/toddler childcare is of high quality that promotes the child's social, emotional, cognitive, and verbal development.

c. Outreach to Fathers/Mothers - Unless documented that it would be contrary to the best interest of the child and/or parent or if required in a court order, the contractor will make extensive efforts to engage fathers/mothers to foster involvement in the infant/toddler's life and to assist the pregnant/parenting youth in obtaining a supportive support network. The program must allow for the father's/mother's select participation in parenting skills trainings, visitations with child and child-parent activities. The father/mother should be encouraged to attend prenatal and/or well-baby medical appointments.

Staffing Ratio

The Contractor must:

a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix
b. The awake ratio will be for non-school hours. School hours are not included in this requirement.
c. For the sleeping hours, all the staff must be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

The staffing ratio includes the youth infant/toddler.

Additional Staff Training Topics

The Contractor must provide the following training topics in addition to those outlined in Section 2.10.e.3. of this Contract:

a. Medical, physical, and psychological aspects of pregnancy.
b. Prenatal and postnatal care.
c. Infant and toddler development.
d. Safe Sleep practices.
e. Childcare.
f. Parenting skills training techniques.
g. Attachment theory.

Reporting

The Contractor must include youth in the development of the treatment plan. The treatment plan must:

a. Assist the youth in preparation and transition to adult living and responsible parenting.
b. Include outcomes identified through the Independent Living assessments.
c. Identify the youth's educational and/or vocational goals.
d. Outline the youth's other personal goals.

In addition to the youth's goals, the treatment plan must address the following:

a. The infant's/toddler's daily needs, establishing daily exclusive time with the infant, providing stimulating development and educational activities with the infant.
b. The infant's/toddler's daily routine or schedule.
c. The youth's coordination and arrangement of medical care for the infant and other necessary services.
d. The youth's participation in parenting skills classes.

Program Performance Objectives

During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

6. Specialized Developmental Disability (SDD)

Definition

The Specialized Developmental Disability (SDD) program provides enhanced residential treatment to youth with intensive and specialized service needs related to developmental disabilities, including Autism, and intellectually disabled youth, who have deficits in social communication skills, sensory activity, and a limited ability to conduct daily living tasks without intensive support.

The Contractors Program Statement should align with the Definition and Symptomology listed here.

Symptomology

A youth whose level of developmental impairment warrants a significant sensory sensitive individualized treatment setting.

Program is designed for youth diagnosed with Autism Spectrum Disorder, or youth with intellectual or developmental disability.

Youth experiencing significant deficits in social communication skills, sensory sensitivity and a limited ability to conduct daily living tasks without intensive support which prevents youth from adjusting satisfactorily to a lessor restrictive treatment environment.

Youth who will benefit from a controlled environment that is tailored to their developmental and functioning level.

Standardized Assessment Tool

The assessment tools identified in Section 2.10.d. of this contract are not required for youth served under the Specialized DD program type.

The Contractor must utilize one or more of the following assessment tools for all youth entering the program, regardless of any previous assessments conducted by any provider:

- Autism Diagnostic Observation Schedule (ADOS) (not more than every three years)
- Pearson's Expressive Vocabulary Test (PEVT)
- Assessment of Functional Living Skills (AFLS)
- Essential for Living (EFL) Quick Assessment (quarterly)
- Essential for Living (EFL) Full Assessment
- Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
- Promoting the Emergence of Advanced Knowledge (PEAK)

These assessments will be completed by the appropriate professional as required by each identified tool. For some tools, this may include a Board-Certified Behavior Analyst (BCBA) or by a professional trained in the utilization of the identified tool.

The Contractor must administer the assessment tool within 21 calendar days of admission, and quarterly thereafter until planned discharge as defined in Section 2.10.v.2).

Services

The youth must have an Applied Behavior Analysis (ABA) treatment plan within 30 days of placement if ABA services are appropriate to the individual youth.

a. An Applied Behavior Analysis (ABA) treatment plan within 30 days of placement if ABA services are appropriate to the individual youth
b. Nurse oversight of side effects with psychotropic medications
c. Family engagement and enrichment activities.
d. Intensive activity-based individual or specialized group therapy at least one time weekly.
e. Independent living skills assessment/preparation and community reintegration to the extent identified as appropriate for the individual youth.
f. Adjunct therapy provided either on site or in the community when these or any other interventions are prescribed by a treating physician or required by an assessment/IEP. *(Examples include recreational therapy, occupational therapy, music therapy, art therapy, speech therapy, physical therapy, and respiratory therapy)*
g. Peer support groups.
h. Family therapy directed toward the establishment and utilization of positive behavioral management and strengthening family relationships.

Staffing Ratio

The Contractor must:

a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix
b. The awake ratio will be for non-school hours. School hours are not included in this requirement.
c. For the sleeping ratio, all the staff must be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Specialized Developmental Disability - Autism

This program designation is targeted at providing specialized services for youth with an autism diagnosis and in need of heightened programming. In addition to the above SDD requirements, the following are additional requirements for the Autism placements:

a. Psychiatric services.
b. Increased therapeutic services.
c. Applied behavioral analyst services (ABA).
d. Additional staff coverage and off the floor coverage.

Program Performance Objectives

During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

7. Intensive Stabilization

Definition

The Intensive Stabilization (IS) program provides a therapeutic environment for youth who are in current crisis or have not been able to maintain stabilized behavior. This program offers intensive specialized services in a trauma-informed short-term program. The intent of the program is to stabilize crisis while diagnostic services and supports are provided to meet the short-term treatment goals of the youth and frequent services. The program will help identify short and long-term treatment goals, community supports, and secure an appropriate living situation for youth which will allow the youth to return to a community-based setting as soon as possible.

The Contractors Program Statement should align with the Definition and Symptomology listed here.

Symptomology

A youth with significant behavior challenges, youth being stepped down from a hospitalization program or youth experiencing repeated placement instability. Youth may be currently experiencing or have a history of active unstable symptoms which may include aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations, suicidal/homicidal ideations), and/or frequent severe

emotional episodes. The youth is non-compliant with and/or not stabilized on medication. The youth has a high risk of serious self-harm and aggression and a lack of intact thought process.

Standardized Assessment Tool

In addition to the assessment tools outlined in Section 2.10.d. the Contractor must utilize the following types of assessments:

a) Biopsychosocial Assessment
The youth and family (whenever possible) participate in the development of a comprehensive, individualized, strength-based, trauma informed, family-focused, culturally responsive assessment that informs and guides service delivery, discharge planning and aftercare services. Assessment is completed by a therapist within 3 days of admission to the program. Assessments are integrated to address multiple life domains, assess for co-occurring mental health and substance use condition, and include a summary of symptoms and a diagnosis. Assessments are conducted face-to-face and include an assessment of natural supports and resources. Screening tools may be used as part of the assessment process.

b) Psychiatric Assessment is completed within 72 hours of admission to the facility. Parent, guardian, caregiver, or support person identified are required to attend the Psychiatric Assessment. It is critical that the youth, Parent/Guardian/Caregiver/Support Person participate in the Psychiatric Assessment. If any medication changes are made the parent or guardian will need to sign a medication consent form. New medications cannot be started without this consent in place.

c) Nursing Assessment will be completed with 24 hours of admission. This assessment will also include an assessment of nutritional needs.

There may be identified conditions, needs, or issues that require further assessment by practitioners of other disciplines. Psychiatric stability will be important for the validity of any additional assessments so consultation with the Psychiatrist will occur prior to scheduling additional assessments. The Therapist will coordinate with referral source in coordinating and making referrals for those assessments. In such instances, an authorization to release information is signed by the guardian/family so that the referral may be made. Examples of additional assessments include but are not limited to neurological, psychological, developmental, occupational, speech, hearing, nutritional, and medical.

The tools must be utilized by a professional trained in the utilization of the identified tool.

Treatment planning:

An initial treatment plan will be developed within 4 days of admission. All stabilization services and interventions must be directly related to the goals and objectives

established in each youth's individual service plan (ISP). The ISP is developed by the youth/family/treatment team in collaboration with the provider agency. Family/caregiver involvement is extremely important and unless contraindicated, should occur from the beginning of treatment, and continue as frequently as possible, as determined appropriate in the ISP.

The ISP must identify the youth's interests, preference, and needs as determine to be appropriate by the treatment team, in the following areas:

- Physical and emotional well-being
- Risk and safety factors
- Nutrition
- Personal care needs
- Cognitive and education abilities
- Recreation and leisure time
- Community participation
- Communication
- Religion and culture
- Social and personal relationships
- And other areas determined important by the youth.

The goal of treatment will focus on stabilizing youth in crisis, supporting and assisting the youth in achieving greater independence and fulfillment in their life, while improving the youth's functioning, participation, and reintegration into the family home/resource home/ or potentially transition into an alternative out of home living situation.

Staffing Ratio

The Contractor must:

a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix
b. The ratio will be for non-school hours. School hours are not included in this requirement.
c. The sleeping ratio, all staff must be awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services

a) Nurse oversight of side effects with psychotropic medications
b) Intensive activity-based individual or specialized group therapy.
c) Family therapy and/or family activity programs.
d) Independent living skills assessment/preparation and community reintegration.
e) Family therapy directed toward the establishment and utilization of positive behavioral management and strengthening family relationships.
f) Aftercare service planning, connecting the youth with services that include coordinating a referral and initial appointment with a local Community Mental Health center for casework services for persons with developmental delays.

g) Youth in the Intensive Stabilization program may be expected to remain enrolled in their “home” school and the Contractor must coordinate with that school to provide educational time and opportunities.

Program Performance Objectives
During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

8. Human Trafficking Survivor

Definition
The Human Trafficking Survivor (HTS) program provides a therapeutic intervention and stabilization environment for youth who are in crisis due to sex or labor trafficking or other severe forms of sexual exploitation. HTS provides intensive, trauma-informed Integrated Behavioral Health stabilization services focused on youth who are typically rescued from trafficking situations. The intent of the program is to stabilize the youth while diagnostic services, supportive relationships and treatment goals are established. The anticipated length of stay could be from 3 to 9 months depending on the familial relations, youth needs and relationship to the trafficker. It is an important consideration to explore power and control dynamics between the youth and the trafficker. When the role of the trafficker is identified as a parent, trusted family member or familial acquaintance, the trafficker has ruptured the youth's perception of trust therefore posing complex and complicated challenges toward possible solutions to build positive relations with others. The program team implements crisis and safety care plans as well as identify short and long-term treatment goals. Preparation toward community reintegration will be contingent upon development of community supports and an appropriate living situation. Final preparation and implementation of discharge plan will be established in the program.

The Contractors Program Statement should align with the Definition and Symptomology listed here.

Symptomology
A youth who has experienced significant trauma and behavioral challenges resulting from commercial sexual exploitation or sex trafficking. Youth may have required psychiatric hospitalization due to history or experiencing active unstable symptoms which may include aggressive behavior toward self or others, psychotic symptoms (delusions, hallucinations), suicidal/homicidal ideations, serious self-injurious behaviors and/or frequent severe emotional episodes.

Standardized Assessment Tool
In addition to the assessment tools outlined in Section 2.10.d., the Contractor must utilize the following types of assessments:

a) Biopsychosocial Assessment - The youth and family (whenever possible) participate in the development of a comprehensive, individualized, strength-based,

trauma informed, family-focused, culturally responsive assessment that informs and guides service delivery, discharge planning and aftercare services. Screening Tools and Assessments are completed by a clinically trained professional as part of the admissions process. Assessments are conducted face-to-face and integrated to address multiple life domains, assess for co-occurring mental health and substance use condition, and include a summary of symptoms, diagnosis, and treatment recommendations.

b) Psychiatric Assessment is completed during the admission process (within one business day) and may include youth, parent/guardian, caregiver, or support person. Recommendations for psychotropic medications may be discussed to reduce distressful symptoms in addition to evidence-based treatment modalities. If any medication changes are made, the parent or guardian will need to sign a medication consent form. New medications cannot be started without this consent in place.

c) Comprehensive Nursing Assessment is completed during the admission process (within one business day) to include youth's history, assessment of physical, behavioral, and mental state, vital signs and other measurements as needed based upon current medical condition. The specially trained registered nurse has the credential as a sexual assault nurse examiner to support sexually assaulted victims and provide a medical forensic examination.

d) Integrated Behavioral Health Team Assessment may include a thorough review from a multi-disciplinary team approach if severity of trauma responses and ongoing psychiatric instability exceeds the anticipated time frame for improvement noted in the treatment plan.

There may be identified conditions, needs, or issues that require further assessment by practitioners of other disciplines. Psychiatric stability will be important for the validity of any additional assessments so consultation with the Psychiatrist and Pediatrician will occur prior to scheduling additional assessments. The Therapist and/or Nurse will coordinate with referral source for making referrals. In such instances, an authorization to release information is signed by the guardian/family so that the referral may be made. Examples of additional assessments include but are not limited to neurological, psychological, developmental, occupational, speech, hearing, nutritional, and medical.

The assessment tools must be utilized by a professional trained in the identified tool.

Treatment planning:

An initial treatment plan will be developed within 30 days of admission. All stabilization services and interventions mush be directly related to the goals and objectives established in each youth’s individual service plan (ISP). The ISP is developed by the youth/family/treatment team in collaboration with the provider agency. Family/caregiver involvement is extremely important and unless

contraindicated, should occur from the beginning of treatment, and continue as frequently as possible, as determined appropriate in the ISP.

The ISP must identify the youth's interests, preference, and needs as determine to be appropriate by the treatment team, in the following areas:

- Physical and emotional well-being.
- Risk and safety factors.
- Nutrition.
- Personal care needs.
- Cognitive and education abilities.
- Recreation and leisure time.
- Community participation.
- Communication.
- Religion and culture.
- Social and personal relationships.
- And other areas determined important by the youth.

The goal of treatment will focus on stabilizing youth in crisis, supporting and assisting the youth in achieving greater independence and fulfillment in their life. Treatment will focus on improving the youth's functioning, participation and reintegration into the family home/resource home or potentially transition into an alternative out of home living situation (independent living).

Staffing Ratio

The Contractor must:

a. Maintain direct care staff to youth ratios as outlined in Schedule B Pricing Matrix

b. The awake ratio will be for non-school hours. School hours are not included in this requirement.
c. For sleeping ratio, all youth must remain awake during this period. Room checks must be conducted at variable intervals of no more than every 15 minutes between checks during sleeping hours.

Services

a) Nursing oversight of medication side effects and supportive services to include sexual assault examination if applicable.
b) Expressive therapeutic activities or specialized group therapy.
c) Independent living skills assessment/preparation and community reintegration.
d) Family therapy and/or family activity programs focused on strengthening family relationships and positive familial coping during crisis
e) Aftercare service planning by connecting the youth with services that include coordinating a referral and initial appointment with a local Community Mental Health center
f) As it pertains to Unaccompanied Refugee Minor (URM) youth, the following services must also be provided:
    1. Bilingual therapist

2. Language interpretation to facilitate case management and service provision.
3. Culturally appropriate training for staff

Program Performance Objectives

During the contract period, the Contractor must track outcome measures as defined in Section 2.12 of this Contract.

Attachment B: Glossary of Acronyms and Forms

AAPI:	Adult-Adolescent Parenting Inventory
ABA:	Applied Behavior Analysis
ABPN:	American Board of Psychiatry and Neurology
AFLS:	Assessment of Functional Living Skills
ADOS:	Autism Diagnostic Observation Schedule
AWOLP:	Absent Without Legal Permission
BCBA:	Board Certified Behavior Analyst
BBI:	Building Bridges Initiative
CAFAS:	Child and Adolescent Functional Assessment Scale
CANS:	Child Assessment of Needs and Strengths
CANS:	Child and Adolescent Needs and Strengths
CANS-SAB:	CANS-Sexually Aggressive Behavior Module
CCI:	Child Caring Institution
CARF:	Commission on Accreditation of Rehabilitation Facilities
CCWIS:	Comprehensive Child Welfare Information System
COA:	Council on Accreditation
CLSA:	Casey Life Skills Assessment
CMH:	Community Mental Health
DCWL:	Division of Child Welfare Licensing
DMA:	Daniel Memorial Assessment
EAGLE:	Education Assessment Guidelines Leading Towards Excellence
FFPSA:	Family First Prevention Services Act
FTM:	Family Team Meeting
FTC:	Family Transition Coordinator
FAPE:	Free Appropriate Public Education
FOM:	Foster Care Online Manual
FFT:	Functional Family Therapy
GED:	General Education Development
HIPPA:	Health Insurance Portability and Accountability Act
HTS:	Human Trafficking Survivor
IEP:	Individualized Education Plan
IEPT:	Individual Education Program Team
IS:	Intensive Stabilization
ISP:	Individual Service Plan
JCAHO:	Joint Commission on Accreditation of Health Care Organizations
LGAL:	Legal Guardian ad Litem
MHBS:	Mental Health Behavior Stabilization
MDHHS:	Michigan Department of Health and Human Services
MiSACWIS:	Michigan Statewide Automated Child Welfare Information System
MISEP:	Modified Implementation, Sustainability, and Exit Plan
MST:	Multi-Systemic Therapy
MI:	Motivational Interviewing
PA:	Physician’s Assistant
PEVT:	Pearson’s Expressive Vocabulary Test

PIHP:	Prepaid Inpatient Health Plan
PCP:	Primary Care Physician
QRTP:	Qualified Residential Treatment Program
RCTAU:	Residential Collaboration and Technical Assistance Unit
RPU:	Regional Placement Unit
REMS:	Risk Evaluation and Mitigation Strategy
SED:	Serious Emotional Disturbance
SDD:	Specialized Developmental Disability
SOGIE:	Sexual Orientation, Gender Identity and Expression
TFA:	Teaching Family Association
WMPC:	West Michigan Partnership for Children

DHS-221:	Medical Passport
DHS-3377:	Clothing Inventory Checklist
DHS-3600:	Individual Service Agreement

Schedule B
PRICING

Payments must not exceed the amounts allocated as identified below. Payments made above the allocated amounts identified will require an amendment to the contract.

Contract Period	Contract Amount
10/01/2024 – 9/30/2027	$

Program/Facility Name	License Number
Bridges Provider Number	**MiSACWIS/CCWIS Number**
Not Applicable	

Service Description	Service Code
Staffing Ratio (Direct Care Worker-to-Youth)	**Security Level**
Awake Hours: Sleeping Hours:	
Sex at birth, including gender identity	**Age Range**
Service Blend Title	**Per Diem**
(Filled/Unfilled)	
Incentive Payment	
Per Diem Effective Date	**Number of Contracted Beds**
10/01/2024	

Unit Title	Per Diem	Effective Date
Aftercare Level 1	$41.78	10/01/2024
Aftercare Level 2	$111.42	10/01/2024
Unit Title	**Per Hour**	**Effective Date**
One-to-One Supervision	$33.99	10/01/2024

Per Diem Unit Definition: One unit equals any 24-hour period during which a youth receives basic supervision and care, and any specialized services, as defined herein. The last day of a youth's placement must not be counted as a unit.