

Northern Arizona HCTC Handbook



An Independent Licensee of the Blue Cross Blue Shield Association

Health
Choice



“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.”

-Margaret Mead

Table of Contents

Overview	6
Introduction.....	7
How to Become an HCTC Home	8
Licensing Regulations.....	8
Recruitment	10
Assessment	11
Criteria for Number of Placements.....	13
HCTC Initial Review Panel	14
Initial Review Panel: Roles and Expectations.....	15
Transitioning from Regular Foster Care/Resource Family to HCTC Provider	16
Requests by HCTC Parents to Hold Additional Employment	16
Tax Information.....	17
Orientation, Training and Professional Development	17
Foster Care Orientation*	17
Requirements*	17
Annual Training	20
Professional Development.....	20
Professional Development Meetings.....	21
Specialized Trainings	21
Member Advisory Committee	22
HCTC Referral Procedure.....	23
HCTC Referral Packets.....	25
General and Informed Consent to Treatment	26
HCTC Referral List.....	28
The Child and Family Team (CFT)	30
What are CFTs?	30
Team Members.....	32
The Role of the HCTC Parent in the CFT Process	32
The Role of the Behavioral Health Home in the CFT Process	33
The Role of Department of Child Safety (DCS) in the CFT Process (for DCS Involved Children).....	33

The Role of HCA in the CFT Process	33
Behavioral Health Service Planning	35
Behavioral Health On-going Service Plan.....	35
Crisis Prevention and Safety Planning	36
Discharge Planning.....	37
Permanency Planning for Children in DCS Custody: Permanency, Long-term Connections, Permanent Relationships and Support through Transitions	38
Maintaining Stability in HCTC Homes	40
HCTC Disruption	41
Services and Supports	42
Services Provided by HCTC Parents	42
Shared Parenting.....	43
Natural Supports.....	45
Transition to Adulthood.....	45
Covered Behavioral Health Services Provided Outside of the Home	47
Covered Service Manual Billing Code Guidelines	47
Billing Limitations.....	48
Transfer of Services to New Behavioral Health Home (Intra-RBHA Transfer)	49
Services Provided by In-Home Consultant/Family Therapist	49
Support Services Provided by the HCTC Licensing Agency	50
Services Provided by DES/Department of Child Safety (DCS).....	51
Behavioral Health Respite.....	51
In-home Consultant/Family Therapist Qualifications, Training, and Supervision.....	57
Qualifications	57
Training	57
Supervision.....	58
Administrative Requirements	60
Confidentiality.....	60
Administrative Requirements for HCTC Parents.....	60
Administrative Requirements for HCTC Licensing Agencies.....	61
Emergency Relocation Procedure.....	62
Significant Incident Reporting/ Incident Accident Death (IAD)	62
HCTC Provider Investigations.....	63

The Role of DCS during an Investigation:.....	64
The HCTC Provider Agency Licensing Specialist’s Role in DCS Investigation	65
The Role of HCA in HCTC Investigations:.....	65
Monitoring	66
Licensing and Monitoring of the HCTC Home.....	66
HCTC Capacity Report	66
<i>AD HOC</i> Reporting To HCA	66
Mechanisms for Resolving Complaints	67
Behavioral Health Member/Consumer Complaints:	67
Complaints about Other Agency Involvement.....	68
Appendix.....	69
Health Homes Information	69
Agencies at a Glance	74
Definitions and Acronyms.....	75
Additional Resources	84
Forms	84

Overview

HCTC (formerly known as TFC (Therapeutic Foster Care) is an innovative team approach provided by experienced, skilled professionals through a family-based treatment environment for children with complex behavioral health care needs as an alternative to institutional care.

Home Care Training for the Home Care Client (HCTC) is a Covered Behavioral Health Service in Arizona available for eligible children with behavioral health issues. It is designed to be intensive, time limited 6-12, with re-evaluation for medical necessity at each monthly CFT. The focus is on addressing the child's behavioral health issues and permanency needs.

[AHCCCS Covered Service Guide Definition:](#)

Home Care Training to Home Care Client (HCTC) services are provided by a behavioral health therapeutic home to a person residing in his/her home in order to implement the in-home portion of the person's behavioral health service plan. HCTC services assist and support a person in achieving his/her service plan goals and objectives and also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services including personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person when necessary to activities such as therapy and visitations and/or the participation in treatment and discharge planning (p. 81 II. D. 5. Home Care Training to Home Care Client).

Health Choice Arizona (HCA) contracts with several HCTC Licensing Agencies throughout the region to recruit, train, license, monitor and support HCTC Families as direct service providers. HCA also partners with DES/DCS to provide joint programming for youth and families involved in both the child welfare and behavioral health systems.

Introduction

As in other areas of the country, Arizona has seen an increased need for family-based programs that are capable of offering services to children in need of community based treatment. In 1989, District III DES/DCS clearly recognized this need in rural northern Arizona, and initiated a Professional Family Foster Care (PFFC) program with two foster families. After a steady process of development and expansion, in 2003 this innovative program joined efforts with the RHBA and its providers to expand Home Care Training for the Home Care Client (HCTC) services to the whole of northern Arizona. HCTC can be described as:

A distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In [HCTC], the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. ...Programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.

(Foster Family-based Treatment Association (FFTA), March 13, 2001.)

Northern Arizona HCTC Parents share certain core values and principles, which lie at the heart of their services and have shaped the development of these services.

These include:

- a strong belief in normalization as a treatment principle;
- the power of family living as a healing influence;
- a belief that all children need and have a right to a permanent family;
- support of family reunification, adoption, kinship care, or other long-term stable family living arrangements to achieve this end;
- a belief in the value of cultural diversity and in the importance of developing competence in dealing with issues of diversity;
- emphasis upon goal-oriented, individualized treatment, using a comprehensive, team approach

Children receiving services in Northern Arizona HCTC Homes come from various places in the HCA region (Coconino, Mohave, Yavapai, Navajo, Gila and Apache Counties). Before the advent of this program, these children would have frequently been placed out of the region in more restrictive, institutional settings such as Residential Treatment Centers, Therapeutic Group

Homes, or Psychiatric Hospitals. The duration of HCTC placement is expected to be 6-12 months or less, with the goal of returning the child home or on to another less restrictive, more permanent setting.

How to Become an HCTC Home

HCTC combines the aspects of nurturing, family environment, and structured treatment to meet the individualized needs of children with serious behavioral health needs, who may have experienced neglect and/or abuse. HCTC Parents must be nurturing, patient, possess strong teamwork skills, and have a concern for youth with specialized needs and their families. Potential HCTC Parents will participate in a Home Study and licensure process that provides the HCTC Provider Agency and the family the opportunity to make an informed decision regarding becoming an HCTC Home. As an HCTC Parent you will become a member of a team designed to address the unique emotional and behavioral needs of the children placed in your home. Following are some additional requirements and information regarding the process of becoming an HCTC Home.

Licensing Regulations

R21-6-331. Requirements for Certification to Provide Specialized Services

- A. A license for a foster parent is a regular license.
- B. If the foster parent has met the additional requirements for certification to provide specialized services, OLR shall document the area of certification on the regular license. If more than one person is identified on the license, both shall meet the additional requirements for certification to provide a specialized service; except the foster parent who is not the primary care giver is exempt from compliance with subsections (E)(1)(a), (E)(2)(a) and (b), (E)(3)(b) and (c), and (E)(4).
- C. The foster parent shall comply with the requirements specified in this Section to renew the certification.
- D. The certification to provide a specialized service:
 - 1. Does not change the renewal date of the regular license; and
 - 2. Shall expire at the next renewal date of the regular license.
- E. The classes of foster homes that provide specialized services and the certification requirements are:
 - 1. Receiving Foster Home (N/A)
 - 2. Medically Complex Foster Home (N/A)

3. Therapeutic Foster Home. This is a foster home that is licensed with a maximum capacity of three foster children, and each foster parent has received specialized training to provide care and services within a support system of clinical and consultative services to foster children with special behavioral health needs, as identified by the Department. In addition to meeting the requirements for a regular license, the foster parent for a Therapeutic Foster Home shall:
 - a. Be at least 21 years of age, and
 - b. Have at least one of the following minimum experience or education:
 - i. One year of experience as a licensed foster parent;
 - ii. Three months' successful experience in child welfare, foster care, behavioral health, education, or a related profession as approved by OLR. "Successful experience" means that the foster parent has been responsible for the health, safety, and well-being of a child or adult with behavioral health needs for a minimum of 20 hours per week without any negative actions, such as termination for cause; or
 - iii. A bachelor's or graduate degree in health care, social work, psychology, or a related behavioral health field.
 - c. Not have employment or commitments that interfere with the foster parent's ability to meet the foster child's special behavioral health needs, including supporting the foster child and as applicable, participating in in-home and community based services;
 - d. Provide the foster child with opportunities to participate in developmentally appropriate community based activities on a regular basis;
 - e. Develop and follow an alternate supervision plan, approved by the Child Placing Agency and the licensing agency, if the foster parent is not available to provide primary care and supervision for a foster child with treatment needs. The alternate supervision plan shall include:
 - i. The name of each adult, age 21 years and older, who can provide supervision if the foster parent is not present;
 - ii. Information about the foster child's behavioral, health, medical, or physical condition that is necessary to provide care;

- iii. Medication that is prescribed to be administered to the foster child while the foster parent is not present and any relevant instructions for the administration of that medication;
 - iv. Specialized training taken by individuals in subsection (i) that is necessary to provide care and supervision of the foster child; and
 - v. Emergency contact information for the foster child, including a means to contact the foster parent, the licensing agency, and Child Placing Agency.
- f. In addition to the training specified under R21-6-303, complete a minimum of 18 hours of training prior to certification, approved by the Department that includes:
- i. Positive behavior development and de-escalation techniques,
 - ii. The purpose and safe use of medications, and
 - iii. Overview of medication interactions and potential medication reactions.
- g. Complete training to care for the special needs of a foster child, as indicated in the placement agreement;
- h. In addition to the training specified under R21-6-303, complete a minimum of 24 hours of training prior to license renewal. The Department shall approve the training curriculum and coordinate the training curriculum through a licensing agency. The training shall include:
- i. Positive behavior development and de-escalation techniques,
 - ii. The purpose and safe use of medications, and
 - iii. Overview of medication interactions and potential medication reactions.

Recruitment

The HCTC Licensing Agencies evaluate the populations served and have recruitment plans including targeting and marketing to attract prospective HCTC Parents. Potential HCTC families may be recruited from an agency's pool of experienced foster families. Provider Agencies may be asked by HCA and/or the HCTC Advisory Committee to recruit in specific geographic areas or for special populations.

HCA has an informational brochure available to HCTC licensing agencies. .

Assessment

R21-6-206. Licensing Agency Foster Home Study and Assessment

- A. The licensing agency shall enter the home study via the Department's electronic database.
- B. To assess the applicant and write the initial home study, the licensing agency shall:
 1. Conduct interviews with each household member, including each child household member, if appropriate to the child's age and developmental level, on at least:
 - a. Two occasions in the applicant's home;
 - b. One occasion with each applicant, individually; and
 - c. One occasion with applicants, jointly, if:
 - i. Applicants are married; or
 - ii. Another adult household member is applying for a license or is currently licensed;
 2. Complete reference checks as follows:
 - a. Obtain written statements via postal mail, electronic mail, or on the form supplied by OLR, from at least five reference sources identified by the applicant;
 - b. Ensure that no more than two references are from relatives; and
 - c. Make personal contact, either in a face-to-face meeting or via telephone, with at least one of the reference sources identified by the applicant;
 3. Provide the applicant with the required forms and information to apply for a Level One fingerprint clearance card;
 4. Request Central Registry record checks for each adult household member for Arizona and from each state these individuals resided in during the previous five years;
 5. Ensure completion of all required training by the applicant;
 6. Ensure the applicant has the proper equipment required by this Chapter, such as age-appropriate beds, for each foster child at the time of placement;
 7. Visit the applicant's home and provide information to help the applicant prepare for the Life Safety Inspection to be conducted by OLR throughout the home and premises.
 8. Request a Life Safety Inspection for the applicant's home and verify any corrections made, if applicable; and

9. Work with each household member to assemble information for self-assessments, using the forms approved by OLR.
- C. The home study shall include a summary of self-assessments, interviews, and observations evaluating the applicant's fitness for licensure, including:
1. Motivation and expectations for becoming a foster parent;
 2. Commitment to the care and supervision of a foster child;
 3. Parenting skills and ability to use a reasonable and prudent parenting standard characterized by a careful and sensible parental decisions that maintain the health, safety, and best interests of a foster child while at the same time encouraging the emotional and developmental growth of the child;
 4. Daily routine and time available to devote to the care of a foster child;
 5. Support network, including friends, neighbors, relatives, and the community;
 6. Personal or family problems and the applicant's success in undergoing rehabilitation and overcoming or coping with these problems, including abuse, neglect, or violence that was:
 - a. Committed by the applicant;
 - b. Committed against the applicant; or
 - c. Witnessed by the applicant;
 7. History of substance use or abuse and the applicant's success in overcoming or coping with these challenges;
 8. Medical, physical, and mental health problems and the applicant's success in overcoming or coping with these problems;
 9. Ability to deal with anger, stress, and separation;
 10. Personal stability, marital stability, and the stability of the household, as applicable;
 11. Stability of residency in Arizona;
 12. Significant life events, including but not limited to job separation, divorce, child custody, bankruptcy, or the death of a family member;
 13. History of complying with court-ordered child support, if applicable;
 14. Attitude toward discipline, discipline of the applicant's children, and willingness to commit to the Department's discipline policy; and
 15. Willingness to share parenting for a foster child with that child's birth family.
- D. In addition, the home study shall address:

1. Household members' ability to meet requirements, as described under R21-6-302;
2. The ability of household members to provide a safe and positive home environment for a foster child;
3. The strengths and needs of the applicant; and
4. The applicant's compliance with licensing requirements as defined in Chapter 6 of this Title.

Criteria for Number of Placements

It is the responsibility of the HCTC Licensing Agency to assess the appropriateness of potential Providers who are applying for licensure. This includes making recommendations on the initial number of beds. For example, even though a family may qualify under OLR regulations to be licensed for up to (3) beds, the HCTC Licensing Agency may determine the family should start with (1) bed due to limited experience or other factors. Research strongly suggests that number of placements in Therapeutic Foster Care is correlated with disruption rates and the overall rate of success. Best Practice is considered to be 1-2 placements per home. However, there are circumstances where Therapeutic Foster Homes demonstrate success with more than this number of placements, depending on a variety of factors such as experience, training, supports, and overall demonstration of positive outcomes for the children placed in their home. HCA believes there should be criteria met prior to increasing number of placements and increases must be approved on an individualized basis.

HCTC Licensing Agencies must carefully consider factors such as:

- Number of biological/adoptive children residing in the home
- Employment outside of the home
- The Therapeutic Foster Care Provider's motivation for fostering more than two special care children
- Any DCS reports involving the Therapeutic Foster Care Provider

According to the FFTA Program Standards for Treatment Foster Care (2013), determination of the number of children and youth to place within a treatment home must consider the needs and abilities of the child, the Treatment Family, and the Program. When considering the child, the Program must take into account the behaviors and needs of the children and youth served and the intensity of the services required as well as what benefits may be realized from the child's

living in the same home as another youth. The potential impact of each child's age, behaviors, and needs on the other must be taken into consideration. Treatment Parents must be assessed for their skills, experience, and support networks and for the ability of the family to meet the individual needs of each person in the home. Treatment Parents' ability can change over time and be influenced by such factors as whether one or both parents work outside the home; the schedules each caregiver keeps; demands placed on caregivers by others living in the home; and the physical makeup of the home (such as the number of bedrooms and their proximity to each other).

Given these considerations, the number of children and youth placed in one treatment home shall generally be one and shall not exceed two without special justification. Such justification may include the need to place a sibling group, the extraordinary abilities of a particular family in relation to the special needs of children and youth, or the potential therapeutic impact provided by the interaction of the children and youth involved.

HCTC Initial Review Panel

It is at the discretion of the licensing agency if they would like to use an Initial Review Panel. The Initial Review Panel's role is to assist the licensing agency in conducting interviews of potential HCTC Families prior to their entrance to the HCTC Program in Northern Arizona. The purpose of the review panel is to interview the family and assess their experience, qualifications and responses to typical scenarios they may be confronted with in providing the HCTC service.

The following is an outline of the HCTC Initial Review Panel Protocol:

- A. For HCTC Licensing Agencies that recruit families licensed as foster parents, the Initial Review Panel would conduct the interview after the family has been identified as a potential HCTC Home.
- B. For HCTC Licensing Agencies that recruit families without a current foster parent license, the Review Panel would conduct the interview after orientation, completion of initial paperwork, background check, Home Study, Foster Parent College Pre-Service Training and prior to the submission for licensure.
- C. Composition of HCTC Review Panel may consist of the following:
 - a. Prospective HCTC Parent(s)
 - b. HCTC Provider Agency Representatives i.e. Licensing Worker, In- Home Consultant, Director/Supervisor and a current HCTC provider
- D. The licensing agency can include:

- Health Home representatives
- DCS representatives

HCA maintains the right to refuse a contract with specific agencies or homes, limit or reduce placements, or decline referrals regardless of OLR licensure.

Initial Review Panel: Roles and Expectations

All panel members will possess a fundamental knowledge of the philosophy and utilization of HCTC services as well as being aware of other HCTC Stakeholders' roles.

Health Home (HH) Representative: Representing the local behavioral health provider.

- Familiar with HH role in utilization of HCTC services
- Possesses a clear understanding of the HCTC referral process, service planning, and transition planning
- Able to incorporate former professional experiences with prospective family (when possible) and how this can aid future relationship
- CFT practice
- Familiar with HH role in facilitating shared parenting
- Familiar with the HCA Out of Home Policy
- Coordination of Care

Licensing Agency: Coordinator and facilitator of Initial Review Panel

- Representing the prospective providers' training progress
- Able to speak to licensing, monitoring, and agency specific issues
- Aware of prospective providers' strengths, history, experience, preference, and training needs

Prospective HCTC Provider: Demonstration of experience, preferences, training desires, and principles of HCTC

- Demonstration of their understanding of the CFT process
- Familiar with Arizona's 12 principles
- Understanding of provider role in service planning and transition planning
- Distinction between HCTC and regular foster care

- Understanding of HCTC as a time limited and goal specific treatment

DCS/DES: Representing child welfare's role related to HCTC

- Distinguishing between HCTC and regular foster care
- Offering historical information when providers are transitioning from regular foster care to HCTC
- Shared parenting
- Transition and permanency planning

Transitioning from Regular Foster Care/Resource Family to HCTC Provider

HCA supports maintaining stability of previously placed foster children who may already reside in newly licensed HCTC homes. HCA expects previously placed foster care youth to make a natural transition from the home in-line with their DCS case plan goals. The HCTC Provider can begin accepting HCTC referrals prior to these children discharging. The interest and wellbeing of the existing foster youth must be regarded when considering HCTC referrals. The combined total of HCTC service and regular foster care youth cannot exceed the OLR License and should be reviewed by the Provider Agency for appropriateness. No new DCS foster placements can be placed in the home after the home converts to HCTC programming. Any exceptions to this (e.g. kinship, teen parent and child placements) must be approved by HCA.

DCS may request a review by the HH to consider previously placed foster youth for HCTC level services in newly licensed homes. A change from foster care to HCTC services can be made based on medical necessity and recommendation of the Child and Family Team.

Requests by HCTC Parents to Hold Additional Employment

HCTC Providers are expected to be able to perform the functions of the program, which entails meeting the individualized service and support needs of children in their care. Being an HCTC parent is considered to be full-time responsibility. A few of the responsibilities includes but is not limited to:

- transporting children to weekly therapy sessions and therapy groups,
- attending monthly CFT's,
- transporting children to monthly medication reviews,
- documenting daily on the child's stay in the HCTC home,

- writing monthly reports.

If a provider performs outside work, independent of HCTC services they must have this approved by the Provider Agency. The Provider Agency is expected to review for any conflict of interest and ensure the hours and types of work do not interfere with HCTC programming. Consideration should be given to the number of HCTC parents in the home, the number of children, and the needs of the current children. The Provider Agency must review this periodically as part of regular monitoring activities and recommend changes as necessary.

Tax Information

HCTC providers are responsible for their own consultation on income tax requirements. HCTC services are not the same as traditional foster care services. HCTC services are funded through Medicaid dollars as covered behavioral health treatment service for eligible youth.

Orientation, Training and Professional Development

HCTC Providers receive orientation, pre-service, annual training and professional development opportunities in order to successfully meet the needs of the children placed in their care. All training should be congruent in philosophy and practice with OLR, HCA and AHCCCS policies and practices, the Arizona Vision and 12 Principles, Foster Parent College Pre-Service Training, and the AHCCCS Advanced HCTC Curriculum.

Foster Care Orientation*

- Types of children in need of this service
- Information on the philosophy and practices of the Provider Agency
- Information on the Arizona Vision and 12 Principles
- The roles and responsibilities of the HCTC Family
- Policies and procedures (including discipline)
- The role of the HCTC Provider Agency in assisting the HCTC Provider in serving children

Requirements*

- Interview with Provider Agency
- Fingerprinting

- Adam Walsh Background Check for each state in which the potential HCTC Provider(s) lived in for the previous 5 years.
- Arizona DCS Background Check
- HCTC Licensing Agencies are responsible for ensuring all HCTC Parents receive training in accordance with DCS Policy Title 21 Chapter 6 Section 303 Training Requirements. All agencies that recruit and license Professional Foster Home providers must provide and credibly document the following training to each provider:
 - 30 hours of pre-service training* utilizing Partnering for Safety and Permanence: Foster Parent College Pre-Service Training; or Deciding Together; or the current regular foster care training method prepared by DCS; and
 - 18 hours of pre-service training utilizing the Arizona Home Care Training to Client (formerly Therapeutic Foster Home) Service Curriculum. *[Effective January 1, 2009, all providers delivering HCTC services must have completed this Curriculum.]*
 - The training curriculum approved by DCS that details how to exercise the reasonable and prudent parenting standard (RPPS);
 - CPR and First Aid Training;
 - Behavioral health management of crisis situations including:
 - Prevention of violent behaviors, (including de-escalation, identification of triggers, crisis and safety planning)
 - Behavior management skills
 - De-escalation techniques
 - Medical/health care issues, procedures, and techniques, including the purpose/use/administration of medications, medication interactions, and potential medication reactions.
 - HCA HCTC Handbook; Provider agencies are required to train on the HCTC Handbook and provide prospective families with a copy. The HCTC Handbook is incorporated by contract to Provider Agency and HCTC Provider expectations.
- Application completion including all documentation required by DCS and OLR;
- Home Study completion by HCTC Provider Agency;
- Arizona State Life Safety Inspection as requested by the HCTC Provider Agency and completed by OLR;

****Note: Orientation and Pre-service training must include the following specific content:***

- Characteristics and needs of children who receive services in the HCTC Home
- The role of the Professional HCTC Provider as a member of the care and treatment team
- The importance of birth parent and family involvement in a child's life
- Methods for appropriately addressing the cultural, ethnic, and religious needs of a child in care
- Trauma, attachment, separation, and loss issues for children and families
- Behavior management policies/practices and skills; including:
 - Setting limits and rules for children in care.
 - Expectations regarding child behavior, including inappropriate conduct, and the methods for discipline with regard to expectations, limits, and rules
 - Use of discipline which is reasonable, developmentally appropriate, related to the infraction, and consistent with any guidelines in the child's case plan
 - Disciplinary methods which help a HCTC Child to build self-control, self-reliance, and self-esteem
 - Communicating rules, consequences, and disciplinary methods to an HCTC Child in a manner appropriate to the child's age, developmental capacity, and ability to understand
 - Delegation of the responsibility.
 - Punishment and maltreatment, including that an HCTC Provider shall not punish or maltreat an HCTC Child, and shall not allow any other person to do so. As used in this section, "punishment or maltreatment" include, but are not limited to, the following actions: any type or threat of physical hitting or striking inflicted in any manner upon the body; verbal abuse, including arbitrary threats of removal from the HCTC Home; disparaging remarks about an HCTC Child or an HCTC Child's natural family members or significant persons; deprivation of meals, clothing, bedding, shelter or sleep; denial of visitation or communication with an HCTC Child's natural family members and significant persons when such denial is inconsistent with the HCTC Child's case plan; cruel, severe, depraved or humiliating actions; locking an HCTC Child in a room or confined area inside or outside of the HCTC Home; and requiring an HCTC Child to remain silent or be isolated for time periods that are developmentally inappropriate
 - Prohibited use of physical or mechanical restraints
 - Confidentiality, including HIPAA guidelines and Protected Health Information (PHI)
 - Emergency procedures

- Resources and supportive services available to children and HCTC Parents
- HCTC billing and payment procedures
- HCTC Provider Agency contact persons and procedures
- The impact of providing HCTC services on the HCTC Parent and their own family and ways to address and cope with this impact
- Specialized topics related to child welfare, health, growth and development
- The Indian Child Welfare Act of 1978 (PL 95-608).

Annual Training

In addition, the HCTC Provider must complete and credibly document the following training:

- Annual First Aid and CPR Training;
- Six hours of training on topics relevant to the health, growth, development, or welfare of a child, or as recommended by OLR, the licensing agency, or the Child Placing Agency.

PER TWO YEAR LICENSING PERIOD

In addition to the training specified (above) under R21-6-303, complete a minimum of 24 hours of training prior to license renewal, half within the first year and half in the second year. The Department shall approve the training curriculum and coordinate the training curriculum through a licensing agency. The training shall include:

- Positive behavior development and de-escalation techniques
- The purpose and safe use of medications, and
- Overview of medication interactions and potential medication reactions.

Professional Development

On-going professional development is an important part of support for HCTC Providers to maintain effective treatment milieus for children with serious emotional and behavioral issues. HCTC Providers, with the support of their Provider Agencies, are expected to:

- Seek out, attend and document specialized training in relevant topics, which develop skills specific to caring for children in need of HCTC Services
- Engage in regular, ongoing, open communication with the HCTC Provider Agency and HCTC In-Home Consultant/Family Therapist
- Participate in review activities with the HCTC Provider Agency, In-Home Consultant/Family Therapist, and peers at least annually to identify strengths, successes, challenges, and areas for improvement

Professional Development Meetings

All HCTC Agencies are required to conduct Professional Development Meetings at a minimum of a quarterly basis with the HCTC Parents. The purpose of these meetings is to provide the HCTC Providers an opportunity to grow and develop as a professional by receiving support and feedback from their peers in a supportive atmosphere. The unique nature of the HCTC profession, barriers, and successes would be discussed in a manner that creates a team approach to development. All HCTC Providers are required to attend and participate in these on-going meetings as a member of the HCTC Program.

Specialized Trainings

Based on the recommendations of the HCTC Licensing Agencies, Health Homes, Member Advisory Committee (MAC), HCA will collaborate to arrange and facilitate advanced trainings, as funding is available, that targets areas of development specific to the efficacy of the HCTC Program or the needs of HCTC Parents.

Member Advisory Committee

The Member Advisory Committee meets on a quarterly basis for the purpose of providing adoptive/kinship/foster families of members in out-of-home placement, advocacy groups and Behavioral Health Homes (BHH) or Integrated Health Homes (IHH) with education and outreach materials to increase awareness, identify and reduce barriers to services, and empower families to participate in the delivery of care and services.

SHCA's DCS Liaison and Care Coordinator will serve as the HCA Member Advisory Council Chair. Additional representation on the Advisory Council will include (but is not limited to) the following:

- HCA OIFA Administrator, HCA Children's Services Administrator, HCA Chief Clinical Officer, HCA Cultural Competency Administrator
- Families, natural supports, peer support and family support
- Integrated Health Homes (IHH)/Behavioral Health Homes (BHH) and Providers
- HCTC Licensing Agencies
- Community organizations/Advocacy groups
- Families of origin

The Advisory Council Chair will be responsible for coordinating development of agenda items, scheduling meetings, identifying participants, meeting minutes and distribution, tracking of follow-up / action items, documenting outcomes, and evaluating the previous year's activities.

Participants can recommend agenda items by contacting the HCA DCS Liaison.

HCTC Referral Procedure

In order to maintain the therapeutic integrity and service capacity of the HCTC Programs in Northern Arizona it is vital that HCTC referrals originate from the Health Homes and are for behavioral health purposes only. While many youth are dually involved in the behavioral health and DCS systems, HCTC services are not available solely for DCS placement purposes. When a child is dually enrolled and in need of HCTC services the referral must be CFT driven and originate from the Health Home.

HCTC Provider homes are not available for emergency or long-term placement by DCS. Although an HCTC Home provides a supportive and nurturing family environment, its function of addressing significant behavioral health needs is not appropriate for youth placed for regular foster care services.

The following procedure describes how a child is referred for HCTC Services:

- A. Any involved party identifies the possible need for HCTC Services.
- B. A Child and Family Team (CFT) meeting is requested and held to consider the appropriateness of HCTC Services for the child.
 1. Children experiencing the following are among those who may be considered appropriate for HCTC Services:
 - i. Moving from a more restrictive setting such as a Hospital, Sub-acute, Level I Residential Treatment Center, Level II Behavioral Health Facility (Therapeutic Group Home), or other Group Home
 - ii. Multiple disruptions related to the child's behavioral health issues
 - iii. High-risk behaviors (e.g. substance abuse, non-suicidal self-injury, sexually reactive, gang affiliation)
 - iv. High probability of child disrupting in a regular foster home or kinship placement
 - v. Intensive Out-patient Services have been provided but not successful (e.g. intensive in-home, support and rehabilitation services, therapy, respite, behavior coach, personal assistance, day programs)
 2. HCTC Services may not be appropriate for all children. Discussion should happen at the CFT to consider any immediate needs that focus on safety and stability of the child and of other children in the home that includes consideration of HCTC

Provider experience, specific treatment needs, and any other individualized needs such as contact with natural families and other natural supports.

- C. The CFT utilizes the Arizona Vision and 12 Principles as a guideline for assessing placement. If the CFT determines that the child would benefit from HCTC Services, the need must be documented on the Behavioral Health Service Plan and approved by team members, including the Health Home Representative. All parties must sign the signature sheet indicating agreement. The Health Home Representative completes the initial referral form and sends to the HCTC Licensing Agency contact.
- D. If the Health Home does not agree with the request for HCTC Services, they must provide an NOA (“Notice of Adverse Benefit Determination”) to the guardian. As part of CFT practice, Teams are asked to brainstorm all available and appropriate options that could potentially be accessed to provide services in the least restrictive manner.
- E. The HCTC Licensing Agency sends the HCTC Services Packet to HCTC Provider Home for review with the In-home Consultant/Therapist.
- F. The HCTC Licensing Agency arranges for the HCTC Provider(s) Home to meet with the child in order to facilitate a match.
- G. The HCTC Provider Homes meet with the CFT to discuss and plan the possible transition.
- H. Following placement identification, the Health Home Behavioral Health Representative completes the service plan and includes the HCTC Licensing Agency with the necessary service codes in order to ensure payment. HCTC payment clarification 1-4 below:
 - 1. Child is involved with DCS so they have CMDP coverage then the HCTC Licensing agency bills CMDP for room and board.
 - 2. Child is involved with DDD and they have ALTCS coverage then HCTC Licensing agency bills ALTCS for room and board.
 - 3. Child is T-19 only with SED Diagnosis - the Mental Health Block Grant will pay for room and board. In that case, the HCTC Licensing agency will bill HCA.
 - 4. If the child is enrolled with CRS and Non-CMDP, then HCA will pay for room and board and the HCTC Licensing agency will bill HCA.
- I. Once a referral is accepted, the CFT should formulate a service transition plan that may include a pre-service or transitional visit, a crisis and safety plan specific to the home, any specialized training or support needs for the family, and initiate discharge planning.

HCTC Referral Packets

Initial Referral

Once a CFT determines HCTC services are necessary, the Health Home Representative completes the 'Referral for HCTC Services' Form, and compiles the HCTC Referral Packet and sends it to the HCTC Licensing Agency contacts. The form must be filled out as completely as possible so the Licensing Agency has accurate information to determine potential matches with their HCTC homes.

The HCTC Licensing Agency then reviews the Referral for HCTC Services Form and Referral Packet and sends the determination acceptance/denial to the Health Home contact within five days of referral.

HCTC Service Packet

An HCTC Service packet is required when placement for a child is requested in an HCTC Home. (See Appendix -- Referral for HCTC Services)

Service Packets must include:

Cover memo requesting HCTC Services. Cover memo includes:

- Reasons for need of HCTC Services
- Behavioral/emotional problems child currently exhibits
- Diagnosis
- Medications (include next refill due date and next medication review date – Health Home must ensure appropriate supply of meds through the service transition)
- Custody status
- Educational/other special needs
- Recent case developments

Other Required documents:

- Listing of child's placement history
- Copies of recent and any prior psychiatric, psychological and/or psycho-educational or other useful evaluations. It may be necessary to obtain a current evaluation if not available
- Copy of most recent Behavioral Health Assessment

- Copy of CFT Behavioral Health Service Plan (documenting need for HCTC services), and signature page
- Crisis Prevention Plan
- Strengths, Needs, and Culture Discovery (SNCD)
- Recent CFT notes and reports
- Reports/summaries completed by therapists treating the child/family.
- Relevant school information, including copies of IEPs and immunization records
- Any other case documentation pertinent to understanding the child's needs
- Provide AHCCCS ID number

Additional Recommended Documents which should be requested to be sent by DCS (if applicable):

- DCS Case Plan (if involved with DCS)
- Pertinent court reports, including Initial Report, most recent court report, and any other reports containing important case information. (Required unless voluntary placement)
- Social History of the child's family
- CASA reports
- JPO reports/dispositions
- Copy of birth certificate, social security number, CMDP number
- Any other case documentation pertinent to understanding the child's needs

General and Informed Consent to Treatment

(See [18.25 General and Informed Consent to Treatment in the Provider Manual](#))

Non-emergency Situations (See section 2.6.10: Special requirements for children)

In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian;
- Foster parent, group home staff or other person with whom the Department of Economic Security/Department of Child Safety (DES/DCS) has placed the child; or
- Government agency authorized by the court.

If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

Individual/Entity	Documentation
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
<i>HCTC Provider/non-DCS Youth*</i>	<i>Copy of power of attorney document or Copy of court order assigning physical custody</i>
Other person/agency	Copy of court order assigning custody
DES/DCS Placements (for children removed from the home by DES/DCS), such as: Foster parents Group home staff Foster home staff Relatives Other person/agency in whose care DES/DCS has placed the child	None required

For any child who has been removed from the home by Department of Child Safety (DCS), the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:

- Evaluation and treatment for emergency conditions that are not life threatening; and
- Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent.

**For any child who is placed in HCTC care but not under custody of DCS, the parent or legal guardian must provide a copy of a Power of Attorney document allowing the provider to sign for medical, dental and educational consents and must update the POA every six months. Teams may additionally choose to use the HCTC Provider-Parent Participation Agreement Form.*

(See Appendix – Provider and Parent Participation Agreement Form)

Emergency Situations

In emergency situations involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required. Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as Notice to Provider Form given to the individual by DCS indicating that the individual is an authorized DCS placement. If the individual does not have this documentation, the provider may also contact the child's DCS caseworker to verify the individual's identity.

HCTC Referral List

In the circumstance where a child has been referred for HCTC Services by their Child and Family Team and an appropriate provider is not available at the time, the child will be placed on the HCTC Referral List. Each HCTC Licensing Agency maintains an HCTC Referral List. Youth will remain on the referral list for up to 60 days. If they still require HCTC placement after 60 days, the Health Home must initiate a new referral.

If a Health Home refers a child for HCTC services and there are no current beds or appropriate matches available, the Health Home must review and offer alternative services and supports

through the CFT that can meet the immediate behavioral health needs of the child. Health Homes must notify the HCTC Licensing Agencies when a child no longer needs placement so the child can be removed from the referral list.

The Child and Family Team (CFT)

The success of the HCTC Program requires a collaborative effort between multiple systems. To be effective, all must cooperate and partner as a true team, in support of the child. In the words of a child in an HCTC Home:

My Team

By YD

I'm scared and I'm lost.

There's nothing for me to see.

I'm hurting inside from all the lies.

I try and I try, but all I do is cry. My pain just won't go away.

I can't go on another day.

But wait, what's that I see?

A shining light at the end of the sky.

There's hope for me now, I can finally smile and be proud.

I have a team and they showed me that I can finally be me.

They help me every day.

They're there when I need them.

They always listen when I'm sad.

They always make me laugh even when I'm mad.

What are CFTs?

The Child and Family Team (CFT) is a group of people which includes, at a minimum, the child and his/her family, the HCTC Parent, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Department of Child Safety or the Division of Developmental Disabilities, etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.

The Child and Family Team is responsible for collaboratively planning and delivering services to the child and family in the most appropriate setting, in a timely fashion, and in accordance with best practices, while respecting the child's and family's cultural heritage. Every child in HCTC services must have an active Child and Family Team. It is mandatory that the HCTC Parents and the child participate in the Team process.

Divide and Conquer: Divide tasks among Child and Family Team members while defining roles. Find the best match between the task and the team member. Utilize family members, DCS Case Managers, CASAs, parent aides, case aides, therapists, HCTC Parents, and natural supports to complete specific assessment and preparation tasks.

Start an on-going dialogue with the child and caregiver to discuss permanency issues, hopes and fears of the child, contact with or thoughts about the natural family, life book development and support needs. These are powerful therapeutic tools that can help the child and the whole Team feel ownership in planning.

Tips for Child and Family Teams about approaching permanency differently:

- Explore and challenge your own beliefs about permanency
- Help children deal with loss and grief
- Help children and teens consider permanency and explore their hopes and fears
- Address issues of support and resistance to permanency by all Team Members
- Re-evaluate barriers at all levels
- Re-explore past connections even if Termination of Parental Rights has been completed
- Find natural supports and placements that agree to provide unconditional commitment and life-long connections
- Provide initial and on-going training and support to care providers
- Address issues related to the foundation of adolescent permanence: loyalty, loss, self-esteem, behavior management, and self-determination (Lewis and Heffernan, 2002)
- Develop ways to honor the child's past
- BE CREATIVE!

Other people may be called upon to assist the Child and Family Team with difficult cases

regarding permanency planning, building permanent relationships, discharge planning and other transitions. People may include HCA Children's Services Department Staff, DCS Management, or other HCTC Parents.

Team Members

The members of this team should include:

- Natural Family and Natural Supports. (This may include any person significantly involved in the child's life including family and/or extended family and their network of associates, friends and neighbors, and community and faith-based organizations)
- The Child
- The HCTC Parents
- The DDD/DCS Case Manager (if applicable)
- The Behavioral Health Home Representative
- Outpatient therapist, psychiatrist, psychologist, Primary Care Physician or other professionals involved in the child's treatment
- Teachers
- Court Appointed Special Advocate (CASA)
- The HCTC Services In-Home Consultant/Family Therapist
- The HCTC Services Provider Agency Representative
- Other involved State Agency Representative (JPO, DDD, ADJC)
- Directly involved attorneys, advocates, paraprofessionals

The Role of the HCTC Parent in the CFT Process

The HCTC Parent plays an important role in the CFT process by bringing first-hand, direct information to the Team on changes in the child's behaviors which may indicate a need for adjustments to treatment, medication, or crisis planning. They also help inform the Team of strengths that can assist in identifying functional and symptomatic improvements. The HCTC Parent should also bring concerns or observations to the Team on the need for more supports or structure on shared parenting or other issues that the RA or DCS may need to address in structuring family contact. The HCTC Provider additionally contributes input on any strengths or needs which support discharge and permanency planning.

The Role of the Behavioral Health Home in the CFT Process

The Behavioral Health Home has a number of roles in the CFT process which include facilitating the CFT process (or ensuring the process is facilitated according to practice guidelines), ensuring the Arizona Vision and 12 Principles are followed and the family's voice and choice are respected, identifying the child's behavioral health needs and facilitating discussion of appropriate treatment services, and adjusting service planning to match current needs. The team process utilizes a strengths-based approach identifying what currently works for the family and how to build on this. To do this they must honor the families' culture and value system. Children and families are more likely to succeed when they have ownership of their goals and the plan to get there. The BHHs assist with this by facilitating the CFT process and partnering with other agencies in the family's life to create continuity in the support the family is receiving.

The Role of Department of Child Safety (DCS) in the CFT Process (for DCS Involved Children)

CFTs are consistent with Team Decision Making and Family Group Decision Making in supporting family-driven, strengths-based planning. It is also consistent with Shared Parenting practices in supporting dialogue and decision-making between the natural family and the alternative caregiver.

The DCS Specialist should ensure that safety and permanency planning are incorporated in CFT decision-making. DCS Case Managers will endeavor to participate in all CFTs of their assigned children. If the DCS Case Manager cannot attend, they will assure another DCS representative will attend in their place. The DCS Mental Health Specialist may also attend the CFTs when possible. Any DCS Representative can participate in the role as guardian at the CFT.

***If a DCS representative is not in attendance, the CFT facilitator will notify the DCS Supervisor, and Program Manager. The CFT can meet without the DCS Specialist present if the supervisor, foster parent or other designee is in attendance.*

The Role of HCA in the CFT Process

HCA is committed to practice improvement across Northern Arizona. HCA is responsible for monitoring BHH capacity and fidelity for the provision of CFT services for children enrolled in the HCA network.

HCA attends meetings or consults with Team Members to assist with barrier resolution or other issues as needed. HCA offers regular CFT training opportunities for BHHs and other stakeholders as needs are identified. As per AHCCCS requirements, HCA also conducts case file reviews, family interviews and System of Care Practice Review (SOCPR) in conjunction with AHCCCS to assess the quality of CFT practice.

Behavioral Health Service Planning

Many children who enter out-of-home care do not verbalize their grief, loss and concerns about disrupted attachments; rather they typically express them through adverse behaviors. Often such behaviors are symptoms or natural responses to the trauma they have experienced or are experiencing. Therefore, children finding themselves in the care of the Department of Child Safety can have the potential of being misdiagnosed with mental health disorders due to symptoms that are a function of their responses to their environment and current situation. Other children may present as asymptomatic. This may be misinterpreted as the child being “fine” and opportunities for much needed support and intervention may be missed which can lead to unhealthy internal and undiagnosed problems such as ulcers, depression, self- medicating or self-harm behaviors.

Those working with children who have experienced trauma, must discover how to help them find appropriate ways to express their hopes, worries, fears, anger, and guilt. Often this means exploring the child’s thoughts about why they are in treatment and providing opportunities to dispel any false beliefs as well as validate their true feelings. It is important that caregivers be open to the reasons and causes for these behaviors and to communicate to the team the behavioral patterns of the children so that appropriate adjustments can be made to the child’s service plan and so that his or her needs can be met.

Behavioral Health On-going Service Plan

Service planning is an on-going, individualized process. Before a child is admitted into a HCTC home, a Behavioral Health Plan, which is child specific, is created by the CFT based upon the strengths and needs of the child and family. This plan includes strengths, short term and long term objectives and goals, needs and options for meeting the needs, services and programs for implementing the plan and meeting the objectives and goals.

A CFT meeting is scheduled, at a minimum, within one month after placement has occurred, and at least monthly thereafter; to review the effectiveness of the plan and to make any needed adjustments to the Behavioral Health Service Plan. Adjustments to the service plan may be identified as needed due to identified strengths and resources, specific strategies for intervention, responses to any adjustment issues and crisis prevention strategies.

Crisis prevention is an important part of the Behavioral Health Plan and should include strategies, interventions and tools to help prevent a disruption or potential crisis as well as specific steps to

take during a crisis. Such tools, interventions and steps are included in a Crisis Prevention Plan. Every HCTC home should have a copy of the Crisis Prevention Plan specific to the child in care and to the HCTC foster family.

Crisis Prevention and Safety Planning

In order to address and plan for barriers which may prevent the implementation of the Behavioral Health Service Plan, the CFT meets to develop a Crisis Prevention Plan. The primary reason for developing this plan is to prevent unnecessary disruptions to the child's HCTC home and to promote the most successful outcome for the child and family. The child and the biological parents and/or guardian must be present when conducting crisis prevention and safety planning.

Crisis Planning follows a four-step model:

- A. Prediction: The CFT facilitates a discussion which centers on the responses to the question, "What is the worst thing likely to go wrong?"
- B. Functional Assessment: The CFT facilitator guides the CFT in deconstructing the predicted crisis to gain an understanding of the unique elements and characteristics of the crisis. What events, behaviors, or behavior sequences are associated with the initial, middle and ending phases of the crisis?
- C. Prevention: Based on the knowledge received during the functional assessment, what options, primarily drawn from the child/family strengths and community supports, can help prevent those events, behaviors, or patterns of behavior associated with the potential crisis.
- D. Crisis Planning: The CFT facilitator leads the CFT in developing steps for managing the crisis in the event it occurs despite the prevention strategies. Crisis Plan steps specifically describes who will do what, when and where. Crisis Prevention Plans often include names and phone numbers of support persons as well as contingencies that may occur.

It is important to note that Crisis Prevention Planning begins during the HCTC Provider's and In-Home Consultant's review of the referral packet. Such reviews should seriously consider the "match" or "fit" with the HCTC family and the overall composition of children already residing in the home in order to ascertain potential crises. This includes assessing the appropriateness of referrals in relation to other Crisis and Safety Plans being implemented in the HCTC home. The In-Home Consultant continues to play a crucial role in implementing the Crisis and Safety Plans that the Child and Family Team has developed based on the individual needs of the child placed and the members of the family currently in the HCTC home. Each Health Home and HCTC

Licensing Agency has policies and procedures that must be followed when a crisis arises and it is the responsibility of the HCTC provider to be familiar with those steps and procedures necessary to curtail and/or prevent a crisis, while implementing the plan for the individual child.

Although the In-Home Consultant is frequently the initial contact the HCTC parents make when a crisis situation arises, there will be occasions when the team will need to conduct an emergency meeting to identify any additional steps required to ensure the safety of the child and other family members or to make any modifications to the current Crisis Prevention Plan. This team meeting may consist of an identified “subgroup” of the CFT or the entire Child and Family Team and status of the crisis.

HCA Crisis Line 1-877-756-4090

Discharge Planning

HCTC Foster Care is a treatment-focused, time-limited service designed to meet the child’s behavioral health needs in a family based setting. Discharge Planning (planning for where the child will go when treatment goals have been met) must start when HCTC services are first initiated. Health Choice Arizona defines “discharge” as the successful achievement of a planned transition to a less restrictive environment. This differs from a “disruption” which includes any other move including moves between HCTC providers and moves to a higher level of care.

Planning for a child’s successful discharge is an important component to service planning. It helps guide the Child and Family Team meetings in assessing needs and establishing appropriate services and interventions. This process also helps the team maintain a focus on permanency for the child.

Covered behavioral health services (including HCTC) can only be provided when the service has been determined to be “medically necessary”. Medically necessary services refer to those services provided by qualified service providers and covered by Health Choice Arizona. Qualified Service Providers are trained and supervised by licensed clinicians who are working within the scope of their expertise. Their aim is to successfully implement the following: the prevention, diagnosis, and treatment of behavioral health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain or regain functional capacity.

This means there must be an identified behavioral health need and that the child can, reasonably, be expected to benefit /improve from the treatment service. CFTs are also expected to explore less restrictive alternatives. This means teams should brainstorm all potential options that could address the behavioral health issues in the least intrusive manner (such as intensive supports to the child and family in their home and community).

HCA has established a “length of Stay” (LOS) standard for HCTC services. The 6-12 month LOS is based on national “Therapeutic Foster Care” standards. LOS should be less if the child meets his/her behavioral health treatment goals sooner or if there is an opportunity to continue treatment in a less restrictive setting with other services and supports. CFTs are required to focus efforts on discharge planning and should regularly discuss the progress and “what it will take” to achieve successful discharge.

Permanency Planning for Children in DCS Custody: Permanency, Long-term Connections, Permanent Relationships and Support through Transitions

State systems will always be faced with budget crises, staff turn-over, high caseloads, limited placement and support resources along with increasing numbers of children with complicated personal and family issues entering care. Therefore, it is imperative for the Behavioral Health and Child Welfare systems to work collaboratively to find creative ways to develop permanent supports for the children we serve. State systems should not be in the business of long-term parenting, but rather function as brokers to find life-long family and community placements and supports for children in out-of-home care.

The Adoption and Safe Families Act of 1997 requires states to focus on children’s need for safety, permanency, and well-being within shortened timeframes. Emphasis is placed on effective teamwork, behavioral health intervention, DCS casework and permanency planning starting the moment a child enters care. Children with special needs require specific focus and attention. The Department of Child Safety believes that children should remain with their family whenever possible. If the court finds, after a thorough DCS investigation, that out-of-home placement is necessary to ensure the health and safety of the child, the initial case plan is nearly always family reunification. The order of preference for Permanency goals are:

- Remain with Family
- Family Reunification
- Adoption (Relative or Non-relative)

- Legal Guardianship (Relative or Non-relative)
- Long-Term Foster Care (this could be HCTC or Regular Family Foster Care based on needs)
- Independent Living

Remember, the primary goal of HCTC is intensive, time-limited treatment of children, NOT long-term placement. Children should be moved to a less restrictive setting once treatment goals have been realized in the HCTC home.

As in a regular Family Foster Care setting, it is understood that attachments develop between the HCTC providers and the child. This is seen as a positive and an important aspect of the treatment process. However, HCTC providers understand the need for children to move on from a therapeutic environment and to form secure attachments with others through long-term, permanent relationships. This process of engagement, attachment and transition between HCTC providers and children is one of the most critical elements of the [HCA] program.

Philosophical Foundation for Permanency Planning (Whitfield et al, Spaulding for Children. 1998):

Behavioral health service planning cannot be done without a roadmap of where the child is going. Integration of permanency planning into behavioral health service planning is critical. Consider the following philosophical foundation:

- No child is un-adoptable (instead of saying a “child is not ready for a family,” say, “What do we need to do to prepare and support a family to meet this child where he/she is at?”).
- The safety of the child is of principle concern through all assessment, planning and preparation activities.
- Children need and deserve, permanent-nurturing relationships within families and communities in order to develop and thrive.
- Child assessment and preparation should be continuously explored throughout the child’s journey through care and are the foundations for appropriate planning in the best interest of each individual child.
- Children need to explore their strengths, challenges, hopes and fears, and areas of vulnerability in relation to preparation for permanency.
- We must explore, honor and respect the importance of a child’s former attachments in order to help integrate the past with the present.

- When preparing children for permanency, we must employ creative methods and resources to accommodate, develop and empower children to be successful.
- Children's caregivers, birth, kin, and other community and natural supports are a key part of the child's assessment, preparation and planning process.
- Collaboration among agencies and all Team Members is crucial to the success of the assessment, preparation and planning process.
- Assessment and preparation of children can be accomplished most effectively through a strengths-based, developmental and ecological approach which honors the voice and choice of the child while also identifying barriers and resource needs over time.

Tools and Techniques: There are tools and resources that the Child and Family Team may want to implement to help facilitate continued awareness for permanency planning. The following resources are suggestions to be considered for use in establishing permanency plans:

- Placement History Summary
- Permanency Reviews
- Life Lines
- Life Books
- Genograms
- Ecomaps
- Strengths, Needs and Cultural Discoveries
- Family Group Decision Making or Team Decision Making Meetings
- Child Specific Recruitment
- Identification of Natural and Formal Supports throughout the Child's Life

Maintaining Stability in HCTC Homes

When children disrupt from a home, it results in additional trauma and feelings of failure, as well as additional loss for the child. Therefore, the HCTC providers and the Child and Family Teams are committed to preserving children's stability in HCTC care. Appropriate crisis prevention planning by the CFT, as noted above, established prior to initiating HCTC services and ongoing, flexible support after a child enters this service is crucial. It is also important for team members to communicate regularly on any difficulties or support needs.

Developing and adhering to effective plans designed to prevent separating the child from his or her HCTC home, while enrolled in HCTC services, cannot be overemphasized. This planning begins at the time of referral with specific consideration made to create a good “match” between the HCTC family and the child who has been referred to the home. Utilizing the Child and Family Team as well as the skills and feedback from the In-Home consultant, respite, approved peer and biological family supports are important resources to use for stabilizing services during high risk periods, such as the first 30 days of placement and prior to discharge. It is extremely important for HCTC providers to identify and discuss barriers, or areas that feel inadequately addressed, with the team in order for resolutions and appropriate supports to be put into place for the child and the HCTC home.

Whenever a CFT member becomes aware that a child’s HCTC services have potential to disrupt, they should immediately request an emergency CFT meeting.

HCTC Disruption

A “disruption” is defined as any immediate and unplanned change in out-of-home care that is not part of the service discharge plan to a less restrictive environment. This includes moves between HCTC providers and moves to a higher level of care. It does not include temporary moves to a hospital or detention if the child returns to the same HCTC home upon discharge from the temporary facility. HCTC providers should be cognizant of their first priority to maintain the stability of the client and placement in their home. If, for some reason, it appears that a disruption is imminent the HCTC provider should call an emergency CFT to determine immediate supports and solutions including a planned respite. HCTC providers are required to allow, at a minimum, 72 hours if they have determined that a child can no longer remain in their home.

Services and Supports

Services Provided by HCTC Parents

HCTC services are not the same as foster care services. They are treatment services provided by a licensed foster family focused on the behavioral health issues of the child being served. HCTC services are funded through Medicaid dollars as a covered behavioral health treatment service for eligible youth. Pay rate for HCTC services reflect the different skill level and service expectations.

As a professional member of the Team, the HCTC Parents in conjunction with the In-home Consultant/Family Therapist provide family-based treatment for seriously emotionally troubled youth who may have experienced abuse or neglect. This approach maximizes the child's opportunity to experience the Arizona 12 Principles. The home serves as a therapeutic environment in which family processes, interactions and activities provide opportunities for needed intervention. Aspects of healthy family life, parenting, and structure are used purposefully to help the children reach their goals. Support from the in-home family therapy process helps build trusting relationships, provides opportunities for problem-solving, and helps establish a therapeutic relationship between child and HCTC Parent

To accomplish this, HCTC Parents engage in a number of activities including:

- Assisting the child in transitioning into the HCTC Home. This may include pre-service visits
- Participate in the Shared Parenting component of the HCTC Program as outlined in Foster Parent College Training and the HCTC Advanced Curriculum
- Providing a supportive, safe environment for the child. Children may be coping with significant grief and loss issues due to separations from their families, previous placements, and communities
- Meeting the individualized physical, emotional, and spiritual needs of children placed in HCTC
- Actively participating in the Child and Family Team Meetings with the child including treatment, discharge, and permanency planning
- Advocating for and assisting children in achieving and maintaining stability in the community, school and home and avoid delinquency

- Participating in family meetings to explore and problem solve issues specific to the household
- Providing behavior management and crisis intervention, as needed
- Providing life and independent living skills instruction based upon individualized needs of the children
- Providing 24/7 supervision of children placed in HCTC, unless outlined in the plan developed by the CFT
- Assisting in implementation of the behavioral aspects of the child's Behavioral Health Service Plan by providing structure, supervision and nurturance
- Supporting Shared Parenting practices in-line with Foster Parent College Training and Advanced Curriculum competencies in consultation with the CFT
- Demonstrating competency with the core abilities in the Foster Parent College Training and HCTC Advanced Curriculum
- Engaging in ongoing consultation with the HCTC In-Home Consultant/Family Therapist
- Participating in Family Therapy Sessions with the In-Home Consultant/Family Therapist
- Provide regular recreational opportunities for child
- Assisting with medical/medication management - Over-the-Counter Medications, Herbs, Special Diets and Homeopathy plans must be followed as prescribed. The use of all medications must be discussed with the child's physician or psychiatrist and with the legal guardian
- Providing primary transportation for children to meet their needs
- Participating in Foster Care Review Board meetings and court hearings (if applicable)
- Adhering to all HCA and OLR discipline policies and contract requirements
- Engaging in regular communication with Child and Family Team Members on treatment needs, including progress, strengths and challenges for the youth
- It is the HCTC parent responsibility to practice self-care and to identify when they need to ask for help.

Shared Parenting

Children placed apart from their families experience grief and loss in many ways, whether it is through removal, death of a parent, parent incarceration, placement outside of their home community, separation from siblings, or mourning of the loss of the parent-child relationship or their idea of what the relationship could or should have been. Therefore, the HCTC Program

requires our HCTC Homes to actively participate in Shared Parenting in order to provide mentoring and coaching for natural families as well as promote continued engagement and communication with the child's family. Children need the opportunity to maintain safe connections with their natural parents and extended family members when possible. A high percentage of children who exit congregate care due to aging out return to the families from which they were removed. Our systems have in the past missed valuable opportunities to preserve the family-child connection through the development of safe, supported interactions.

Shared parenting approaches allow for modeling of healthy skills and the opportunity for parents to practice in a safe setting for the child. When team members can demonstrate appropriate boundaries, healthy communication and shared goals, children may more easily develop trust and feel less drawn to loyalty binds.

Building effective alliances with others who are sharing parenting responsibilities with the HCTC Parents is paramount to treating children who have experienced trauma and maltreatment. In order for children to experience successful outcomes during and after placement in HCTC, it is crucial for HCTC Parents and the Child and Family Team to honor and incorporate a family's culture and tradition in activities designed to meet the treatment needs of the child. As HCTC Parents create, encourage, and nurture opportunities to increase parent/family involvement, children's opportunities for experiencing healthier transitions out of HCTC or reunions with natural family placements are increased. Some of the components included in the Shared Parenting responsibilities are describing and modeling personal parenting techniques, mentoring, maintaining safe environments during the shared parenting experience, and helping families assess and meet the individual needs of their child.

In circumstances when members of the natural family are available and no legal barriers or safety risks exist, the CFT should work actively towards facilitating shared parenting which may include telephone/written contact, visits, shared decision-making, and family therapy. Even if there are no immediate plans for the youth to return to his/her natural family, shared parenting can still be pursued.

"Therapeutic visitation" is not a covered behavioral health service therefore CFTs need to discuss shared parenting, visitation, contact, etc. as distinct from the need for family therapy.

Under no circumstance should the CFT or HCTC Providers suspend shared parenting or contact

or withdraw it for punitive purposes. If CFT members feel that interactions with the natural family are counter-productive or detrimental to the youth, these concerns should be brought to the CFT's attention and addressed appropriately. Shared parenting can be emotionally challenging for youth, their natural family, and the HCTC Family and should therefore be facilitated deliberately and with diligent therapeutic oversight. Shared parenting is the responsibility of the whole CFT, not just the HCTC Parents. CFTs should discuss any specific needs or supports which might assist HCTC Providers in their role.

Natural Supports

Behavioral health treatment is only one part of helping children in HCTC services be successful. It is important for Child and Family Teams to consider informal resources and how those resources can be engaged in promoting successful outcomes for children and their families. The use of natural supports that exist in the community may be an alternative in assisting an individual or family in developing a sense of social belonging, dignity and self-esteem. Natural supports may include friends, neighbors, and members of a faith organization, peers from work, volunteers from community programs or others that exist naturally in the family's support system. Natural supports usually know the family well, often have a level of trust established with them already, and they will often remain a part of the family's life after formal service delivery has ended. Use of natural supports can be promoted through involvement in community programs, activities, and projects; volunteer experience; or social contact with one's immediate family, relatives, friends and neighbors.

Transition to Adulthood

Nationally, there are more than 20,000 young adults who "age-out" of the foster care system each year. Many of these young adults have limited family connections and are not prepared to make it on their own. A disturbing number face disheartening outcomes, including: homelessness, unemployment, imprisonment, addiction, young parenthood, discontinuation of education, and even death; while others have a chance at lasting connections, leadership, employment, higher education, and social and emotional success.

Young adults have a combination of unique needs as they transition into adulthood. This is particularly true when they jointly include the areas of mental health, substance abuse, child welfare system involvement, housing and educational needs. Perhaps no other change in age involves as many significant adjustments as that of a young person in the child welfare system

that turns age eighteen.

- Service providers or availability of services and supports may change.
- The child now becomes the primary decision maker (instead of the parent or legal guardian).
- Legal status changes may occur, such as leaving the child welfare system or becoming a legally independent adult.
- He or she may be permitted to get a driver's license for the first time.
- Housing, finances, food and other necessities of life become the primary responsibility of the young adult.
- The young adult may experience other transitions including placement and community changes.
- Social expectations may exist for the person to "act like an adult" and manage these changes with minimal difficulty or adjustment.
- He or she may experience adjustments that his or her peers do not have to face, such as balancing completion of high school with maintaining his or her own budget and housing and such.

Youth who are in out of home care during the stages of transition to adulthood face unique vulnerabilities. While receiving services in an HCTC Home, many opportunities are created for youth to learn and practice skills related to adult responsibilities and challenges.

Through the CFT process, skills specific to this transition can be identified in the Behavioral Health Service Plan and implemented while in an HCTC home. The HCTC provider plays a valuable role in supporting practice opportunities, assessing further transition needs, and monitoring progress in such areas as:

- Independent living skills
- Developing natural supports
- Exploring family finding
- Behavioral health needs
- Housing
- Employment
- Education

- Community safety
- Social skills
- Decision making and problem solving
- Accessing services and supports

The sole responsibility does not fall upon the HCTC Family to provide these services and training but rather allow for a safe environment where these skills can be practiced. It is the task of the CFT to determine which natural or formal supports are most appropriate to provide the formal skills training. It is crucial that the team incorporate Transition to Adulthood services as early as 16 years old.

Covered Behavioral Health Services Provided Outside of the Home

Children placed in an HCTC Family often need additional services outside the home. Examples might include: psychiatric care, individual, family, group psychotherapy or other covered services. The BHH is responsible for securing covered services in accordance with the [AHCCCS Covered Behavioral Health Services Guide](#). Services should be identified by the Child and Family Team based on the individualized needs of the child.

The BHH must identify a primary point of contact for the child/family in the behavioral health system. Responsibilities include: developing partnerships that will coordinate individualized service plans with the child/family and other entities; and advising the team of natural supports, resources, services and providers that might benefit the family. The Behavioral Health Representative also partners with the family to make sure the process runs smoothly, goals are achieved, discharge planning is accomplished, services are coordinated and successes are recognized.

Covered Service Manual Billing Code Guidelines

- HCPCS Code: S5109 HA-Home Care Training to Home Care Client, per session (Child)
- Age 0-17 years
- Billing Provider Type: Behavioral Health Therapeutic Home (A5)
- Place of Service: Home (12) Other (99)
- Billing Unit: Per diem

Billing Limitations

As per the AHCCCS Covered Behavioral Health Services Guide, the following billing limitations apply for HCTC Services:

1. Personal care services, skills training and development and home care training family services (family support) are provided by the behavioral health therapeutic home provider and are included in the HCTC rate. All other counseling, evaluation, support and rehabilitation services provided to the AHCCCS member may be billed using the appropriate procedure code.

The following exception applies:

Based on behavioral health recipient needs, the following support services may be provided and billed on the same day that HCTC services are provided through a manual over-ride process. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

- Personal Care Services (T1019)
 - Skills Training and Development (H2014/H2014HQ)
 - Home Care Training Family Services (S5110)
 - Self-help /Peer Services (H0038)
 - Psychosocial Rehabilitation Services (H2017)
2. The HCTC procedure code does not include any professional services; therefore, professional services provided should be billed by the appropriate provider using the appropriate CPT codes.
 3. *The HCTC procedure code does not include day program services, this service should be billed by the appropriate provider using the appropriate procedure code.* Room and board services are to be billed separately. The State-funded HCPCS code for room and board is to be used for all persons except for state-placed children (i.e., DCS or AOC) whose room and board should be paid by the placing agency.
 4. A licensed professional who supervises and trains the behavioral health therapeutic home provider may not bill these functions. Employee supervision and training has been built into the procedure code rate.
 5. Pre-training activities associated with the HCTC setting is included in the rate.
 6. This service may not be billed outside the HCTC procedure code rate by either the licensed professional or behavioral health therapeutic home provider.
 7. Prescription drugs are not included in the rate and should be billed by appropriate providers using the appropriate NDC procedure codes.

8. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.
9. Emergency transportation provided to an AHCCCS member is not included in the rate and should be billed separately by the appropriate provider using the appropriate transportation procedure codes.
10. Non-emergency transportation is included in the rate and cannot be billed separately.
11. Any medical services provided to persons, excluding those medical services included in the AHCCCS covered service array as set forth in this guide should be billed to the member's health plan.
12. HCTC Services cannot be encountered/billed on the same day as service code S5151, Unskilled respite care, not hospice; per diem.

Transfer of Services to New Behavioral Health Home (Intra-RBHA Transfer)

If you want to change or transfer your Behavioral Health Home you will need to coordinate with your CFT team.

Services Provided by In-Home Consultant/Family Therapist

The role of the In-Home Consultant includes the provision of in-home family therapy, and support and consultation to the HCTC Family. They advise the HCTC Family on referral decisions and provide ongoing clinical consultation, which includes participation in the Child and Family Team. They are required to be available 24/7 to provide consultation in order to assist in de-escalation and stabilization in the home (i.e. crisis intervention).

Consultation and supervision services provided by the In-home Consultant/Family Therapist include:

- Participating in referral decisions and review of HCTC Services packets
- Developing and supporting the therapeutic environment in the home
- Coaching on behavioral management strategies
- Consultation with the HCTC Family on characteristic of behavioral health diagnoses
- Assistance in the development and implementation of Shared Parenting skills
- Participating in crisis prevention and intervention
- Consulting with the Child and Family Team

- Providing feedback on parenting strengths and areas for development (i.e. attitudes, beliefs, family culture, problem solving, behavior management approach, nurturing, religious beliefs, child development, and personalizing the child's behaviors)
- Partnering with HCTC Parents on their professional development opportunities

In home family therapy is recommended to occur monthly or more often as needed. The In-home Consultant/Family Therapist facilitates these meetings and it is required when appropriate that both HCTC Parents and all children be present as well as anyone else who shares living quarters in the house (exceptions are to be negotiated between the HCTC Parents, the therapist and the Child and Family Team). These meetings can take place in the home or in the community. The purpose of the meetings is to strengthen the family as a unit and work through any adjustment or communication difficulties the child or family may be experiencing.

The therapy sessions create a structured time and place for processing current family events and urgent matters (i.e.: family conflict, a new child placed in the home, a farewell, etc.)

- The therapist utilizes family dynamics, family interaction, and individualized roles in order to facilitate the development of a constructive dialogue between family members
- Family therapy encourages all individuals to speak up about issues with which they may be dealing and may include creative therapeutic interventions such as (i.e. role play, art activities, therapeutic board games, etc.)
- Therapy should integrate aspects of each child's individual treatment plan and must include goals, objectives and outcomes
- Family therapy gives family members insight into their own roles, and utilizes the strengths and resourceful dynamics of the family
- Special attention is given to new family members in order to ease their transition into the family and into family therapy sessions
- The Consultant/Therapist should be familiar with and have a copy of the Crisis Prevention Plan and the Safety Plan (if applicable), and should check in to make sure things are working and recommend adjustments back to the CFT if necessary.

Support Services Provided by the HCTC Licensing Agency

The HCTC Licensing Agency provides supportive services to the HCTC Home as follows:

- Facilitate monthly professional development meetings
- Be available to the family to assist in navigating "the system"

- Promote and support Shared Parenting
- Maintain contact with In-home Consultant/Family Therapist to coordinate additional supports needed in the home
- Attend scheduled CFTs
- Conduct Annual Review for each HCTC home
- Develop and monitor Improvement Plans for HCTC Families that need to address areas of improvement
- Recruit and develop Respite Homes
- Ensure respite services are available

Services Provided by DES/Department of Child Safety (DCS)

For children in the care and custody of the State, the DCS Specialist represents the child as the legal guardian. The DCS Specialist has the responsibility of coordinating the child welfare related planning for the child. DCS provides the Room and Board portion of the HCTC daily rate.

It is important for the DCS Specialist to bring issues related to Safety, Permanency, and Well-being to the CFT so that DCS case planning integrates smoothly with behavioral health service planning and HCTC services. The DCS Specialist should also partner with the Team to address any issues and encourage Shared Parenting.

Behavioral Health Respite

The purpose of behavioral health respite is for the rest and relief of the caregiver, while maintaining quality care of the individual in order to meet their social, emotional and physical needs. Respite care is an effective tool that can revitalize and strengthen families. There is a national collective body of evidence that shows that rest and relief for the primary caregiver increases the quality of care and longevity of care provided to the individual by the primary caregivers. In this section HCA clarifies:

1. Discussion of respite occurring at Child and Family Team meetings
2. Appropriate care and supervision during respite
3. Medical necessity and documentation
4. Types of respite
5. Decisions and modifications to respite services
6. Requirements of Licensed/Certified Respite Agency

7. Requirements of Respite Provider/Staff Member
8. Claims/Billing Information

1. Discussion of Respite at Child and Family Team meetings

Respite care can be an essential part of the overall support that families may need to care for a child with a special need or challenging behavioral health issues. The family/caregiver's need for rest and relief to maintain quality of care and longevity of care for the child is to be discussed at the Child and Family Team. Information about respite, as a behavioral health service, will be shared with families and individuals at the Child and Family Team. This will ensure that a discussion and decisions can be made at the team meeting to determine if respite is needed and the appropriate use of this service. This is also a good time to identify respite needs in a child's Crisis Prevention Plan or Service Plan, including unplanned or emergency respite. *Use of respite must be documented in the Behavioral Health Service Plan, with corresponding billing codes identified.* The family/caregiver will determine how respite will be used. Respite is not intended to be used as a "placement" for a child because other services, supports are not available.

2. Appropriate Care and Supervision during Respite

Since not all families have the same needs, respite care should always be geared to individual child/family needs, by identifying the type of need and matching that need to the appropriate services (see AHCCCS Covered Behavioral Health Services Guide). In the event of regular and ongoing supervision for the member, the team should look at the most appropriate setting, skills of the provider, and objectives to determine the appropriate service to meet the needs of the individual. The need should be clearly stated on the Behavioral Health Service Plan with appropriate services listed. Respite will be discussed, reviewed, and evaluated for efficiency and effectiveness for the child and the family on a regular basis.

Matching the needs of the child with a provider is critical. The goal is to utilize natural supports when available. The intention of respite services are to provide formal supports while families are developing natural supports and moving towards independence. Billable respite services are for licensed respite providers only.

3. Medical Necessity and Documentation

All behavioral health respite services must be determined by the Child and Family Team as a medically necessary covered service and must be included in the Behavioral Health Service Plan.

The availability and use of natural supports and other community resources that meet the caregiver's or child's need, must also be considered and documented on the Behavioral Health Service Plan. Documentation, according to the HCA Provider Manual, of the member's needs, diagnosis, etc. and the supports needed is to be found in the member's chart.

Respite need and service will be discussed, reviewed, evaluated and documented for efficiency and effectiveness for the individual and the family every six months.

4. Types of Respite

There are several types of respite services available. They include in-home, out of home, HCTC, community/center based, and emergency respite. Respite can be planned, unplanned, or put into place in an emergency. Respite is available hourly, daily or overnight. Children in HCTC placement can access any of these respite services (they are not limited to services through HCTC Providers). However, children placed in HCTC homes may not be placed for respite in a regular foster home.

- In-home respite care takes place in the home of the caregiver. This has the advantage of convenience and familiarity for the child. In-home respite may be provided by another HCTC Provider, staff from DBHS Certified Community Service Agency (CSA), or behavioral health staff from a licensed behavioral health clinic.
- Out-of-home respite takes place in a qualified respite provider's home, including another HCTC Home, or other location other than the individual's home by staff from a CSA or Licensed Behavioral Health Clinic.
- HCTC families may provide respite services for HCTC clients to support other HCTC families in the HCA network. HCTC families may provide daytime and/or overnight respite services. This service, as with all other respite services, must be discussed, reviewed and approved for appropriateness through the Child and Family Team and documented in the Behavioral Health Service Plan.
- Community/Center based respite care by licensed behavioral health facilities may provide daytime or overnight care for the individual. This may include after school and weekends and usually occurs in a group setting.
- Emergency Respite offers a temporary, limited placement for an unexpected circumstance due to an acute behavioral health need with the intent that the family or caregiver will resume care of the child as defined by the CFT. Approval of this type of care will occur between the Behavioral Health Home and guardian/caregiver with the agreement that respite needs will be discussed, reviewed and determined to be medically necessary

through the Child and Family Team and a Crisis and Safety Plan, or other service needs will be identified and provided. *It is the responsibility of the HCTC family and Licensing Agency to coordinate all emergency services with the guardian; the guardian is responsible to ensure the safety of the child when an emergency department visit is required.*

5. Decisions and Modifications

Any changes in respite and the behavioral health service plan must be made with the child's family/caregiver and team's knowledge and contribution.

Covered behavioral health services may include living skills training, personal care, behavioral health day programs or other services that are geared to the individual and family needs. This is based on the Child and Family Team decision with the child and family.

If natural supports and community resources are an option, but, there is a need for training of these resources, the team can enlist the expertise, skills and resources of the Child and Family Team, community, other families, clinics and HCA to create and provide the training to increase the capacity of the natural supports and community.

6. Requirements of a Licensed/Certified Respite Agency:

- Provide the medically necessary respite services identified by the Child and Family Team
- Demonstrate communication and coordination with BHH regarding the respite services
- Ensure proper documentation including any specific needs for additional supervision or crisis and safety planning to protect the child and/or others
- Ensure qualified staff meet the needs of children receiving services
- Provide safe transportation to regularly scheduled programs, and appointments, including school or work, as appropriate

7. Requirements of the Respite Provider/Staff Member:

- Secure all medical and transportation releases, instructions and emergency contacts from the caregiver, including any specific needs for additional supervision or crisis and safety planning to protect the child and/or others
- Receive instructions from the caregiver (or in concert with the BHH, as appropriate) regarding the individual's needs as well as the Behavioral Health Service Plan

- Provide supervision for the period of time authorized
- Ensure medications are taken as prescribed (including written medication authorization and instructions for use of medication by the guardian/caregiver)
- Provide first aid and appropriate attention to illness or injury
- Provide for the appropriate nutritional needs of the individual (including any special dietary needs)
- Provide safe transportation to regularly scheduled programs and appointments, including school or work, as appropriate
- Report any accidents or unusual incidents on required forms
- Ensure individualized progress notes are documented consistently and in sufficient detail to allow a review for quality and appropriateness of services provided, including:
 - type and place of service provided (i.e., in-home or facility respite)
 - the date and time of service
 - duration
 - a brief description of the service provided related to the individual's identified needs, (what actually occurred, such as taking a walk, going to a community event, reading, etc.)
 - a brief description of the client's response to respite
 - staff signature and date signed

8. Billing Guidelines and Requirements (per the AHCCCS Covered Behavioral Health Services Guide):

- Two codes can be utilized for respite services: S5150 for up to 12 hours in a day (in 15 minute units) and S5151 for more than 12 hours in a day (1 per diem unit). S5150 and S5151 cannot be billed on the same day. S5150 has a maximum of 48 units or 12 hours per member per day.
- Respite is billed based on a calendar day (12:00a.m. to 11:59p.m.) Only use the per diem code, S5151, when respite services are provided for greater than 12 hours in any one calendar day. Example: If a member is in overnight respite from 10a.m. Saturday through 8a.m. Sunday morning the billing would be as follows:
- Day 1 (Saturday): 10a.m. through 11:59p.m. = 14 hours = S5151 for 1 per diem unit
- Day 2 (Sunday): 12 midnight through 8a.m. = 8 hours = S5150 for 32 units (1 unit = 15 minutes)

- Unfortunately, this can negatively impact a family by reaching 600 hours of respite services per year; however, this is a Covered Behavioral Health Services Guide billing requirement. S5151, the per diem code, “counts” as 24 hours.
- Respite services for an enrolled member are limited to a maximum of 600 hours of respite services for each contract year (October 1st) per person. Individuals enrolled in both the DES/DDD system and the behavioral health system receive a combined total of 600 hours as a maximum allocation.
- Title XIX funds cannot be utilized to pay for services over the 600 hours. If an BHH authorizes respite services in excess of the 600 hours, the BHH will be responsible for paying the Fee For Service (FFS) provider either directly or via payment made by HCA for the respite services rendered in excess of the 600 hours utilizing Non-Title XIX funds. The FFS provider may not be paid for Non-Title XIX services depending on the availability of funds.
- HCTC services cannot be encountered/billed on the same day as respite per Diem (S5151). This means that HCTC Families may use and bill respite or a portion of a day (S5150, under 12 hours) while also billing for a full day of HCTC Services. Children who are placed in an HCTC Home may use another HCTC Home for respite OR any other approved/contracted behavioral health respite provider.
- There is no group billing for respite services; respite services are billed individually for each member. For example, if a provider provides three hours of respite for three children, then three hours of respite services may be billed under each of the three children for a total of 9 hours of billable respite services.
- A respite provider who also transports the behavioral health member cannot bill respite services for the amount of time that the member was being transported. If a respite provider picks up a member at home, school or elsewhere, or transports the member to a scheduled program or appointment during the respite period, this service would be billed with only the appropriate transportation codes. For example, the respite provider picks the member up after school at 3 p.m. and transports them to the respite facility, traveling 12 miles and 30 minutes. The provider would encounter 12 miles with the appropriate transportation code. When the child arrives at the respite location at 3:30p.m., respite begins and the time spent in respite is billed with the appropriate respite code. The provider bills either respite or transportation, but not time spent providing both services simultaneously.

In-home Consultant/Family Therapist Qualifications, Training, and Supervision

Qualifications

The HCTC Program requires that an In-home Consultant/Family Therapist be assigned to work with every HCTC Family.

- If the HCTC Licensing Agency hires employees, the In-home Therapist must be a Master's-level clinician or must hold a Bachelor's degree in behavioral health and be designated as a BHP or BHT with the appropriate supervision (a minimum of 4 hours per month by Behavioral Health Professional).
- If the HCTC Licensing Agency contracts with independent practitioners, the practitioner must be Master's-level and hold an independent level license in good standing with the Arizona Board of Behavioral Health Examiners.

The HCTC Licensing Agency shall ensure that the In-Home Consultant/Family Therapist has the knowledge and skills necessary to perform the duties consistent with the HCTC Program.

Training

HCTC Licensing Agencies utilize In-Home Consultants/Family Therapists who have experience in working with family systems, childhood abuse, trauma and behavioral management. They must have an understanding of the unique behavioral health needs of children involved with DCS and of Positive Behavioral Support concepts. They are required to be trained in and comply with the Arizona Vision and 12 Principles and the Northern Arizona HCTC Handbook. *In-Home Consultant/Family Therapists contracted by HCTC Licensing Agencies are strongly encouraged to complete the Advanced HCTC Training hosted by the Licensing Agency.*

The HCTC Licensing Agency will ensure the In-home Consultant/Family Therapist receives orientation and training that at minimum includes:

- Information on HCA, the public behavioral health system and other state agencies
- Overview of the Arizona Children's Vision and 12 Principles
- Information regarding the unique behavioral health service needs for children involved with DCS
- Child and Family Team Practice
- Northern Arizona HCTC Handbook
- Shared Parenting

- Positive Behavioral Support Concepts
- Confidentiality/HIPAA and PHI
- Cultural competency
- Coordination of care
- Practices in the treatment and prevention of behavioral health disorders, including Clinical Guidance Documents
- Overview of covered services
- Proper documentation and record keeping
- Ethical behavior such as staff and client boundaries
- Prevention and intervention with violent behaviors
- Management of crisis situations
- Symptomology of persons diagnosed with behavioral health problems
- Effects of medication

The HCTC Licensing Agency shall ensure that verification of the trainings listed above is documented as follows:

- Name of the staff member
- Name and date of training
- Signature and professional credential or job title of the individual who verified the staff member received the training

Supervision

The HCTC Licensing Agency shall ensure that the In-Home Consultant/Family Therapist develops, implements, monitors, and complies with a written plan for clinical supervision for the agency. A written plan for clinical supervision shall ensure that clinical supervision addresses the treatment needs of all clients/families.

The HCTC Licensing Agency shall ensure that clinical supervision is provided to the In-home Consultant/Family Therapist by an individual who has skills and knowledge in the behavioral health services that the agency is authorized to provide and the populations served by the agency.

The HCTC Licensing Agency shall ensure that:

- A BHT, or BHP not licensed at the independent practitioner level, who works full time receives at least (4) hours of clinical supervision in a calendar month;
- A BHT, or BHP not licensed at the independent practitioner level, who works part time receives at least (1) hour of clinical supervision for every 40 hours worked; and
- Clinical supervision occurs on an individual or group basis and may include clinical supervision in response to an incident.

The HCTC Licensing Agency shall ensure that clinical supervision includes:

- Reviewing and discussing client behavioral health issues, behavioral health services, or records;
- Recognizing and meeting the unique treatment needs of the clients served by the agency;
- Reviewing and discussing other topics that enhance the skills and knowledge of staff members.

The HCTC Licensing Agency shall ensure that the (4) hours of clinical supervision required for a behavioral health technician or behavioral health professional not licensed at the independent practitioner level is documented at least once a month, to include:

- The date of the clinical supervision,
- The name, signature, phone number, and professional credential or job title of the staff member receiving clinical supervision,
- The signature and professional credential or job title of the individual providing clinical supervision and the date signed,
- The duration of the clinical supervision,
- A description of the topic or topics addressed in clinical supervision
- Whether clinical supervision occurred on a group or individual basis, and
- Identification or recommendation of additional training that may enhance the staff member's skills and knowledge.

Administrative Requirements

Confidentiality

Confidentiality must be maintained at all times. All paper records such as daily logs, medication logs and notebooks must be stored in a locked area or file cabinet. Laptops with client documentation must be password protected. All e-mail communication containing Protected Health Information (PHI) must only be sent by encrypted/secure e-mail.

HCTC Families must be well informed of and comply with HIPAA (Health Insurance Portability and Accountability Act) regulations on the use and disclosure of individuals' PHI. This is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Administrative Requirements for HCTC Parents

- Maintain AHCCCS, HCA, OLR, and HCTC Licensing Agency status as a provider in good standing
- Demonstrate income and expense management
- Obtain and maintain required professional liability insurance
- Document, on a daily and monthly basis, child's progress according to standards required by AHCCCS, the HCTC Licensing Agency and HCA
- Maintain program records, as required by AHCCCS, HCA, and the HCTC Licensing Agency. Information on each child should be maintained in a separate binder. Upon discharge and on request, deliver all information to the HCTC Licensing Agency
- HCTC families must comply with documentation requirements outlined in [the Provider Manual](#) (see 18.13.1 Minimum Elements of the Behavioral Health Assessment).
- Paper medical records and documentation must include:
 - Date and time;
 - Signature and credentials;
 - Legible text written in blue or black ink or typewritten;
 - Corrections with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made, and the initials of the person altering the record. Correction fluid or tape is not allowed; and
 - If a rubber-stamp signature is used to authenticate the document/entry, the individual whose signature the stamp represents is accountable for the use of the stamp. A progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry.

- Electronic medical records and documentation must include:
 - Safeguards to prevent unauthorized access;
 - The date and time of entries in a medical record as noted by the computer's internal clock; The personnel authorized to make entries using provider established policies and procedures;
 - The identity of the person making an entry; and
 - Electronic signatures to authenticate that a document is properly safeguarded and the individual whose signature is represented is accountable for the use of the electronic signature.

Administrative Requirements for HCTC Licensing Agencies

- Maintain licensing file as required which includes a copy of current license for each home
- In the licensing file, or in a separate file, keep records specifically pertaining to the HCTC Program
- In separate files keep documentation from CFT meetings, including the current treatment plan and the HCTC Family's monthly report, incident reports and any other child specific documentation
- Comply with OLR and HCA contract requirements
- Maintain regular communication with HCA regarding HCTC Home Inventory and census information
- Submit Quarterly Reports to HCA (See monitoring requirements section)
- Ensure that each staff member completes an orientation before providing services. Orientation of a staff member includes reviewing (at minimum):
 - Client rights
 - Agency policies and procedures necessary for the performance of the staff member's duties
 - An overview to the TXIX behavioral health system
 - The Northern Arizona HCTC Handbook
 - An overview to Child and Family Team Practice
 - The staff member's job description
 - Procedures for responding to a fire, a disaster, a hazard, a medical emergency, and a client experiencing a crisis situation
 - Informing the staff member of the requirement to immediately report suspected or alleged abuse, neglect, or exploitation or a violation of a client's rights
 - Identifying the location of client records and how client records and information are protected
- Ensure that on-going training is provided as needed and documented to maintain or enhance staff skills in meeting the unique needs of the client populations served by the agency

Emergency Relocation Procedure

HCTC Services in Northern Arizona are spread across numerous provider agencies, homes, Health Homes and a large geographic area. In the event that an HCTC Home has to be emergently displaced or relocated due to a natural disaster (forest fire, weather, flood), local emergency (house fire, municipal matter, environmental hazard), or otherwise; it's imperative to have a process in place where HCTC Clients can be accounted for and their safety assured.

Each Provider Agency will develop an emergency response procedure. It is their responsibility to train HCTC Families on the Agency's emergency protocol prior to family accepting referrals. This protocol should at least address the following:

- Maintaining emergency contact information for HCTC Providers (names, home/cell phone, address, etc.). In the case of a large scale evacuation the emergency contact persons should reside outside of the HCTC Home's immediate geographic area whenever possible.
- Protocol for families to contact Agency in the event of an emergency relocation
- Provider Agency's process for contacting the HCTC Client's guardian, natural family, RA, etc.
- In the case of an emergency relocation, the Provider Agency will report the above information to SHCA including measures being taken to assure clients' safety and the plan for interim service delivery.

Significant Incident Reporting/ Incident Accident Death (IAD)

If, during the time that HCTC Services are provided, an incident occurs that involves a suicide attempt, self-injurious behavior, an injury to a member; a medication error or adverse medication reaction, a member's AWOL, a crime committed on the premises, or any other incident that causes harm to the member or requires the member to receive medical care, the incident is reported and documented as follows:

- HCTC Providers must report the incident to DES/DCS on Form FC-122
- HCTC Providers must report any incident, accident or death as defined by [the Provider Manual](#) (see 18.18 Reporting of Incidents, Accidents, and Deaths of a healthcare recipient to Health Choice Arizona within 48 hours. Incident, Accident, Death Reports (IAD) must be used for reporting incidents, accidents and deaths of enrolled healthcare members.
- Navigate to the Incident, Accident and Death reporting system by going to https://gmportal.azahcccs.gov/WF_Public_Default.aspx.
- The incident is investigated within five working days. After the notification above a written report is developed and provided to the natural parent and/or guardian, the HH Representative, and the SHCA Quality Management Department that includes:

- The agency name and license or certification number
- The date and time of the incident
- The name of the member or members involved in the incident
- The location of the incident
- A description of the incident, including events leading up to the incident
- The names of individuals who observed the incident
- A description of the member's physical and behavioral health condition before and after the incident
- A description of the action taken by the HCTC Home, including the names and dates of individuals notified of the incident
- Whether the client received or was referred for medical services as a result of the incident
- A description of the action taken by the HCTC Home to prevent a similar incident from occurring in the future
- The name, title, signature, and date signed of the individual investigating the incident and preparing the report

HCTC Provider Investigations

Investigations of out of home providers shall be conducted following DES/DCS policy as outlined in ADES Policy Manual Chapter 2, Section 4.2. The following procedures apply regarding DCS investigation of a report of child abuse or neglect occurring in an HCTC Home.

The case may be assigned to a DCS Program Specialist or Case Manager from an office outside of the area serviced by the out of care provider home. The standard for removing children from HCTC Homes in an emergency is the same as any other DCS case; 'Present or Imminent Danger'. In emergency situations, the DCS investigator may remove children prior to consultation; however, the DCS Investigator shall notify the following persons of the removal promptly, but no later than twenty-four (24) hours:

- Child(ren)'s Case Manager
- Parent
- Health Home
- Unit Supervisor
- Child's attorney
- HCTC Provider Agency Licensing Worker
- OLR
- CASA
- Program Manager or designee, and

- The Assistant Attorney General if the child is placed in the physical custody of the provider

The initiation of a DCS investigation in an HCTC Home will be according to the DES/DCS Aggravated Response Time Policy:

- High Risk: Responds immediately but no later than two (2) hours;
- Moderate Risk: Responds promptly, but no later than twenty-four (24) hours;
- Low Risk: Responds promptly, but no later than forty-eight (48) hours;
- Potential Risk: Responds promptly, but no later than seventy-two (72) hours, excluding weekends and holidays

The Role of DCS during an Investigation:

- DCS takes the lead in conducting and coordinating investigation activities
- If a removal occurs and a new provider is needed, the ongoing case manager will coordinate this with the Health Home and Provider Agency through the CFT process
- DCS will ensure the safety of the child, investigate the allegations to determine their merit, and share concerns (if any) about the provider
- DCS will follow their agency policy and procedures to complete the investigation; this includes appropriate timeframes, coordination with law enforcement if needed, safety and risk assessment, notification to parent(s) and other identified team members, etc.
- Within five working days after completing the investigation convene a case conference that includes the following individuals/agencies:
 - The out-of-home provider
 - The DCS Investigator
 - Each child's case manager and/or his or her supervisor
 - The providers licensing worker and/or supervisor
 - OLR
 - Health Home Representative
 - HCA
 - In-home Consultant/Family Therapist

(The purpose of the conference will be to process any issues raised by the investigation and attempt to eliminate any residual negative effects.)

The HCTC Provider Agency Licensing Specialist's Role in DCS Investigation

- Notify the HCA Children's Services Manager and Network Monitoring Administrator of the investigation within 24 hours of notification by DCS
- Obtain a release of information from the HCTC parents for DCS and the Provider Agency to be able to share investigation findings with HCA
- Refrain from divulging information to the HCTC Parents while investigation is in process
- Participate in conferences with DCS and/or HCA as requested to accomplish resolution to the problem
- Assist in development and implementation of corrective actions if necessary
- Address all identified licensing issues or concerns
- Provide information to HCA on the outcome of the investigation, including license revocation or corrective actions

The HCTC Provider Agency, in conjunction with the Licensing Authority, may place the HCTC Parent(s) on a corrective action plan to remedy the problem. The plan of corrective action is implemented if the complaint is correctable in a specified period of time without jeopardizing the health or safety of a child.

Criteria to be considered in determining whether to require corrective action:

- The nature of the violation
- Whether the violation can be corrected
- Whether the HCTC Provider understands the violation and shows a willingness and ability to participate in a plan to correct the problem
- The length of time required to correct the problem
- Whether the violation or similar violations have occurred before
- Whether the HCTC Provider has had previous corrective action, and their success in achieving the goals
- Any other similar or comparable factors which would demonstrate the HCTC Provider's willingness and/or ability to follow through with the plan and avoid problems in the future

The Role of HCA in HCTC Investigations:

HCA may place the HCTC Provider Agency on a corrective action plan to address any issues resulting from the investigation. HCA may request or pursue additional information to determine any additional actions that may need to be taken. HCA maintains the right to refuse referrals of children to any HCTC Home regardless of licensure status or investigation outcomes if there are concerns regarding the safety or therapeutic reliability and effectiveness of provider.

Monitoring

Licensing and Monitoring of the HCTC Home

- HCTC Licensing Agencies are responsible for the following licensing and monitoring activities:
- Comply with all OLR and HCA Licensure and Contract requirements
- Conduct initial and annual home inspections
- Conduct monthly home visits
- Cooperate with DCS on investigations resulting from hotline reports
- Conduct licensing inquiries when incidents occur that do not necessitate DCS investigation
- Implement and monitor Corrective Action Plans if needed after an investigation or licensing inquiry
- Make recommendations to OLR, DES, HCA at completion of Corrective Action Plan
- Maintain compliance with OLR and HCA contract requirements
- Monitor documentation and training as required

HCTC Capacity Report

HCA will coordinate monthly maintenance of the HCTC Capacity Report. The report will include the following information by HCTC Licensing Agency:

- HCTC Provider Name
- City/location
- HCTC Licensing Agency/Contact Information
- In-home Family Consultant Name
- Child's AHCCCS ID
- Number of approved and licensed HCTC beds per home
- Number of approved and licensed respite or transitional beds per home
- Placement types (e.g. male/female, age restrictions, etc.)
- Filled/vacant beds

Licensing Agencies are expected to cooperate with regular requests from HCA for census information. This includes reporting accurate data and responding to requests in a timely manner.

AD HOC Reporting To HCA may request any of the following information on an AD-HOC basis:

- Summary of recruitment activities
- Total number of HCTC Homes/beds, HCTC Respite Homes/beds, and youth receiving services by county

- Losses/Gains including the number of new HCTC Homes/beds, Respite Homes/beds and youth by county and any reduction or loss of homes
- Number of youth on the Referral List
- Number of planned discharges and type of discharge (i.e. return to parent, step down, adoption, etc.)
- Number of disruptions (Please use the definitions in this handbook)
- Number and appropriate use of Emergency Safety Response
- Number of Professional Development meetings and/or trainings held by county
- Number of In-home Consultant/Family Therapists and any gaps in coverage (length of time, interim plan)
- Number of HCTC Parents engaged in mentoring of another HCTC Home
- Identification of specific barriers and any plans to address these barriers

HCA will review reports and any additional measures such as complaint data, data validation results, and overall contract compliance at least annually.

Mechanisms for Resolving Complaints

Behavioral Health Member/Consumer Complaints:

A complaint is defined as an expression of dissatisfaction. Possible subjects for complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

All persons enrolled with HCA have access to a complaint process for expression of dissatisfaction with any aspect of their care. Complaints about behavioral health services should always be encouraged to be resolved at the lowest possible level, yet it is equally important that persons understand that a formal complaint process is also available when needed.

HCA Member Services Department is responsible to coordinate communications with eligible and enrolled persons and acts as, or coordinates with advocates, behavioral health providers and others to resolve issues.

Member Services: 1-800-322-8670

This department:

- Educates and notifies persons about their rights and the process for filing complaints in a manner that is understandable

- Resolves complaints in an expeditious and equitable manner and with due regard for the dignity and rights of all persons. HCA is required to dispose of each complaint and provide oral or written notice within 14 calendar days
- Maintains confidentiality and privacy of complaint matters and records at all times
- Communicates timely information on matters and decisions related to the complaint to affected parties
- Involves the active cooperation and participation as deemed appropriate of providers with a direct interest in the matter under review

Complaints about Other Agency Involvement

Complaints about Licensure Issues should be directed to the HCTC Licensing Agency. Complaints about DCS should be directed to the local Program Supervisor, Program Manager, and/or Program Administrator. You can also contact Arizona Ombudsman Citizen's Aide at www.azoca.gov or Toll Free 1 (800) 872-2879.

Appendix

Health Homes

Information **HCA Health Homes**

Provider Name	Provider Address	Provider City	Provider State	Provider Zip Code	Provider Referral Phone Number
Child And Family Support Service	1515 E CEDAR AVE, STE D2	Flagstaff	AZ	86004	928-774-0775
Child And Family Support Service	8652 E EASTRIDGE RD, STE 103	Prescott	AZ	86314	928-775-2500
Community Bridges Inc	5734 E HOPE LANE	Globe	AZ	85501	928-425-2415
Community Bridges, Inc	803 W MAIN ST	Payson	AZ	85541	928-468-0022
Community Bridges, Inc	110 E 2ND ST	Winslow	AZ	86047	928-289-1222
ChangePoint Integrated Health	103 N First Ave	Holbrook	AZ	86025	928-524-6126
ChangePoint Integrated Health	2500 SHOW LOW LAKE RD, BLDG A & B	Show Low	AZ	85901	928-537-2951
ChangePoint Integrated Health	1015 E SECOND ST	Winslow	AZ	86047	928-289-4658
ChangePoint Integrated Health	423 S MAIN ST	Snowflake	AZ	85937	928-536-6869
Encompass Health Services Inc	463 S LAKE POWELL BLVD	Page	AZ	86040	928-645-5113

HCA Health Homes Site Listing

Provider Name	Provider Address	Provider City	Provider State	Provider Zip Code	Provider Referral Phone Number
Encompass Health Services Inc	170 N MAIN	Fredonia	AZ	86022	928-643-7230
Encompass Health Services Inc	4103 E FLEET	Littlefield	AZ	86432	928-347-4566
Horizon Health And Wellness	478 Hagen Road	Globe	AZ	85501	928-402-9297
Horizon Health And Wellness Globe	2250 HIGHWAY 60, SUITE 1	Globe	AZ	85501	928-402-8032
Little Colorado Behavioral Health	470 W CLEVELAND	St Johns	AZ	85936	928-337-4301
Little Colorado Behavioral Health	50 N HOPI	Springerville	AZ	85938	928-333-2683
Mohave Mental Health Clinic	1145 MARINA BLVD	Bullhead City	AZ	86442	928-758-5905
Mohave Mental Health Clinic	3505 WESTERN AVE	Kingman	AZ	86409	928-757-8111
Mohave Mental Health Clinic	2187 SWANSON	Lake Havasu City	AZ	86403	928-855-3432
Mohave Mental Health Clinic	151 Riviera Ste. B	Lake Havasu City	AZ	86403	928-855-3432

HCA Health Homes Site Listing

Provider Name	Provider Address	Provider City	Provider State	Provider Zip Code	Provider Referral Phone Number
Mohave Mental Health Clinic	2580 HWY 95, STE 209	Bullhead City	AZ	86442	928-757-8111
Mohave Mental Health Clinic	915 Airway Avenue	Kingman	AZ	86401	928-757-8111
Southeastern Arizona Behavioral Health Services, Inc	996 NORTH BROAD ST, STE 9 & 10	Globe	AZ	85501	928-425-2185
Southwest BH Services	2580 HWY 95, STE 119-125	Bullhead City	AZ	86442	928-763-7776
Southwest BH Services	1515 E CEDAR AVE, STE B2	Flagstaff	AZ	86004	928-779-4550
Southwest BH Services	404 W AERO DR	Payson	AZ	85541	928-474-3303
Southwest BH Empowerment Center	302 W AERO DR	Payson	AZ	85541	928-474-3303
Southwest BH Services	2215 HUALAPAI MOUNTAIN RD, STE H & I	Kingman	AZ	86401	928-753-9387
Southwest BH Services	7600 E FLORENTINE AVE, STE 101	Prescott Valley	AZ	86314	928-717-1800

HCA Health Homes Site Listing

Provider Name	Provider Address	Provider City	Provider State	Provider Zip Code	Provider Referral Phone Number
Southwest BH Services	7600 E FLORENTINE Rd.	Prescott Valley	AZ	86314	928-775-7088
Southwest BH Services	809 HANCOCK RD, STE 1	Bullhead City	AZ	86442	928-763-7776
Southwest BH Services	1845 MCCOLLOCH BLVD, STE B1	Lake Havasu City	AZ	86403	928-453-2661
Southwest BH Services	7763 E FLORENTINE RD, STE 101 102 103 104	Prescott Valley	AZ	86314	928-775-7088
Spectrum Healthcare Group	8 E COTTONWOOD ST, BLDG A	Cottonwood	AZ	86326	928-634-2236
Spectrum Healthcare Group	2880 HOPI DR	Sedona	AZ	86336	928-282-4886
Spectrum Healthcare Group	8 E COTTONWOOD ST, BLDG C	Cottonwood	AZ	86326	928-634-2236
Spectrum Healthcare Group	452 FINNIE FLATS RD	Camp Verde	AZ	86322	928-634-2236
Spectrum Healthcare Group	651 WEST MINGUS AVE	Cottonwood	AZ	86326	928-203-5410
The Guidance Center	2187 N VICKEY ST	Flagstaff	AZ	86004	928-527-1899
The Guidance Center	220 W GRANT ST	Williams	AZ	86046	928-635-4272
The Guidance Center	2695 E INDUSTRIAL DR	Flagstaff	AZ	86004	928-527-1899

HCA Health Homes Site Listing

Provider Name	Provider Address	Provider City	Provider State	Provider Zip Code	Provider Referral Phone Number
West Yavapai Guidance Clinic	505 S CORTEZ	Prescott	AZ	86303	928-445-7730
West Yavapai Guidance Clinic	642 DAMERON DR	Prescott	AZ	86301	928-445-5211
West Yavapai Guidance Clinic	3345 N WINDSONG DR	Prescott Valley	AZ	86314	928-445-5211
West Yavapai Guidance Clinic	625 HILLSIDE AVE	Prescott	AZ	86301	928-445-5211
West Yavapai Guidance Clinic	555 W ROAD 3 NORTH	Chino Valley	AZ	86323	928-445-5211
Windhaven Psychiatric Op Site	3347 N WINDSONG DR	Prescott Valley	AZ	86314	928-582-6411

Northern Arizona HCTC Handbook – Revised 2019

Agencies at a Glance

Agency	Phone	Counties Served	Foster Care	Adopt	Kinship FC	Kinship Adopt	Respite	Medically Fragile	Therapeutic HCTC	DDD / CDH	Same Sex Couples	Spanish FP College
AmeriPsych	928-775-6392	Ya,Co,Mo,Gi,Ap	X	X	X	X	X	X			X	X
Arizona Children's Association	928-443-1991	Ya,Co, Na, Ap	X	X	X	X	X	X			X	
Az Baptist Children's Services	928-606-0623	Ya, Co	X	X	X	X	X					
Catholic Charities	602-943-3843	Co, Ya, Mo, NA,	X	X	X	X	X	X	X			X
Child and Family Support Services	928-707-3749	Ya,Co, Ma					X		X		X	
Christian Family Care	602-234-1935	Co, Ya	X	X	X	X	X	X		X		
Community Provider of Enrichment Services	602-659-3681	Ap,Co,Gi,Ma, Mo,Na,Ya	X	X	X	X	X	X	X	X	X	
Human Resource Training	928-514-8229	Mo, Co, Ya, Na, Ap	X	X	X	X	X	X		X	X	X
Pathways of Arizona	928-326-1129	Mo, Co, Ya, Gi, Na,	X	X	X	X	X		X		X	X
Sequelcare	928-777-3280	Co, Ya, Ma, Mo, Na, Ap, Gi							x		x	
County Key: Ap=Apache; Co=Coconino; Gi=Gila; Ma - Maricopa; Mo=Mohave; Na=Navajo; Ya=Yavapai												

Definitions and Acronyms

Administrative Office of the Courts/Juvenile Probation Office (JPO): The Juvenile Justice Services Division of the Arizona Supreme Court, Administrative Office of the Courts, is responsible for the effective administration of juvenile justice programs for delinquent and incorrigible youth in coordination with the juvenile courts. Activities are consistent with constitutional, statutory, and administrative requirements which focus on treatment and rehabilitation as well as protection of the community and youth. Programs include delinquency prevention, treatment, probation, statewide automation and other related activities.

Adult Team: A group of people which includes at a minimum the adult member and a behavioral health representative. Teams must also consider the inclusion of family members and other individuals important in the life of the adult member. Decisions related to care are made at the Adult Team.

Department of Child Safety: Referenced in this manual as DES/DCS; the state agency that operates the Department of Child Safety and DES foster care system. The DCS system is divided into six “Districts”. District III covers Apache, Coconino, Navajo, and Yavapai Counties. District IV covers Mohave County. Department of Child Safety (DCS) is a program mandated under ARS §8- 802 for the protection of children alleged to be abused and neglected. This program provides specialized welfare services that seek to prevent dependency, abuse and neglect of children. The Department of Child Safety program receives, screens and investigates allegations of child abuse and neglect, performs assessments of child safety, assesses the imminent risk of harm to the children and evaluates conditions that support or refute the alleged abuse or neglect and need for emergency intervention. This program also provides services designed to stabilize a family in crisis and to preserve the family unit by reducing safety and risk factors.

Arizona Department of Economic Security/Division of Developmental Disabilities

(DES/DDD): The Division of DES that provides services throughout the state of Arizona through institutional and community-based programs to DES/DDD eligible persons. Their Mission is to support the choices of individuals with disabilities and their families by promoting and providing, within communities, flexible, quality, consumer-driven services and supports. The DDD system is divided into six “Districts”. District III covers Apache, Coconino, Navajo, and Yavapai Counties. District IV covers Mohave County.

Arizona Department of Economic Security/Office of Licensing and Regulation (OLR): The Division of DES that is responsible for protecting the health, safety, and well-being of children and vulnerable adults receiving care or supports in DES regulated programs. Family Home Licensing serves as the licensing authority for Family Foster Homes, Child Developmental Homes and Adult Developmental Homes. Child Welfare Licensing serves as the licensing authority for group homes and shelters for children, adoption and child placing agencies.

Arizona Department of Juvenile Corrections (ADJC): The Arizona Department of Juvenile

Corrections (ADJC) is responsible for juveniles adjudicated delinquent and committed to its jurisdiction by the county juvenile courts. It is accountable to the citizens of Arizona for the promotion of public safety through the management of the state's secure juvenile facilities and the development and provision of a continuum of services to juvenile offenders, including rehabilitation, treatment and education.

Arizona Health Care Cost Containment System (AHCCCS): State Medicaid authority which oversees the provision of Title XIX and Title XXI covered services to eligible persons. In addition, AHCCCS provides health care services to non TXIX persons. It is possible for a person to be on AHCCCS but not qualify for TXIX/TXXI. AHCCCS oversees the provision of behavioral health services for Medicaid eligible children and families through contracts with HCA and other T/ RBHAs throughout the state of Arizona to provide “covered behavioral health services”.

Arizona Vision and 12 Principles: The guiding ideas driving the behavioral health system of care for children in Arizona.

Child and Adolescent Service Intensity Index (CASII): The function of the CASII is to assist with coordinating resources based on the child's identified level of service intensity. CFTs are expected to use the CASII to inform case manager assignment for children/adolescents with complex needs. The CASII suggests level of service intensity based on the following dimensions: I. Risk of Harm; II. Functional Status; III. Co-Occurrence of Conditions; IV. Recovery Environment; V. Resiliency and/or Response to Services; VI. Involvement in Services.

Child and Family Team (CFT): The Child and Family Team is a group of people that includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.

Clinical Guidance Documents/Practice Protocols: AHCCCS has researched and published a number of Clinical Guidance Documents to assist behavioral health providers in Arizona's public behavioral health system. These documents are also known as Clinical and Recovery Practice Protocols.

Crisis Prevention Plan: In order to address and plan for barriers to implementing the Behavioral Health Service Plan, the CFT meets to develop a Crisis Prevention Plan. The primary reason for developing this plan is to prevent unnecessary disruptions in the child's placement and to promote the most successful outcome for the child and family. This plan should be reviewed and updated regularly.

Comprehensive Medical and Dental Plan (CMDP): An AHCCCS health plan administered through DES who provide for the medical needs of children in the care and custody of the state.

Court Appointed Special Advocate (CASA): A Division of the Arizona Supreme Court. The program promotes and supports community-based volunteers who are appointed, in selected cases, through the court to provide advocacy for the best interests of abused and neglected children who are involved in the juvenile courts. CASA volunteers are members of the service team, have access to case records, attend case staffings, FCRB reviews and court hearings and may be involved in all DCS case-related activities.

Covered Behavioral Health Services Guide: This comprehensive array of behavioral health services can be provided to TXIX/TXXI children and families through the HCA network based on medical necessity. A full description may be found on the [AHCCCS website](#).

Data Validation Review: HCA review of the member's clinical record/provider charts against billed encounters submitted to HCA to ensure accuracy in coding and electronic submission of encountered billings/reporting and to prevent fraud and abuse.

Dedicated Case Manager: HCA requires dedicated case managers who have lower caseloads (typically less than 18 children) and focus on intensive behavioral health case management for children with complex needs. The Child and Adolescent Service Intensity Instrument (CASII) is used to assist in assessing service needs for high-need youth. AHCCCS refers to these case managers as High Needs Case Managers.

Disruption: Any change of placement of a child that is not a part of a planned discharge to a less restrictive environment. This includes moves between HCTC Providers and moves to higher levels of care. It does not include temporary moves to a hospital or detention if the child returns to the same HCTC Placement on discharge from the temporary facility.

Early Periodic Screening, Diagnosis and Treatment (EPSDT): A mandatory comprehensive and preventative child health program for TXIX individuals under the age of 21. This program requires that any medically necessary health care service identified in a screening be provided to an EPSDT recipient. EPSDT requires states to assess a child's health needs through initial and periodic examinations and evaluations to assure that health problems are diagnosed and treated early, before they become more complex and treatment more costly. States must perform medical, vision, hearing, and dental check-ups based on standardized schedules.

Eligible - Title TXIX: Persons who have been determined by AHCCCS to be eligible to receive behavioral health services based on certain factors such as citizenship and financial information.

Eligible – Title TXXI (KidsCare): Children who are under 19 years of age may qualify for behavioral health benefits as determined by AHCCCS, even if the family income is too high for the family to receive benefits.

Family Support Partner (FSP): Family Support is a covered behavioral health service. FSPs are responsible for creating an environment to increase a family's ability to effectively interact with

and care for their family member in the home and community. As a family member who has traveled a similar path, the Family Support Partner provides hope, and role models the possibility of recovery to every person they serve. The Family Support Partner is expected to use their own experiences as a vehicle to establish rapport and relationship building with the family. They provide an important point of contact for family members and act as a key avenue of access to services provided by the behavioral health system.

Family Group Decision Making (FGDM): Family Group Decision Making (FGDM) is a model used by DCS with select families which focuses on family strengths and capacity for change rather than on problems and deficits. FGDM was first used in New Zealand in 1989 as part of child welfare reform. The basic structure of the model involves bringing together extended family members to decide on a plan of safety and placement for children. A FGDM meeting may be a one-time meeting rather than an on-going structure such as with the CFT.

Family to Family: A family-centered, neighborhood-based system of foster care, promoting permanence for all children. Key concepts in Family to Family philosophy include shared parenting, community involvement, permanency, stability and family connection.

Foster Care Review Board (FCRB): A Division of the Arizona Supreme Court. The legislature established the FCRB in 1978 in response to concerns that foster children were languishing in out-of-home care. The primary role of FCRB is to advise the juvenile court on progress toward achieving a permanent home for a child involved in a dependency action and in an out-of-home placement. Under the Adoption Assistance and Child Welfare Act, the FCRB is mandated to make determinations in four key areas: 1) safety, necessity and appropriateness of placement; 2) case plan compliance; 3) progress toward mitigating the need for foster care; 4) a target date by which the child may be returned home or placed for adoption or legal guardianship. The FCRB reviews the case within six months of the original date of placement and every six months after that while the child remains in out-of-home care.

Guardian Ad Litem: The legal representative appointed by the court to represent the best interest of the client. A child in DCS care may have both a GAL and an attorney, with the GAL representing what he or she feels is best for the child and the attorney representing what the child wants.

Health Insurance Portability and Accountability Act (HIPAA): Bill passed by Congress in 1996 that was intended to reform healthcare efforts with relation to portability, accountability and administrative simplification. Portability ensures that individuals moving from one health plan to another will have continuity of coverage and will not be denied coverage under pre-existing condition clauses. Accountability significantly increases the federal government's fraud enforcement authority in many areas. Administration simplification goals: 1) uniform national standards for the electronic transmission of certain transactions, 2) ensuring the privacy of certain patient information, 3) ensuring the security of electronic health information and electronic signatures, 4) the creation of single identification numbers for all participants, and 5) reductions in the costs of administrative operations. Violations of the Act or noncompliance with the Standards can result in heavy fines or other penalties.

Member Advisory Committee: The Member Advisory Committee meets on a minimum of a quarterly basis at HCA for the purpose of providing adoptive, kinship, foster families and families of origin with education, trainings and outreach materials. This meeting provides an avenue that empowers families to participate in the delivery of care for their children.

HCTC In-Home Consultant/Family Therapist: Master's level clinicians who provide in-home family therapy, and support and consultation to the foster family. They advise the foster parents on placement decisions and provide ongoing clinical consultation, which includes participation on the Child and Family Team.

HCTC Licensing Agency: An agency that contracts with HCA to recruit, develop, license, and support HCTC Homes.

HCTC Licensing Agency Program Coordinator: An individual associated with the HCTC licensing Agency who coordinates the HCTC program.

Health Home (Behavioral Health Home (BHH) or Integrated Health Home (IHH)): The behavioral health provider/clinic that is providing direct behavioral health services, care management (BHH) and in specialized clinics, primary medical care (IHH) to a child.

Home Care Training to the Home Care Client (HCTC): HCTC services are provided by a behavioral health therapeutic home to a person residing in his/her home in order to implement the in-home portion of the person's behavioral health service plan. HCTC services assist and support a person in achieving his/her service plan goals and objectives and also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services including personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person when necessary to activities such as therapy and visitations and/or the participation in treatment and discharge planning.

Indian Health Service (IHS): The bureau of the United States Department of Health and Human Services that is responsible for delivering public health and medical services to American Indians throughout the country. The federal government has direct and permanent legal obligation to provide health services to most American Indians according to treaties with Tribal Governments.

Individualized Education Plan (IEP): A written statement for providing special education services to a child with a disability that includes the pupil's present level of educational performance, the annual goals and short-term measurable objectives for evaluating progress toward those goals and the specific special education and related services to be provided.

Inter-RBHA Transfer: Refers to the transfer of fiscal and clinical responsibility for a member to another RBHA. Policy guidelines can be found in the AHCCCS/ HCA Provider Policy Manual Section 3.17.

Intra-RBHA Transfer: Refers to the transfer of fiscal and clinical responsibility for a member between Health Homes (HH's) within the HCA region. Policy guidelines can be found in the AHCCCS/ HCA Provider Policy Manual Section 3.17.

Joint Protocol Agreements: The AHCCCS contract with HCA requires the RBHAs to have Joint Protocol Agreements with various State Agencies, including DCS, DDD, JPO, and ADJC. These Agreements were developed through a collaborative process and must be updated annually. The Agreements outline how HCA and its providers will partner with State Agencies to provide coordinated care for dually served members. These agreements are posted on the HCA website.

Mandatory Reporting: Arizona's Mandatory Reporting Law (ARS 13-3620) provides that all persons having responsibility for the care of children are obligated to report suspected child abuse and neglect. The law specifically names physicians, hospital interns or residents, surgeons, dentists, osteopaths, chiropractors, podiatrists, county medical examiners, nurses, psychologists, school personnel, social workers, peace officers, parents, counselors or any other persons having responsibility for the care or treatment of children. Reports must be made even if the information is not gained from first-hand knowledge. The mandatory reporting law provides penalties for those mandated to report suspected child abuse and neglect but who fail to do so. The law also provides immunity from civil and/or criminal liability or penalty for those who do report suspected child abuse and neglect, provided the report is made in good faith, regardless of whether or not a determination is made that abuse has occurred.

Medically Necessary Covered Services: Covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.

Meet Me Where I Am (MMWIA): This program is focused on reduction of congregate and out of home care through intensive support and rehabilitation services to prevent out-of-home placement or to support a child returning home from placement. Services are available 24/7 and are matched to the child and family's needs.

Natural Supports: Natural supports are individuals that are part of the family's life may include friends, neighbors, members of a faith organization, peers from work, volunteers from community programs or others that exist naturally in the family's support system. Natural supports usually know the family well, often have a level of trust established with them already, and they will often remain a part of the family's life after formal service delivery has ended. Use of natural supports can be promoted through involvement in community programs, activities, and projects; volunteer experience; or social contact with one's immediate family, relatives, friends and neighbors.

Health Choice Arizona (HCA): The agency that administers TXIX and non-TXIX behavioral health programs throughout Northern Arizona under contract with AHCCCS. HCA oversees and monitors the HCTC Program in Northern Arizona.

Notice of Adverse Benefit Determination (NOA): Formerly known as the Notice of Action, see AHCCCS/ HCA Provider Policy 5.1. For Title XIX/XXI covered services, notice by the HH to the guardian must be provided following: 1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension or termination of a previously authorized service; and 3) the denial, in whole or in part, of payment for a service that is not TXIX/XXI covered.

Permanency: In a strengths and community-based system of care, permanency means much more than a placement. Permanency in this broader context means establishing, supporting and maintaining life-long, permanent, meaningful connections.

Permanency Planning Hearing: The Adoption Assistance and Safe Families Act of 1997 (ASFA), establishes a permanency planning hearing for children in care that occurs within 12 months of a child's entry into care. At the hearing, there must be a determination of whether and when a child will be returned home, placed for adoption, referred for legal guardianship, or another planned permanent living arrangement if the other options are not appropriate. Under ASFA, states must file a petition to terminate parental rights (TPR) and concurrently, identify, recruit, process and approve a qualified adoptive family on behalf of any child that has been in foster care for 15 out of the most recent 22 months.

Positive Behavioral Support (PBS): This national evidenced-based practice is developing as an important component of providing services to children and families in a strength-based manner. Attention is focused on understanding the conditions in the environment that contribute to challenging behavior, and modifying those conditions to strengthen desirable behavior. It is an approach to helping people improve their difficult behavior based upon:

- **Understanding** that people do not control others, but seek to support others in their own behavior change process.
- **Belief** that there is a reason behind most difficult behavior. People with difficult behavior should be treated with compassion and respect and are entitled to effective services.
- **Application** of a large and growing body of knowledge about how to better understand people and humane changes in their lives that can reduce the occurrence of difficult behavior.
- **Conviction** to continually move away from coercion – the use of unpleasant events to manage behavior.

Preliminary Protective Hearing/Preliminary Protective Conference (PPH or PP5): When a dependency petition has been filed by DCS, a Preliminary Protective Hearing will be held within 5 to 7 days from the child's removal. A conference with identified parties is held prior to the hearing at which efforts are made to try and reach an agreement about the child's placement, services that should be provided and visitation with the child. The results of this meeting are discussed at the hearing and the court makes orders about placement, visitation and services. If the parent or guardian denies the allegations in the petition, the court may set a date for an initial dependency hearing.

Primary Care Physician (PCP): An individual responsible for the management of an eligible person's health care that includes, but is not limited to, a physician who is a family practitioner, general practitioner, pediatrician, general internist, obstetrician, gynecologist, certified nurse practitioner, or under the supervision of a physician, a physician's assistant. The PCP must be an individual, not a group or association, such as a clinic.

Prior Authorization: An action taken by a RBHA or a subcontracted provider that approves the provision of a covered service prior to the service being provided. In the HCA region, CFTs can approve or deny medically necessary covered behavioral health services without prior authorization, but only a medical practitioner can deny placement in Level I facilities.

Protected Health Information (PHI): For HIPAA purposes, PHI is defined as all individually identifiable information that is transmitted or maintained, with the exclusion of certain education and employment records. Individuals and agency's responsible for adherence to HIPAA compliance guidelines are accountable for the standards related to confidentiality, including transmission and maintenance of this information.

Provider Manual (AHCCCS/ HCA): The Provider Manual describes public behavioral health system requirements for any entity that directly provides behavioral health services within Arizona's public behavioral health system. These entities may include: Behavioral Health Providers, Regional Behavioral Health Authorities, and Tribal Regional Behavioral Health Authorities. The Provider Manual can be access from the HCA website homepage.

Recovery: A term used in adult behavioral health treatment. A philosophy and approach which is strengths focused and encourages Hope, Choice, Empowerment and Spirituality. "Recovery is remembering who you are, and using your strengths to become all you were meant to be" (Meta 2005). Recovery is trusting in yourself, believing that you can make decisions regarding your life and taking personal responsibility.

Report and Review Hearing: The Court is required to review the status of each dependent child regularly. These Review Hearings are held at least every six months. Prior to each review, the DCS Specialist prepares a report that describes the services offered/provided to the parent(s) to correct the problems which resulted in the child becoming a dependent. It also discusses the parents' progress and cooperation in these services and recommendations for either reunification or an alternative permanent plan.

Room and Board: Defined by AHCCCS as provision of lodging and meals to a person residing in a residential facility, supported independent living, or HCTC setting. For children in DCS custody, DCS typically pays the room and board rate.

Seriously Mentally Ill (SMI): A condition of persons who are 18 years of age or older and who, as a result of a mental disorder, exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive

treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

SMI Determination: An AHCCCS algorithm completed by a CRN (Crisis Response Network) approved psychiatrist, psychologist or psychiatric nurse practitioner and used for final determination of whether or not an adult is SMI.

Surrogate Parent: A court appointed educational representative for a minor child. This person acts “in place of” a minor child’s biological or adoptive parent when that parent is unwilling or unable to make educational decisions. A Surrogate may not be an employee of a government agency and must act in the best interests of the child. The DCS Specialist must file a motion with the court to appoint a Surrogate Parent.

Team Decision Making (TDM): A process initiated through the DCS system when a child is removed from the home; when protective custody is being considered; when a change in placement is being considered; or prior to a child’s return home. A TDM meeting brings together families, supportive relatives, friends and service providers to address safety and risks.

Telemedicine: The practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data through interactive audio, video or data communications that occurs in the physical presence of the behavioral health recipient. HCA also uses the telemedicine network for “videoconferencing” in order to provide increased accessibility for providers and stakeholders to participate in meetings and trainings.

Temporary Assistance to Needy Families (TANF): A federal public assistance program which provides both cash and medical benefits based on income and resource criteria and deprivation of a minor child.

Temporary Custody Notice (TCN): A written notice (CPS-1000A) that is given to the parent, guardian or custodian stating the reason for removal and the circumstances that placed the child at imminent risk of harm.

Termination of Parental Rights (TPR): The process by which a parent’s rights to his or her child are legally and permanently terminated, after which the child becomes eligible for adoption.

Wellness Recovery Action Plan (WRAP): A self-management and recovery plan. A structured system to monitor uncomfortable and distressing symptoms that can help reduce, modify or eliminate symptoms by using planned responses. (Mary Ann Copland). It is designed to increase personal empowerment, improve quality of life, and assist in achieving one’s goals, and decrease intrusive or troubling feelings and behaviors.

Additional Resources

Here are some additional resources that you can find online. Click the links to find the documents:

- [Arizona Department Of Child Safety Contacts and Field Offices](#)
- [Arizona Vision and 12 Principles](#)
- [Foster and Kinship Caregivers Resource Packet](#)
- [Behavioral Health Services for Children in Foster Care Flyer](#)
- [Crisis Services for Children in Foster Care Flyer](#)
- [FAQs for Foster and Kinship Caregivers \(English\)](#)
- [FAQs for Foster and Kinship Caregivers \(Spanish\)](#)
- [HCA Resources Desktop Guide for Children](#)

Forms

HCA has forms on our website that you can use. Click the links to find them on our website:

- [HCTC Referral Form](#)
- [HCTC Provider and Parent Agreement Form](#)

Notes

Notes