

HOME CARE TRAINING to the HOME CARE CLIENT
FAMILY PARTICIPATION AGREEMENT

HCTC is a behavioral health treatment service that utilizes a therapeutic family environment to address identified behavioral health needs. To achieve maximum success, the child, biological/adoptive family, HCTC providers, clinic and other involved parties work collaboratively toward identified treatment goals. This document is intended to establish communication among all team members and define expectations for the family's participation in the process.

AHCCCS Enrollment:

Children must be enrolled in AHCCCS during their time in HCTC.

It is the parent's/legal guardian's responsibility to ensure enrollment/re-enrollment:

_____ Child is currently Title XIX eligible and enrolled in AHCCCS _____ Exp.Date

_____ Parent/legal guardian is responsible for medical expenses incurred during lapses

Medical/Dental Care:

To ensure the health of the child and for the protection of the HCTC family, a physical exam and dental exam (completed at family's or guardian's expense) is required before the child enters the HCTC program.

_____ Date of last physical exam Physician's name: _____

**If requirement is not met: A health screening must be completed within 72 hours of placement
AND a complete physical exam must be completed within 30 days**

_____ Date of last dentist exam Dentist's name: _____

A dental exam must be completed within 30 days or every 6 months

Routine medical care is coordinated by: Parent/Guardian or HCTC Provider (circle one)

Power of Attorney (attached) must be completed by the parent/guardian prior to placement to allow HCTC Parents to authorize medical/behavioral health treatment.

_____ Power of Attorney completed and notarized

Financial Responsibility:

If the child is not involved with DCS, the team discusses the financial needs of child:

_____ Allowance _____

_____ School expenses _____

_____ Vacation expenses _____

_____ Other _____

Adjustment Period in HCTC:

The first few weeks are a time of adjustment for the child, for the parents, and for the HCTC providers. Carefully planning parent/child communication can enhance the success of treatment.

Face to face visits will occur _____
(where, how frequently)

Phone contact will be _____ (frequency) for _____ minutes.

HCTC Client Name:

Ongoing HCTC Treatment and Participation:

The Child and Family Team will work collaboratively to identify the family's needs and priorities, develop short term objectives and long term goals, and define the services and supports to achieve them. You may be asked to participate in services such as Individual Therapy, Family Therapy, Parenting Classes, Transition Services and Shared Parenting. Parent participation is critical throughout treatment and participation with phone calls, counseling appointments, home visits, parenting classes and other activities is expected. Abrupt changes in the treatment setting may have detrimental effects. It is expected that you will discuss an unplanned removal of the child with the Team, and give at least 72 hours notice to all members, so alternative supports can be put into place.

Religious Preference:

We respect the needs of the young person and the religious preferences of the family.

Religious preference: _____

The family/young person is comfortable with:

While in HCTC they may attend church with the HCTC provider

While in HCTC, the young person will attend church with their own family.

While on respite, the young person will attend church with respite provider (discuss).

Discharge Planning:

Length of stay in HCTC is anticipated to be approximately 12 to 18 months, requiring active engagement from all parties in order to prepare the child and family for the child's return to home and community.

Together, the CFT members will define "success," and identify the behaviors that will indicate the child is ready to return home. They will create and regularly adjust the treatment plan and services to achieve this goal.

What are the primary treatment goals that are driving this client's placement in HCTC?

Goal 1: _____

Goal 2: _____

Goal 3: _____

My signature below indicates I understand the HCTC treatment process, and agree to actively participate in all phases of this agreement I helped to create:

Parent/Guardian Date

Child/Youth Date

HCTC Provider Date

RA Representative Date

Other Date