DocuSign Envelope ID: 893C0398-F00E-4293-809B-13EEB704A018

NEBRASKA
Good Life. Great Service.
DEPT. OF ADMINISTRATIVE SERVICES

Pete Ricketts, Governor

January 28, 2021

Mr. William Clark
Saint Francis Ministries, Inc. DBA Saint Francis Ministries in Nebraska
509 E. Elm St.
Salina, KS 67401-2353

Dear Mr. Clark:

Per Section II.T.1. of Contract 86793 O4 and upon the terms and conditions of the Agreement to Terminate, the State of Nebraska (State) and Saint Francis Ministries, Inc. (Saint Francis) have agreed to terminate the entire Contract number 86793 O4 to provide full service case management to the Department of Health and Human Services.

If Saint Francis is in agreement, please sign and return the Agreement to Terminate, which accompanies this letter.

If you have any questions regarding this action, you may contact me at 402-471-1428.

Sincerely,

DocuSigned by:
Annette Walton
2358B0EE0E87446...

Annette Walton
Buyer, State Purchasing Bureau

cc: Doug Carlson, Materiel Administrator, AS Materiel Division
Gregory Walklin, Procurement Administrator, Department of Health and Human Services.

Doug Carlson, Materiel Administrator & Deputy Director

Department of Administrative Services | MATERIEL DIVISION

1526 K Street, Ste. 130
Lincoln, Nebraska 68508

OFFICE 402-471-6500
FAX 402-471-2089

das.nebraska.org

DocuSign Envelope ID: 893C0398-F00E-4293-809B-13EEB704A018

Agreement to Terminate

Contract 86793 O4

This Agreement to Terminate ("Agreement") is made and entered into by and between the State of Nebraska ("State") and Saint Francis Community Services in Nebraska, Inc. ("Subrecipient"), parties to Subaward 86793 O4/Contract 86793 O4 ("Contract"). The Subrecipient and the State may sometimes hereafter be referred to collectively as the "Parties" or individually as a "Party."

WHEREAS, Subsection T.1., Early Termination of Section II., Terms and Conditions of the Contract permits the State and the Subrecipient to terminate the Contract in whole or in part upon mutual written agreement;

WHEREAS, such subsection also requires the parties to agree in writing upon the termination conditions;

WHEREAS, the Parties have agreed to terminate the entire Contract and to the conditions upon termination;

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged by the Parties, the Parties agree as follows:

1. Termination Conditions. The Contract shall terminate only if a separate, replacement contract for case management services in the Eastern Service Area ("Replacement Contract") is executed by the State and Subrecipient.

2. Termination. Upon the Effective Termination Date, as defined herein, the entire Contract shall be terminated.

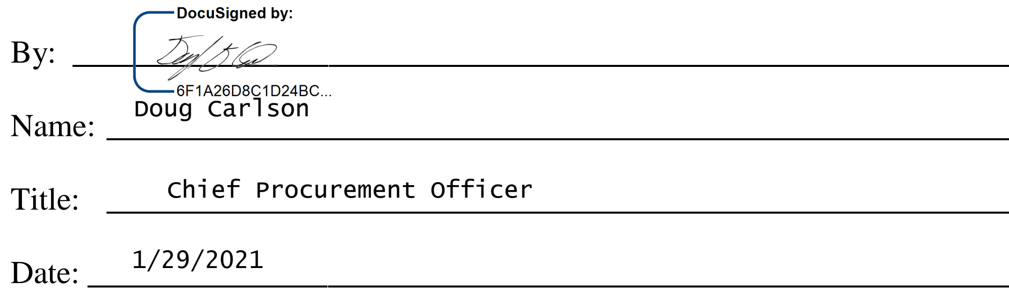
3. Effective Termination Date. The Contract shall terminate simultaneously with the effective date and time of the Replacement Contract ("Effective Termination Date").

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date of the last signature set forth below.

[The remainder of this page is intentionally left blank. Signature page follows.]

DocuSign Envelope ID: 893C0398-F00E-4293-809B-13EEB704A018

DEPARTMENT OF ADMINISTRATIVE SERVICES, STATE OF NEBRASKA



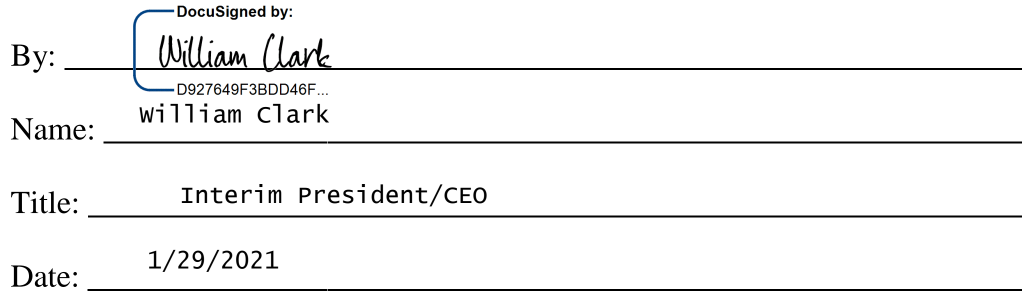
By: ______________________

Name: Doug Carlson

Title: Chief Procurement Officer

Date: 1/29/2021

SAINT FRANCIS COMMUNITY SERVICES IN NEBRASKA, INC. , INC.



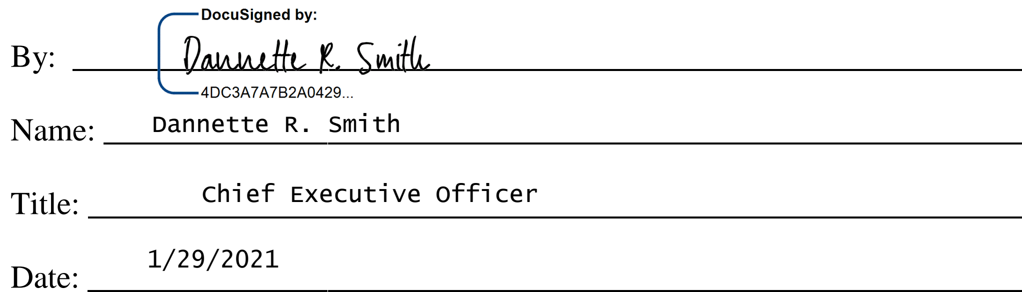
By: ______________________

Name: William Clark

Title: Interim President/CEO

Date: 1/29/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE OF NEBRASKA



By: ______________________

Name: Dannette R. Smith

Title: Chief Executive Officer

Date: 1/29/2021

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

PAGE 1 of 2	ORDER DATE 09/11/20
BUSINESS UNIT 25870241	BUYER ANNETTE WALTON (AS)

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

CONTRACT NUMBER
86793 O4

VENDOR NUMBER: 2587838

VENDOR ADDRESS:

SAINT FRANCIS MINISTRIES INC
DBA SAINT FRANCIS MINISTRIES IN NEBRASKA
509 E ELM ST
SALINA KS 67401-2353

THE CONTRACT PERIOD IS:

JULY 02, 2019 THROUGH JUNE 30, 2024

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5995 Z1

Contract to supply and deliver Full Service Case Management to the State of Nebraska as per the attached specifications for the period July 2, 2019 through June 30, 2024. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Diane Carver
Phone (Office): 800-423-1342 x 3026
Phone (Cell): 316-249-3839
Fax: 316-249-3839
E-Mail: Diane.Carver@st-francis.org

(7/2/19 sc)

Amendment One as attached. (ms 08/21/19)

AMENDMENT TWO (2) AS ATTACHED. (10/24/19 sc)

AMENDMENT THREE (3) AS ATTACHED. (9/11/20 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	INIT AWARD YR 1 DO NOT EXCEED JULY 2, 2019 THROUGH JUNE 30, 2020	29,496,575.0000	$	1.0000	29,496,575.00
2	INIT AWARD YR 1 STARTUP COST JULY 2, 2019 THROUGH JUNE 30, 2020	1,043,904.0000	$	1.0000	1,043,904.00

DHHS Division Director

BUYER

9/16/2020

MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	09/11/20
BUSINESS UNIT	BUYER
25870241	ANNETTE WALTON (AS)

VENDOR NUMBER: 2587838

CONTRACT NUMBER
86793 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
3	INIT AWARD YR 2 DO NOT EXCEED JULY 1, 2021 THROUGH JUNE 30, 2022	41,385,588.0000	$	1.0000	41,385,588.00
4	INIT AWARD YR 3 DO NOT EXCEED JULY 1, 2022 THROUGH JUNE 30, 2023	43,454,880.0000	$	1.0000	43,454,880.00
5	INIT AWARD YR 4 DO NOT EXCEED JULY 1, 2023 THROUGH JUNE 30, 2024	45,627,612.0000	$	1.0000	45,627,612.00
6	INIT AWARD YR 5 DO NOT EXCEED JULY 1, 2024 THROUGH JUNE 30, 2025	47,908,980.0000	$	1.0000	47,908,980.00
7	OPT REN 1 YR 6 DO NOT EXCEED JULY 1, 2025 THROUGH JUNE 30, 2026	50,304,444.0000	$	1.0000	50,304,444.00
8	OPT REN 2 YR 7 DO NOT EXCEED JULY 1, 2026 THROUGH JUNE 30, 2027	52,819,656.0000	$	1.0000	52,819,656.00
	Total Order				**312,041,639.00**

BUYER INITIALS

AMENDMENT THREE
Contract 86793 O4
Full Service Case Management for the State of Nebraska
Between
The State of Nebraska and Saint Francis Community Services in Nebraska, Inc.

This Amendment (the "Amendment") is made by the State of Nebraska and Saint Francis Community Services in Nebraska, Inc. (the "Contractor") parties to Contract 86793 O4 (the "Contract") and upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract upon execution as follows:

Insurance requirements for Medical Payments and Umbrella/Excess Liability will be deleted and replaced with:

1. Under Commercial General Liability

Medical Payments	$5,000 any one person per occurrence

2.

UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$4,000,000 per occurrence

3. Section III.G.3. EVIDENCE OF COVERAGE will be deleted and replaced with the following:

EVIDENCE OF COVERAGE
The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

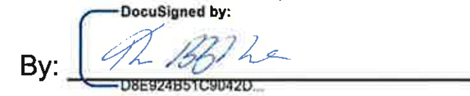
State Purchasing Bureau
Buyer: Annette Walton
Email: annette.walton@nebraska.gov

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

This Amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska	Contractor: Saint Francis Community Services in Nebraska, Inc.
By:	By: 
Name: Doug Carlson	Name: Thomas Blythe
Title: Materiel Administrator	Title: Chief Operating Officer
Date: 9/16/2020	Date: 9/11/2020

DocuSign Envelope ID: 79D22766-ED92-4A27-AFBA-46EB20A43BDB

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	10/24/19
BUSINESS UNIT	BUYER
25870241	ANNETTE WALTON (AS)

CONTRACT NUMBER
86793 O4

VENDOR NUMBER: 2022440

VENDOR ADDRESS:

SAINT FRANCIS COMMUNITY SERVICES
IN NEBRASKA INC
509 E ELM ST
SALINA KS 67401-2353

THE CONTRACT PERIOD IS:

JULY 2, 2019 THROUGH JUNE 30, 2024

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5995 Z1

Contract to supply and deliver Full Service Case Management to the State of Nebraska as per the attached specifications for the period July 2, 2019 through June 30, 2024. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Diane Carver
Phone (Office): 800-423-1342 x 3026
Phone (Cell): 316-249-3839
Fax: 316-249-3839
E-Mail: Diane.Carver@st-francis.org

(7/2/19 sc)

Amendment One as attached. (ms 08/21/19)

AMENDMENT TWO (2) AS ATTACHED. (10/24/19 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	INIT AWARD YR 1 DO NOT EXCEED JULY 2, 2019 THROUGH JUNE 30, 2020	29,496,575.0000	$	1.0000	29,496,575.00
2	INIT AWARD YR 1 STARTUP COST JULY 2, 2019 THROUGH JUNE 30, 2020	1,043,904.0000	$	1.0000	1,043,904.00
3	INIT AWARD YR 2 DO NOT EXCEED	41,385,588.0000	$	1.0000	41,385,588.00

DocuSigned by:
Bo Botelho
488D27AFF895455...

DHHS Division Director

10.25.19 Dorothy Walton 10/25/19
BUYER

10/25/19
MATERIEL ADMINISTRATOR

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	10/24/19
BUSINESS UNIT	BUYER
25870241	ANNETTE WALTON (AS)

VENDOR NUMBER: 2022440

CONTRACT NUMBER
86793 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	JULY 1, 2021 THROUGH JUNE 30, 2022				
4	INIT AWARD YR 3 DO NOT EXCEED JULY 1, 2022 THROUGH JUNE 30, 2023	43,454,880.0000	$	1.0000	43,454,880.00
5	INIT AWARD YR 4 DO NOT EXCEED JULY 1, 2023 THROUGH JUNE 30, 2024	45,627,612.0000	$	1.0000	45,627,612.00
6	INIT AWARD YR 5 DO NOT EXCEED JULY 1, 2024 THROUGH JUNE 30, 2025	47,908,980.0000	$	1.0000	47,908,980.00
7	OPT REN 1 YR 6 DO NOT EXCEED JULY 1, 2025 THROUGH JUNE 30, 2026	50,304,444.0000	$	1.0000	50,304,444.00
8	OPT REN 2 YR 7 DO NOT EXCEED JULY 1, 2026 THROUGH JUNE 30, 2027	52,819,656.0000	$	1.0000	52,819,656.00
	Total Order				**312,041,639.00**

BUYER INITIALS

AMENDMENT TWO
CONTRACT NUMBER 86793
FULL SERVICE CASE MANAGEMENT FOR THE STATE OF NEBRASKA
Between The State of Nebraska and St. Francis Community Services

This Amendment (the "Amendment") is made by the State of Nebraska and St. Francis Community Services, parties to Contract 86793-O4 (the "Subaward"), and upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the Subaward as follows:

Pursuant to Article II of the Addendum One to Contract, Additional Negotiated Terms, Parties have established an Operational Start Date of 10/21/2019. Cases shall be transferred according to Attachment 1, Case Load Transfer.

Attachment 2, Summary of Federal Funds, hereby replaces and supersedes the attachment "Award of Initial Funds" that is attached to and incorporated with Amendment One, fully executed 8/28/19.

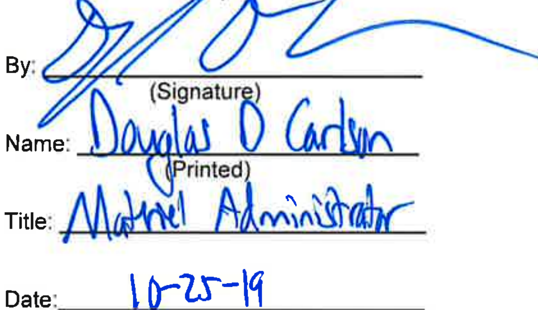
Because cases shall be transferred starting the week of October 21, rather than January 1, and because Saint Francis Community Services is assuming costs of the current Eastern Service Area Lead Agency, the costs of providing full service case management, including payment to service providers, will increase. Thus, upon execution line 1 will be deleted and superseded with:

Line No.	Description	Qty.	UOM	Unit Cost
1	INIT AWARD YR 1 DO NOT EXCEED JULY 2, 2019 THROUGH JUNE 30, 2020	29,496,575.00	$	1

This amendment and any attachments hereto will become part of the Subaward. Except as set forth in this Amendment, the Subaward is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Subaward or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska Dept. of Admin. Svc.



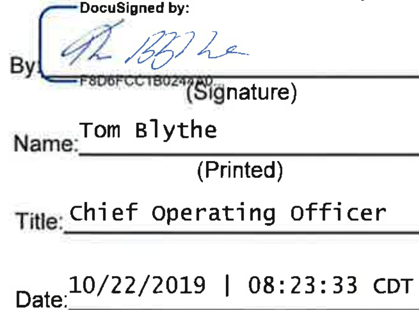
By: ____ (Signature)

Name: Douglas D Carlson (Printed)

Title: Material Administrator

Date: 10-25-19

Subrecipient: St. Francis Community Services



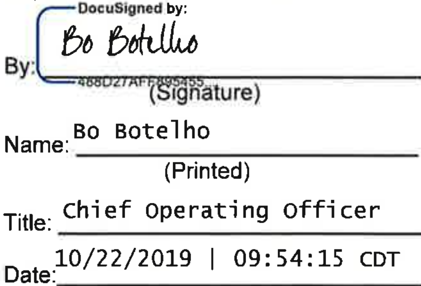
By: ____ (Signature)

Name: Tom Blythe (Printed)

Title: Chief Operating Officer

Date: 10/22/2019 | 08:23:33 CDT

Department of Health and Human Services



By: ____ (Signature)

Name: Bo Botelho (Printed)

Title: Chief Operating Officer

Date: 10/22/2019 | 09:54:15 CDT

Attachment 1
Case Load Transfer

Transfer of cases between October 2019 – December 2019
Estimate 1507 cases (includes out of home youth and in home families) to be staffed and transferred from PromiseShip to Saint Francis.

These numbers change daily based on family dynamics, so this is an overall estimate to give context to each week. All new referrals, as well as any that DHHS managed during transition, would move to Saint Francis as of January 1, 2020. This plan allows for staffing of families to begin Sept. 30th – Oct. 18th for the initial round of transfer.

Week of Oct 21 – **310 cases to transfer**

Week of Oct 28 – **171 cases to transfer**

Week of Nov 4 – **171 cases to transfer**

Week of Nov 11– **171 cases to transfer**

Week of Nov 18– **171 cases to transfer**

Week of Nov 25– **171 cases to transfer**

Week of Dec 2 – **171 cases to transfer**

Week of Dec 9 – **171 cases to transfer**

12/16/19 – 12/20/19 – excess case transfer

Attachment 2 – Summary of Federal Funds

SUBRECIPIENT INFORMATION	
Subrecipient Name	Saint Francis Community Services of Nebraska, Inc.
Subrecipient DUNS Number	104078258
Parent DUNS Number	N/A
Principal Place of Performance	Omaha, NE
Nebraska Congressional District	2nd

FUNDING TOTALS	
Total Amount of Federal Funds Obligated By this Action	$6,276,803.70
Total Amount of State Cash Funds Obligated	$0
Total Amount of State General Funds Obligated	$13,356,049.16
Total Amount of Federal Funds Obligated	$16,140,525.84
Total Amount of Federal Award Committed to Subrecipient	$16,140,525.84
TOTAL SUBAWARD	$29,496,575.00

Federal Agency Name	Catalog of Federal Domestic Assistance (CFDA) Name	CFDA Number	Federal Award Date	Federal Award Identifier Number (FAIN)	Amount of Federal Funds Obligated
Administration for Children and Families	Title IV-E Foster Care	93.658	October 1, 2018	G-1901NEFOST	$9,863,722.14
Administration for Children and Families	Title IV-E Foster Care	93.658	October 1, 2018	G-1901NEFOST	$6,276,803.70

86793 O4 Change Order Request

SFM Original Budget	Jan-20	Feb-20	Mar-20
Budgeted Caseload	190	480	960
Budgeted Placement costs	$ 187,040	$ 472,521	$ 945,043
	$ 984.42	$ 984.42	$ 984.42

Per NE DHHS/Promiseship	Jan-19	Feb-19	Mar-19
Promiseships Caseload	1,800	1,800	1,800
Placement Costs	$ 3,246,945	$ 3,012,861	$ 3,313,889
	$ 1,803.86	$ 1,673.81	$ 1,841.05

Our new assumptions	Oct-19	Nov-19	Dec-19
Caseload	540	1,080	1,800
Change in Placement costs	$ 819.44	$ 689.39	$ 856.63
	$ 255,457	$ 272,022	596,890

$ 1,124,370

86793 O4 Change Order Request

	NE Proposed	
Total Direct Expenses	$ 25,792,914	
Service Fees	$ 2,579,291	
Total All Expenses	$ 28,372,205	
Placement Costs(using Promiseship model instead of SFM)	$ 1,124,370	see sheet 2
Revised NE Full Case Management Change order	$ 29,496,575	

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	08/21/19
BUSINESS UNIT 25870241	BUYER ANNETTE WALTON (AS)

CONTRACT NUMBER
86793 O4

VENDOR NUMBER: 2022440

VENDOR ADDRESS:

SAINT FRANCIS COMMUNITY SERVICES
IN NEBRASKA INC
509 E ELM ST
SALINA KS 67401-2353

THE CONTRACT PERIOD IS:

JULY 2 2019 THROUGH JUNE 30, 2024

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5995 Z1

Contract to supply and deliver Full Service Case Management to the State of Nebraska as per the attached specifications for the period July 2, 2019 through June 30, 2024. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Diane Carver
Phone (Office): 800-423-1342 x 3026
Phone (Cell): 316-249-3839
Fax: 316-249-3839
E-Mail: Diane.Carver@st-francis.org

(7/2/19 sc)

Amendment One as attached. (ms 08/21/19)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	INIT AWARD YR 1 DO NOT EXCEED JULY 2, 2019 THROUGH JUNE 30, 2020	18,025,812.0000	$	1.0000	18,025,812.00
2	INIT AWARD YR 1 STARTUP COST JULY 2, 2019 THROUGH JUNE 30, 2020	1,043,904.0000	$	1.0000	1,043,904.00
3	INIT AWARD YR 2 DO NOT EXCEED JULY 1, 2021 THROUGH JUNE 30, 2022	41,385,588.0000	$	1.0000	41,385,588.00
4	INIT AWARD YR 3 DO NOT EXCEED	43,454,880.0000	$	1.0000	43,454,880.00

8/21/19 PC 8/22/19
BUYER
MATERIEL ADMINISTRATOR 8/28/19

R43500|NISH0004|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	08/21/19
BUSINESS UNIT	BUYER
25870241	ANNETTE WALTON (AS)

VENDOR NUMBER: 2022440

CONTRACT NUMBER
86793 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	JULY 1, 2022 THROUGH JUNE 30, 2023				
5	INIT AWARD YR 4 DO NOT EXCEED JULY 1, 2023 THROUGH JUNE 30, 2024	45,627,612.0000	$	1.0000	45,627,612.00
6	INIT AWARD YR 5 DO NOT EXCEED JULY 1, 2024 THROUGH JUNE 30, 2025	47,908,980.0000	$	1.0000	47,908,980.00
7	OPT REN 1 YR 6 DO NOT EXCEED JULY 1, 2025 THROUGH JUNE 30, 2026	50,304,444.0000	$	1.0000	50,304,444.00
8	OPT REN 2 YR 7 DO NOT EXCEED JULY 1, 2026 THROUGH JUNE 30, 2027	52,819,656.0000	$	1.0000	52,819,656.00
	Total Order				**300,570,876.00**

BUYER INITIALS

R43500|NISH0004|NISH0003 20150901

AMENDMENT ONE
Contract 86793 O4
Full Service Case Management for the State of Nebraska
Between
The State of Nebraska and Saint Francis Community Services

This Amendment (the "Amendment") is made by the State of Nebraska and Saint Francis Community Services (the "Contract"), parties to Contract and upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract upon Execution by both parties as follows:

1. All contract lines will be deleted and replaced with the following:

Line No.	Description 1	Description 2	Quantity	UOM	Unit Cost
1	INIT AWARD YR 1 DO NOT EXCEED	JULY 2, 2019 THROUGH JUNE 30, 2020	$ 18,025,812.00	$	1
2	INIT AWARD YR 1 STARTUP COSTS	JULY 2, 2019 THROUGH JUNE 30, 2020	$ 1,043,904.00	$	1
3	INIT AWARD YR 2 DO NOT EXCEED	JULY 1, 2021 THROUGH JUNE 30, 2022	$ 41,385,588.00	$	1
4	INIT AWARD YR 3 DO NOT EXCEED	JULY 1, 2022 THROUGH JUNE 30, 2023	$ 43,454,880.00	$	1
5	INIT AWARD YR 4 DO NOT EXCEED	JULY 1, 2023 THROUGH JUNE 30, 2024	$ 45,627,612.00	$	1
6	INIT AWARD YR 5 DO NOT EXCEED	JULY 1, 2024 THROUGH JUNE 30, 2025	$ 47,908,980.00	$	1
7	OPT REN 1 YR 6 DO NOT EXCEED	JULY 1, 2025 THROUGH JUNE 30, 2026	$ 50,304,444.00	$	1
8	OPT REN 2 YR 7 DO NOT EXCEED	JULY 1, 2026 THROUGH JUNE 30, 2027	$ 52,819,656.00	$	1

2. Attachment 1 – Award of Initial Funds will be replaced with the following document:

AWARD OF INITIAL FUNDS

SUBRECIPIENT INFORMATION	
Subrecipient Name	Saint Francis Community Services of Nebraska, Inc.
Subrecipient DUNS Number	104078258
Parent DUNS Number	
Principal Place of Performance (City/State/Country/Zip Code + 4)	Salina, KS, USA, 67401-1340
Nebraska Congressional District	Choose an item.

FUNDING TOTALS	
Total Amount of Federal Funds Obligated	$9,863,722.14
Total Amount of State Cash Funds Obligated	$
Total Amount of State General Funds Obligated	$8,162,085.86
Total Amount of Federal Award Committed to Subrecipient	*$9,863,722.14*
TOTAL SUBAWARD	$18,025,808.00

Federal Agency Name	Catalog of Federal Domestic Assistance (CFDA) Name	CFDA Number	Federal Award Date	Federal Award Identifier Number (FAIN)	Amount of Federal Funds Obligated
Administration for Children and Families	Title IV-E Foster Care	93.658	October 1, 2018	G-1901NEFOST	$9,863,722.14

This amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date of execution by both parties below.

State of Nebraska

By: ______________________

Name: Doug Carlson

Title: Materiel Administrator

Date: 8/28/19

Contractor: Saint Francis Community Services

By: ______________________

Name: Thomas Blythe

Title: COO + President

Date: 8/14/2019

DHHS Director

By: ______________________

Name: Matthew T. Wallen

Title: Director

Date: 8-20-19

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 4	07/02/19
BUSINESS UNIT	BUYER
25870241	ANNETTE WALTON (AS)

CONTRACT NUMBER
86793 O4

VENDOR NUMBER: 2022440

VENDOR ADDRESS.

SAINT FRANCIS COMMUNITY SERVICES
IN NEBRASKA INC
509 E ELM ST
SALINA KS 67401-2353

AN AWARD HAS BEEN MADE TO THE VENDOR/CONTRACTOR NAMED ABOVE FOR THE SERVICES AS LISTED BELOW FOR THE PERIOD:

JULY 2, 2019 THROUGH JUNE 30, 2024

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5995 Z1

Contract to supply and deliver Full Service Case Management to the State of Nebraska as per the attached specifications for the period July 2, 2019 through June 30, 2024. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Diane Carver
Phone (Office): 800-423-1342 x 3026
Phone (Cell): 316-249-3839
Fax: 316-249-3839
E-Mail: Diane.Carver@st-francis.org

(7/2/19 sc)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	ADMINISTRATIVE COST INITIAL AWARD YEAR ONE	136,599.0000	$	1.0000	136,599.00
2	MONTHLY FAMILY PRESERVATION INITIAL AWARD YEAR ONE	341,398.0000	$	1.0000	341,398.00
3	MONTHLY ON-GOING CASE MGT INITIAL AWARD YEAR ONE	136,559.0000	$	1.0000	136,559.00
4	DIRECT SERVICES INITIAL AWARD YEAR ONE	68,280.0000	$	1.0000	68,280.00
5	MONTHLY OUT-OF-HOME CARE INITIAL AWARD YEAR ONE	819,355.0000	$	1.0000	819,355.00
6	ANNUAL DO NOT EXCEED AMOUNT INITIAL AWARD YEAR ONE	18,025,808.0000	$	1.0000	18,025,808.00

DHHS Division Director

7/3/19 Annette Walton / AC
BUYER

Doug Carlson / bp 7/3/19
MATERIEL ADMINISTRATOR

R43500|NISK0002|NISK0032 20150901

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 4	07/02/19
BUSINESS UNIT	BUYER
25870241	ANNETTE WALTON (AS)

VENDOR NUMBER: 2022440

CONTRACT NUMBER
86793 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
7	INITIAL STARTUP COSTS INITIAL AWARD YEAR ONE	1,043,904.0000	$	1.0000	1,043,904.00
8	ADMINISTRATIVE COST INITIAL AWARD YEAR TWO	313,527.0000	$	1.0000	313,527.00
9	MONTHLY FAMILY PRESERVATION INITIAL AWARD YEAR TWO	783,818.0000	$	1.0000	783,818.00
10	MONTHLY ON-GOING CASE MGT INITIAL AWARD YEAR TWO	313,527.0000	$	1.0000	313,527.00
11	DIRECT SERVICES INITIAL AWARD YEAR TWO	156,764.0000	$	1.0000	156,764.00
12	MONTHLY OUT-OF-HOME CARE INITIAL AWARD YEAR TWO	1,881,163.0000	$	1.0000	1,881,163.00
13	ANNUAL DO NOT EXCEED AMOUNT INITIAL AWARD YEAR TWO	41,385,589.0000	$	1.0000	41,385,589.00
14	ADMINISTRATIVE COST INITIAL AWARD YEAR THREE	329,204.0000	$	1.0000	329,204.00
15	MONTHLY FAMILY PRESERVATION INITIAL AWARD YEAR THREE	823,009.0000	$	1.0000	823,009.00
16	MONTHLY ON-GOING CASE MGT INITIAL AWARD YEAR THREE	329,204.0000	$	1.0000	329,204.00
17	DIRECT SERVICES INITIAL AWARD YEAR THREE	164,602.0000	$	1.0000	164,602.00
18	MONTHLY OUT-OF-HOME CARE INITIAL AWARD YEAR THREE	1,975,221.0000	$	1.0000	1,975,221.00
19	ANNUAL DO NOT EXCEED AMOUNT INITIAL AWARD YEAR THREE	43,454,868.0000	$	1.0000	43,454,868.00
20	ADMINISTRATIVE COST INITIAL AWARD YEAR FOUR	345,664.0000	$	1.0000	345,664.00
21	MONTHLY FAMILY PRESERVATION INITIAL AWARD YEAR FOUR	864,159.0000	$	1.0000	864,159.00
22	MONTHLY ON-GOING CASE MGT INITIAL AWARD YEAR FOUR	345,664.0000	$	1.0000	345,664.00

An pk

BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
3 of 4	07/02/19
BUSINESS UNIT	BUYER
25870241	ANNETTE WALTON (AS)

VENDOR NUMBER: 2022440

CONTRACT NUMBER
86793 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
23	DIRECT SERVICES INITIAL AWARD YEAR FOUR	172,832.0000	$	1.0000	172,832.00
24	MONTHLY OUT-OF-HOME CARE INITIAL AWARD YEAR FOUR	2,073,982.0000	$	1.0000	2,073,982.00
25	ANNUAL DO NOT EXCEED AMOUNT INITIAL AWARD YEAR FOUR	45,627,612.0000	$	1.0000	45,627,612.00
26	ADMINISTRATIVE COST INITIAL AWARD YEAR FIVE	362,947.0000	$	1.0000	362,947.00
27	MONTHLY FAMILY PRESERVATION INITIAL AWARD YEAR FIVE	907,367.0000	$	1.0000	907,367.00
28	MONTHLY ON-GOING CASE MGT INITIAL AWARD YEAR FIVE	362,947.0000	$	1.0000	362,947.00
29	DIRECT SERVICES INITIAL AWARD YEAR FIVE	181,473.0000	$	1.0000	181,473.00
30	MONTHLY OUT-OF-HOME CARE INITIAL AWARD YEAR FIVE	2,177,681.0000	$	1.0000	2,177,681.00
31	ANNUAL DO NOT EXCEED AMOUNT INITIAL AWARD YEAR FIVE	47,908,992.0000	$	1.0000	47,908,992.00
32	ADMINISTRATIVE COST FIRST OPTIONAL RENEWAL YEAR SIX	381,094.0000	$	1.0000	381,094.00
33	MONTHLY FAMILY PRESERVATION FIRST OPTIONAL RENEWAL YEAR SIX	952,736.0000	$	1.0000	952,736.00
34	MONTHLY ON-GOING CASE MGT FIRST OPTIONAL RENEWAL YEAR SIX	381,094.0000	$	1.0000	381,094.00
35	DIRECT SERVICES FIRST OPTIONAL RENEWAL YEAR SIX	190,547.0000	$	1.0000	190,547.00
36	MONTHLY OUT-OF-HOME CARE FIRST OPTIONAL RENEWAL YEAR SIX	2,286,566.0000	$	1.0000	2,286,566.00
37	ANNUAL DO NOT EXCEED AMOUNT	50,304,442.0000	$	1.0000	50,304,442.00

AW

BUYER INITIALS

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
4 of 4	07/02/19
BUSINESS UNIT 25870241	BUYER ANNETTE WALTON (AS)

VENDOR NUMBER: 2022440

CONTRACT NUMBER
86793 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	FIRST OPTIONAL RENEWAL YEAR SIX				
38	ADMINISTRATIVE COST SECOND OPTIONAL RENEWAL YEAR SEVEN	400,149.0000	$	1.0000	400,149.00
39	MONTHLY FAMILY PRESERVATION SECOND OPTIONAL RENEWAL YEAR SEVEN	1,000,372.0000	$	1.0000	1,000,372.00
40	MONTHLY ON-GOING CASE MGT SECOND OPTIONAL RENEWAL YEAR SEVEN	400,149.0000	$	1.0000	400,149.00
41	DIRECT SERVICES SECOND OPTIONAL RENEWAL YEAR SEVEN	200,074.0000	$	1.0000	200,074.00
42	MONTHLY OUT-OF-HOME CARE SECOND OPTIONAL RENEWAL YEAR SEVEN	2,400,894.0000	$	1.0000	2,400,894.00
43	ANNUAL DO NOT EXCEED AMOUNT SECOND OPTIONAL RENEWAL YEAR SEVEN	52,819,664.0000	$	1.0000	52,819,664.00
	Total Order				**325,531,500.00**

AW OK
BUYER INITIALS

ADDENDUM ONE to Contract
CONTRACT NUMBER 86793 O4
FULL SERVICE CASE MANAGEMENT FOR THE STATE OF NEBRASKA
Between The State of Nebraska and St. Francis Community & Residential Services, Inc.

This Addendum One to Contract (the "Addendum") is made by the State of Nebraska ("State") and St. Francis Community & Residential Services, Inc. ("Subrecipient"), parties to Subaward 86793 O4 (the "Subaward"), and upon mutual agreement and other valuable consideration the parties agree to and hereby amend the Subaward as follows:

I. NEGOTIATED TERMS PURSUANT TO THE REQUEST FOR PROPOSAL

Pursuant to the terms of the Request for Proposal ("RFP") and requiring final negotiation between the parties after the Intent to Award, the following sections are hereby amended to be included in the Subaward.

For the purposes of this Addendum, the following terms are defined:

Year One: The time period commencing with the Operational Start Date through June 30, 2020.
Year Two: The time period commencing July 1, 2020 through June 30, 2021.
Year Three: The time period commencing July 1, 2021 through June 30, 2022.
Year Four: The time period commencing July 1, 2022 through June 30, 2023.
Year Five: The time period commencing July 1, 2023 through June 30, 2024.

Below, section headers are boldfaced for ease of reading. Previous requirements contained in the RFP are hereby restated, for reference, and italicized. Additions (or, as specifically designated, amendments), follow, non-italicized.

Article V, Paragraph D. PERFORMANCE REQUIREMENTS FOR SERVICE DELIVERY, 4.a
The Subrecipient is required to expand the availability of trained foster and adoptive families in the Eastern Service Area during the terms of the subaward, as measured by a ratio of placements to children. The baseline and performance targets will be established and mutually approved prior to subaward execution. DHHS will provide reimbursement rates for Resource Family care to the Subrecipient. Please see RFP 5995 Z1 Attachment Three: Service Area Monthly Summary Report.

The Subrecipient shall maintain foster and adoptive homes while bringing up Resource Family homes in the Eastern Service Area. The base for each year is the number of out-of-home placements for the previous year. DHHS shall provide Subrecipient the number of out-of-home placements by June 30 of each year. For the first year, DHHS shall provide Subrecipient the number of out-of-home placements by the Operational Start date.

The parties have agreed that Subrecipient must achieve the following performance targets:

- Year One: By July 1, 2020, the Subrecipient must have trained Resource Families to meet the placement needs of 5% (five percent) of the children placed out of home.
- Year Two: By July 1, 2021, the Subrecipient must have trained Resource Families to meet the placement needs of an additional 8% (eight percent) of the children placed out of home over the average base of Year One.
- Year Three: By July 1, 2022, the Subrecipient must have trained Resource Families to meet the placement needs of an additional 12% (twelve percent) of the children placed out of home over the average base of Year Two.

- Year Four: By July 1, 2023, the Subrecipient must have trained Resource Families to meet the placement needs of an additional 12.5% (twelve and one half percent) of children placed out of home over the average base of Year Three.
- Year Five: By July 1, 2024, the Subrecipient must have trained Resource Families to meet the placement needs of an additional 12.5% (twelve and one half percent) of children placed out of home over the average base of Year Four. Subrecipient shall maintain this percentage throughout any renewals or extensions of this Subaward.

Article V, Paragraph E.7.b - Performance-Based Contracting
The percent of the Subrecipient's subcontracted expenditures that are required to be performance-based will be mutually agreed upon prior to execution of subaward.

The parties have agreed that the following percentages of the Subrecipient's subcontracted expenditures must be performance-based:
- Year One: 50% (fifty percent)
- Year Two: 55% (fifty-five percent)
- Year Three: 60% (sixty percent)
- Year Four: 65% (sixty-five percent)
- Year Five (as well as throughout any renewals or extensions): 70% (seventy percent)

Conformance with this percentage shall be determined as of the June 30 of each year.

Article V, Paragraph H.1.a. Financial Requirements / Cost Allocation Plan/Administrative Expenditures
The Cost Allocation Plan and methodology shall be submitted to enable DHHS to claim administrative funds under Title IV-E. The document shall be in a format prescribed by DHHS.

The parties have agreed that the Subrecipient may use any format to meet this requirement, provided, however, said format includes all of the information required under Paragraph H.1.a, and is otherwise consistent with all applicable laws and with the Subaward.

Article V, Paragraph H.3.a Financial Requirements /Source Documentation/Service Expenditures
The Subrecipient and Second Tier Subrecipients must separate direct Resource Family care payments from other service delivery expenses and keep records of direct Resource Family care payments that are readily reviewable and traceable to source documentation in a format acceptable to DHHS including, but not limited to, payments to foster parents by check, electronic funds transfers, or other payment types.

The parties have agreed that Subrecipient may meet the requirement of Paragraph H.3.a by providing documents and records in any format, provided it is electronic. Notwithstanding any other provision in this Subaward, DHHS reserves the right to require further documentation when reasonably necessary to determine the particular expenses claimed by Subrecipient for Resource Family payments, including but not limited to records readily reviewable and traceable to source documentation.

Article V Paragraph H.3.c. Financial Requirements / Source Documentation/Service Expenditures:
The Subrecipient shall input documentation for services provided to children and families in the DHHS N-FOCUS or successor computer system using a format prescribed by DHHS. The Subrecipient shall input documentation for all services provided, except ongoing case management activities, at its discretion but no later than forty-five (45) calendar days following the end of the month in which the service was provided. The documentation must be readily reviewable and traceable to source documentation and reconciled to Subrecipient's financial statements so as to qualify for Title IV-E claiming. The obligation to provide documentation to DHHS, including but not limited to, source documentation of all services provided shall

survive the expiration or termination of this subaward. The required format will be provided to the awarded Subrecipient.

The parties have agreed that Subrecipient must use DHHS N-FOCUS, or successor computer system, for the provision of source documentation, as well. Source documentation shall include but not be limited to authorization and billing for services.

Article V, Paragraph H.8.a. Financial Requirements / Financial Statements
The financial statements will include a balance sheet, income statement, and statement of cash flows in a format to be agreed upon during subaward negotiations.

The parties have agreed that Subrecipient must use the Financial Statement Template, attached to this Addendum as Appendix 1.

Article V, Paragraph L-1-a. RETAINAGE AND PERFORMANCE MEASUREMENTS - Overview
A performance target for each measure will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.

The following performance targets have been agreed upon by the parties:

Article V, Paragraph L-2-b.i. Recurrence of Substantiated Maltreatment.
This outcome measures the rate of recurrence, expressed as a percentage, of substantiated maltreatment in a 12-month period in the Eastern Service Area, whether or not the child was involved with the court system. The Subrecipient is expected to achieve a lower % than the agreed upon target for recurrence of maltreatment.

This section quoted above is hereby revised and replaced with the following: "This outcome measures the rate of recurrence, expressed as a percentage, of substantiated maltreatment in a 12-month period in the Eastern Service Area, whether or not the child had an open case served by the Subrecipient. The Subrecipient must achieve a lower percentage than the indicator established by the Administration for Children and Families statewide data indicators ("indicators") used to determine a state's substantial conformity with titles IV-B and IV-E of the Social Security Act through the Child and Family Services Reviews. Subrecipient must meet the requirements of the current indicators provided by the Administration for Children and Families, even if said indicators change throughout the term or any renewal or extension of this Subaward.

Article V, Paragraph L-2-b.ii - Average Time to Successful Case Closure for Non-Court Involved Children.
This outcome measures the average time to case closure (in days) for Non-Court Involved Children, on a rolling 12-month average, for non-court children who exited care. The Subrecipient is expected to achieve a lower % than the agreed-upon target for average length of stay for Non-Court Involved Children.

For Non-Court Involved Children, the Subrecipient must average less than 91 (ninety-one) days to case closure, or must meet the State's average to case closure throughout the rest of the state (excluding the Eastern Service Area), whichever is less.

Article V, Paragraph L-2-b.iii - Rate of Removal of Non-Court Involved Children (in-home).
This outcome measures the average rate of removal, on a rolling 12-month average, [of] children originally assigned to the Subrecipient as part of in-home, non-court involved cases. The Subrecipient is expected to maintain an equal or lower % than the agreed-upon target using evidence-based services designed to preserve families.

The Subrecipient must average an amount equal or lower to an 8.1% (eight point one percent) rate of removal, or must average an amount equal to or lower than (1) The rate of removal of the State of Nebraska's average throughout the rest of the state (excluding the Eastern Service Area), or (2) The average of Service Areas, whichever is lower. The State must provide Subrecipient its average rate of removal on a monthly basis, beginning with the provision of the average rate of removal at the Operational Start Date.

Article V, Paragraph L-2-b.iv - Median Months to Reunification for Court Involved Children, in foster care.
This outcome measures all children discharged from foster care to reunification who had been in foster care for 8 days or longer. The Subrecipient is expected to achieve a lower median months than the agreed-upon target for months to reunification for court involved children.

Subrecipient must achieve a median of less than 10 (ten) months.

Article V, Paragraph L-2-b.v - Rate of Court Involved Children in Foster Care for 24 Months or More who Achieve Permanency.
This outcome incentivizes helping children with a longer than average stay in foster care achieve a positive permanency outcome. It measures the average time to achieve positive permanency (defined as Reunification, Adoption, or Guardianship) in years, on a rolling 12-month average, for court involved children. The Subrecipient is expected to achieve a lower % than the agreed-upon target.

The Subrecipient must achieve a percentage equal to or greater than the indicator established by the Administration for Children and Families statewide data indicators ("indicators") used to determine a state's substantial conformity with titles IV-B and IV-E of the Social Security Act through the Child and Family Services Reviews. Subrecipient must meet the requirements of the current indicators provided by the Administration for Children and Families, even if said indicators change throughout the term or any renewal or extension of this Sub-award.

Article V, Paragraph M.2.a. REPORTING REQUIREMENTS (DELIVERABLES / Financial Reports
Financial Statements must include a balance sheet, income statement and statement of cash flows in a format to be agreed upon during sub-award negotiations.

The parties have agreed that Subrecipient must use the Financial Statement Template, attached to this Addendum as Appendix 1.

Article V, Paragraph M. 3.a. REPORTING REQUIREMENTS (DELIVERABLES / Expenditures:
The Subrecipient must track and report, quarterly and annually, all federal and state expenditures, including administrative costs, in a format to be agreed upon during subaward negotiations.

The parties have agreed that the Subrecipient may use any format to meet this requirement, provided, however, said format includes all of the information required under Paragraph M.3a, and is otherwise consistent with all applicable laws and with the Subaward.

Article V, Paragraph M.10.b. REPORTING REQUIREMENTS (DELIVERABLES / Critical Incident Reports)
The Subrecipient shall provide to DHHS a written report of the Critical Incident within four (4) hours on the DHHS-approved format.

The parties have agreed that Subrecipient must use the Critical Incident Reporting Form attached to this Addendum as Appendix 3.

II. ADDITIONAL NEGOTIATED TERMS

The parties have further agreed on the following:

Operational Start Date
The parties have set an Operational Start Date of no later than January 1, 2020. The parties agree that transition from the previous vendor may need to occur prior to January 1, 2020, and will work cooperatively to ensure that cases may be transitioned as necessary. The Subrecipient shall work with DHHS to designate cases to transfer and case managers who are ready to accept cases as part of the transition process. Transition of cases shall be managed jointly by the DHHS and the Subrecipient to ensure a smooth transfer of case management. Any transition, however, is still contingent on Subrecipient's readiness to perform as required under the Subaward. See Article V, Paragraph G.

If said Operational Start Date occurs any time before January 1, 2020, the period from the Operational Start Date until December 31, 2020 shall constitute the first period for all Performance Measurements set forth in Article V, Paragraph L, instead of a twelve-month period set forth in those sections. All other periods for the Performance Measurements shall remain as set forth in the Subaward. All other clauses contingent on the Operational Start Date contained in the Subaward shall operate based on the agreed-upon Operational Start Date.

Case Management Ratio
In its proposal, Subrecipient provided information on staffing levels and case management ratios.

Subrecipient recognizes the statutory requirement of 12-17 cases per Case Manager. Within its proposal it has identified a total of 116 Bachelor's level staff whose primary responsibility is case management based upon the population served. Subrecipient's allocation of the staff below to case management services allows for Subrecipient to meet the statute without additional cost to its proposal. Staff allocation (below) may change to meet the actual Case Management needs, thus ensuring statutory case load requirements are met.

- 62 to provide service to children in out of home placement;
- 30 to provide Case Management to youth placed in Kinship Homes; and
- 24 to serve children maintained in their own homes.

Subrecipient has thus agreed that it shall meet the requirements set forth in Neb. Rev. Stat. § 68-1207.

NFOCUS Access
In its proposal, Subrecipient provided the following:
Saint Francis Ministries will use the DHHS SAQWIS system (N-FOCUS) to track case management activities under this award. A secure connection can be maintained between each Saint Francis device and the N-FOCUS system using an encrypted VPN. Saint Francis Ministries uses Cisco AnyConnect to ensure this and provides remote users with secure IPsec (IKEv2) or SSL VPN connections to the Cisco 5500 Series Adaptive Security Appliance (ASA). This is industry-standard VPN encryption technology that ensures security and safety of data transfer.

This section quoted above is hereby revised and replaced with the following:
In accessing NFOCUS under this Sub-award, Subrecipient shall use Citrix with a multi-factor authentication. This will require all users to install a unique user certificate in their web browser, as well as a Citrix client.

This addendum and any attachments hereto will become part of the Sub-award. Except as set forth in this Addendum, the Sub-award is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this amendment and the Sub-award or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this addendum as of the date of execution by both parties below.

State of Nebraska	St. Francis Community & Residential Services, Inc.
By: Doug Carlson lbp (Signature)	By: Robert N. Smith (Signature)
Name: Doug Carlson lbp (Printed)	Name: Robert N. Smith (Printed)
Title: Materiel Administrator	Title: CEO
Date: 7/3/2019	Date: July 1, 2019

Department of Health and Human Services

By: ______________________
(Signature)

Name: Matthew T. Waller
(Printed)

Title: Director

Date: 7-3-19

APPENDIX 1 FINANCIAL STATEMENT TEMPLATE

Company
Monthly Statement of Activities
Month Day, Year (Month End)

	Monthly Amt	Contract Year to Date July 1, 2018-June 30, 2018	Contract to Date
Revenue, gains and other support:			
Child Welfare Juvenile Services Subaward			
Nebraska DHHS CFS State Funds	$ -	$ -	
ACF Federal Funds	$ -	$ -	
Total revenues, gains and other support	$ -	$ -	
Expenses:			
Management and General	$ -	$ -	
Program Services	$ -	$ -	
Total Expenses	$ -	$ -	
Net	$ -	$ -	

APPENDIX 1 FINANCIAL STATEMENT TEMPLATE

Company
Monthly Statement of Functional Expenses
Month Day, Year (Month End)

	Monthly Amount			State Fiscal Year	
	Management and General	**Program Services**	**Total**	**July 1, 2019 - June 30, 2019**	**Contract to Date**
Expenses:	$ -	$ -	$ -	$ -	$ -
Salaries and Related Expenses	$ -	$ -	$ -	$ -	$ -
Salaries and wages	$ -	$ -	$ -	$ -	$ -
Employee Benefits (Health/Retirement)	$ -	$ -	$ -	$ -	$ -
Payroll Taxes and unemployment	$ -	$ -	$ -	$ -	$ -
Other Expenses	$ -	$ -	$ -	$ -	$ -
Total Salaries and Related Expenses	$ -	$ -	$ -	$ -	$ -
Operating Expenses	$ -	$ -	$ -	$ -	$ -
Occupancy	$ -	$ -	$ -	$ -	$ -
Supplies	$ -	$ -	$ -	$ -	$ -
Advertising and direct mail	$ -	$ -	$ -	$ -	$ -
Communications	$ -	$ -	$ -	$ -	$ -
Equipment	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -
Training	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -
Depreciation	$ -	$ -	$ -	$ -	$ -
Interest	$ -	$ -	$ -	$ -	$ -
Miscellaneous	$ -	$ -	$ -	$ -	$ -
Total Operating Expenses	$ -	$ -	$ -	$ -	$ -
Direct Service Expenses	$ -	$ -	$ -	$ -	$ -
Foster Care Maintenance	$ -	$ -	$ -	$ -	$ -
Foster Care Provider Admin and Support	$ -	$ -	$ -	$ -	$ -
All other Direct Services	$ -	$ -	$ -	$ -	$ -
Total Direct Services	$ -	$ -	$ -	$ -	$ -
Total Expenses	$ -	$ -	$ -	$ -	$ -

Company
Statement of Financial Position
Month Day, Year (Month End)

Assets	
Current Assets	
Cash	-
Accounts and Contracts receivable (note unallowances)	-
Unconditional promices receivable	-
Note receivable	-
Prepaid expenses	-
Other	-
Total current assets	-
Property, Plant, and Equipment	-
Other	-
Total Assets	-
Liabilities and Net Assets	
Current Liabilities	
Accounts payable	-
Notes Payable	-
Accrued salaries & fringe benefits	#REF!
Total current liabilities	#REF!
Long-Term Liabilities	-
Total Liabilities	-
Net assets:	
Unrestricted	-
Temporarily restricted	-
Permanently restricted	-
Total net assets	-
Total liabilities and net assets	-

Company
Accounts Payable Aging Report
Month Day, Year (Month End)

Provider	0-29	31-59	60-89	90-119	120+	Total
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Insert	0	0	0	0	0	0
Total	0	0	0	0	0	0

Company
Statement of Cash Flows
Month Day, Year (Month End)

Cash flows from operating activities:		
Increase (Decrease) in Change in Net Assets	$	-
Year-end fund balance adjustment	$	-
Adjustments to reconcile increase in net assets to net cash used in operating activities:		
Depreciation	$	-
Decreases (increases) in changes in assets:		
Accounts receivable	$	-
Prepaid expenses	$	-
Increase (decrease) in liabilities:		
Accounts payable	$	-
Other liabilities	$	-
Deferred revenue	$	-
Net cash used in operating activities	$	-
Cash flows from financing activities:		
Purchase of fixed assets	$	-
Increase in investments	$	-
Net cash provided by financing activities	$	-
Net increase (decrease) in cash	$	-
Cash, End of Last Month	$	-
Cash, End of this Month	$	-

APPENDIX 1 FINANCIAL STATEMENT TEMPLATE

Transaction Date	Transaction Type	Document Code	Transaction Description	Orgn #	Orgn Description	Account #	Account Description	Income Statement Description	Fund Sourcing	Fund #	Fund Description	Transaction Activity	Payment Date

APPENDIX 3

Department of Health and Human Services
Division of Children and Family Services

CRITICAL INCIDENT REPORTING

Name of Child:		Date of Birth:	Age:
State Ward: ☐ Yes ☐ No	Non-Court Involved Youth: ☐ Yes ☐ No	MC and/or Intake #:	
Sibling Names (if applicable):			

Type of Report:
☐ Initial Report ☐ Update

☐ DEATH OF CHILD:

1. Child is involved in a CFS case as a ward, non-court involved, active intake; OR
2. Death of a child who, at the time of death, was: not a ward of the state; not in a non-court involved case; or not in an active intake and the death was: 1) a result of abuse or neglect; or 2) a result of suspected abuse or neglect; or 3) abuse or neglect was a contributing factor.
3. Death of a child in a foster home, private agency, child care facility, juvenile detention facility, staff secure juvenile facility and other programs and facilities licensed by or under contract with the Department. This includes, license child caring agencies; residential caring facilities; certified homes or facilities such as an Extended Family Home; licensed or approved foster homes.

☐ NEAR FATALITY: Life threatening condition or serious injury resulting from abuse or neglect.

☐ SEXUAL ABUSE: Allegations of sexual abuse of a State Ward and the alleged perpetrator is a current or past out-of-home care provider.

☐ SAFE HAVEN: Any child thirty days old or younger who is left in the custody of an employee on duty at a hospital licensed by the State of Nebraska.

☐ ACCEPTED REPORTS OF ABUSE OR NEGLECT ALLEGATIONS THAT OCCUR IN:

1. Licensed Child Caring Agencies, such as group homes, emergency shelters, child care centers (foster homes licensed by a child placing agency are not included);
2. Residential Caring Facilities including the Regional Centers at Lincoln, Hastings, and Norfolk; Beatrice State Development Center; youth detention facilities; Psychiatric Residential Treatment Facilities; Treatment Group Homes; out of state residential facilities.
3. Any facility that is licensed or certified by more than one entity i.e., Medicaid and Developmental Disabilities; Developmental Disabilities/CFS.
4. Any certified facility or home such as an Extended Family Home.

☐ SUICIDE OR ATTEMPTED SUICIDE of a state ward or child with whom DHHS is involved in an active non-court case or initial assessment.

☐ ELOPEMENT of a youth from a state run facility.

☐ LAW ENFORCEMENT: Legal allegations or arrests of DHHS youth for serious illegal/criminal activity (i.e. homicide, manslaughter, near fatality of another person, sexual assault, 1st or 2nd degree assault, aggravated or armed robbery, etc.)

☐ HIGH PROFILE: Any other event that is highly concerning, poses potential liability, or is of emerging public interest, such as contacts involving the media.

APPENDIX 3

OTHER: Please describe:

When did Incident Occur?	Where did Incident Occur?
Describe the Incident:	

Alleged Perpetrator:

☐ Legal parent ☐ Foster Parent ☐ Facility Staff ☐ Siblings ☐ Foster Siblings
☐ Unknown ☐ Other Household Member (Describe):______________________
☐ Other (Describe):______________________

Were the child's parents notified of the incident?
☐ Yes ☐ No

Submit to:

DHHS.CPSCriticalIncident@nebraska.gov
Local Service Area Administrator
Local CFS Administrator

For public information purposes only; not part of contract.

Request for Proposal Number 5995 Z1
Contract Number 86793 O4
Proposal Opening:

In accordance with Nebraska Revised Statutes §84.712.05(3), the following material(s) has not been included due to it being marked proprietary.

None

1.

Form A &
Request for Proposal for Contractual Services

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free work place.

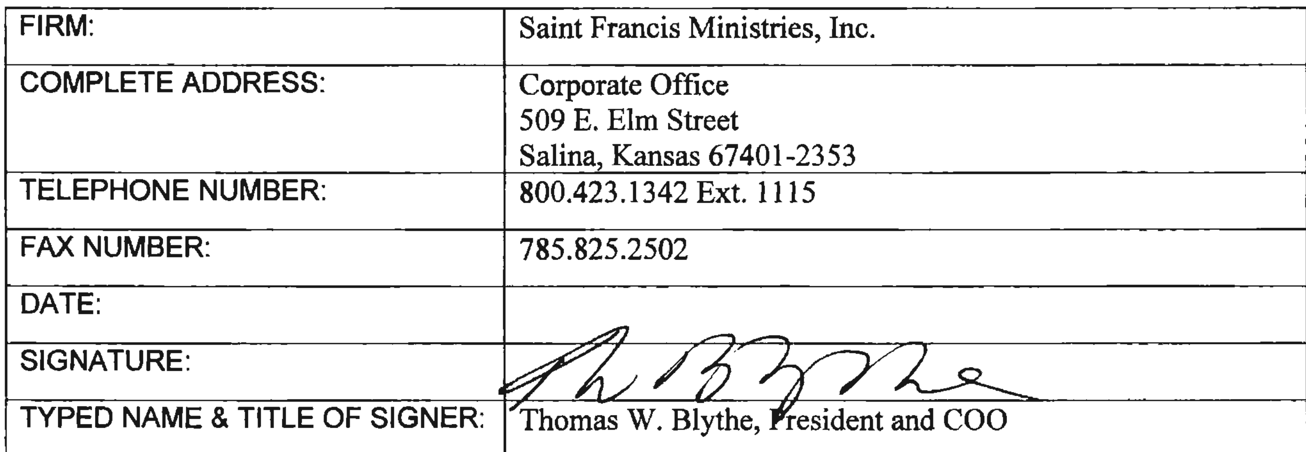
Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

__X__ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

______I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)



FIRM:	Saint Francis Ministries, Inc.
COMPLETE ADDRESS:	Corporate Office 509 E. Elm Street Salina, Kansas 67401-2353
TELEPHONE NUMBER:	800.423.1342 Ext. 1115
FAX NUMBER:	785.825.2502
DATE:	
SIGNATURE:	[signature]
TYPED NAME & TITLE OF SIGNER:	Thomas W. Blythe, President and COO

Form A
Bidder Contact Sheet
Request for Proposal Number 5995 Z1

Form A should be completed and submitted with each response to this RFP. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	Saint Francis Community & Residential Services, Inc.
Bidder Address:	Corporate Office 509 E. Elm Street Salina, Kansas 67401-2353
Contact Person & Title:	Thomas W. Blythe; President and COO
E-mail Address:	Tom.Blythe@St-Francis.org
Telephone Number (Office):	800.423.1342 Ext. 1115
Telephone Number (Cellular):	785.488.6254
Fax Number:	785.825.2502

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	Saint Francis Community & Residential Services, Inc.
Bidder Address:	Corporate Office 509 E. Elm Street Salina, Kansas 67401-2353
Contact Person & Title:	Diane Carver; Vice President for Children and Families Services
E-mail Address:	Diane.Carver@st-francis.org
Telephone Number (Office):	800.423.1342 Ext. 3026
Telephone Number (Cellular):	316-249-3839
Fax Number:	785.825.2502

Saint Francis
MINISTRIES

Sections
2, 3, 4
initialed

State of Nebraska State Purchasing Bureau
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508
Phone: (402) 471-6500

SOLICITATION NUMBER	RELEASE DATE
RFP 5995 Z1	January 9, 2019
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
April 4, 2019 2:00 P.M. Central Time	Annette Walton / Nancy Storant

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska (State), Department of Administrative Services (DAS), Materiel Division, State Purchasing Bureau (SPB), is issuing this Request for Proposal (RFP) Number 5995 Z1 for the purpose of selecting a qualified bidder to provide Full Service Case Management for Child Welfare Services. A more detailed description can be found in Section V. The resulting subaward may not be an exclusive subaward as the State reserves the right to subaward for the same or similar services from other sources now or in the future. Under federal law, the resulting contract awarded will also be a "subaward," and the Contractor will also be a "subrecipient," as defined by 45 CFR § 75.2.

The term of the subaward will be five (5) years commencing upon execution of the subaward by the State and the bidder (Parties). The subaward includes the option to renew for two (2) additional one (1) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this subaward beyond the termination date when mutually agreeable to the Parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: **http://das.nebraska.gov/materiel/purchasing.html**.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.04, State contracts in effect as of January 1, 2014, and contracts entered into thereafter, must be posted to a public website. The resulting contract, the RFP, and the successful bidder's proposal or response will be posted to a public website managed by DAS, which can be found at http://statecontracts.nebraska.gov.

In addition and in furtherance of the State's public records Statute (Neb. Rev. Stat. § 84-712 et seq.), all proposals or responses received regarding this RFP will be posted to the State Purchasing Bureau public website.

These postings will include the entire proposal or response. Bidders must request that proprietary information be excluded from the posting. The bidder must identify the proprietary information, mark the proprietary information according to state law, and submit the proprietary information in a separate container or envelope marked conspicuously in black ink with the words "PROPRIETARY INFORMATION". The bidder must submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992) THE BIDDER MAY NOT ASSERT THAT THE ENTIRE PROPOSAL IS PROPRIETARY. COST PROPOSALS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA. The State will then determine, in its discretion, if the interests served by nondisclosure outweighs any public purpose served by disclosure. (See Neb. Rev. Stat. § 84-712.05(3)) The bidder will be notified of the agency's decision. Absent a State determination that information is proprietary, the State will consider all information a public record subject to release regardless of any assertion that the information is proprietary.

If the agency determines it is required to release proprietary information, the bidder will be informed. It will be the bidder's responsibility to defend the bidder's asserted interest in non-disclosure.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, proposal, or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a proposal or response to this RFP, specifically waives any copyright or other protection the contract, proposal, or response to the RFP may have; and, acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a proposal or response to this RFP, and award of a contract. Failure to agree to the reservation and waiver will result in the proposal or response to the RFP being found non-responsive and rejected.

Any entity awarded a contract or submitting a proposal or response to the RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and

attorney fees and expenses, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or the proposals and responses to the RFP, awards, and other documents.

TABLE OF CONTENTS

TABLE OF CONTENTS iii

GLOSSARY OF TERMS vi

I. PROCUREMENT PROCEDURE 1

- A. GENERAL INFORMATION 1
- B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS 1
- C. SCHEDULE OF EVENTS 2
- D. WRITTEN QUESTIONS AND ANSWERS 3
- E. PRICES 3
- F. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory) 3
- G. ETHICS IN PUBLIC CONTRACTING 3
- H. DEVIATIONS FROM THE REQUEST FOR PROPOSAL 4
- I. SUBMISSION OF PROPOSALS 4
- J. BID PREPARATION COSTS 4
- K. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL 4
- L. BID CORRECTIONS 4
- M. LATE PROPOSALS 5
- N. PROPOSAL OPENING 5
- O. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS 5
- P. EVALUATION COMMITTEE 5
- Q. EVALUATION OF PROPOSALS 5
- R. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS 6
- S. BEST AND FINAL OFFER 6
- T. REFERENCE AND CREDIT CHECKS 6
- U. AWARD 6

II. TERMS AND CONDITIONS 8

- A. GENERAL 8
- B. NOTIFICATION 9
- C. NOTICE (POC) 9
- D. GOVERNING LAW (Statutory) 9
- E. BEGINNING OF WORK 9
- F. CHANGE ORDERS 10
- G. NOTICE OF POTENTIAL CONTRACTOR BREACH 10
- H. BREACH 10
- I. NON-WAIVER OF BREACH 11
- J. REMEDIES FOR NONCOMPLIANCE 11
- K. SEVERABILITY 11
- L. INDEMNIFICATION 12
- M. ATTORNEY'S FEES 13
- N. PERFORMANCE BOND 13
- O. ASSIGNMENT, SALE, OR MERGER 13
- P. FORCE MAJEURE 14
- Q. CONFIDENTIALITY 14
- R. OFFICE OF PUBLIC COUNSEL (Statutory) 14
- S. LONG-TERM CARE OMBUDSMAN (Statutory) 14
- T. EARLY TERMINATION 15
- U. CONTRACT AND GRANT CLOSEOUT 15

III. CONTRACTOR DUTIES 17

- A. INDEPENDENT CONTRACTOR / OBLIGATIONS 17
- B. EMPLOYEE WORK ELIGIBILITY STATUS 18
- C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory) 18
- D. COOPERATION WITH OTHER CONTRACTORS 19

E. PERMITS, REGULATIONS, LAWS 19
F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES 19
G. INSURANCE REQUIREMENTS 20
H. ANTITRUST 22
I. CONFLICT OF INTEREST 22
J. STATE PROPERTY 23
K. SITE RULES AND REGULATIONS 23
L. ADVERTISING 23
M. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory) 23
N. DISASTER RECOVERY/BACK UP PLAN 24
O. DRUG POLICY 24

IV. PAYMENT 25

A. COSTS 25
B. TAXES (Statutory) 25
C. INVOICES 25
D. INSPECTION AND APPROVAL 25
E. PAYMENT 26
F. LATE PAYMENT (Statutory) 26
G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS 26
H. ACCESS TO RECORDS 26
I. AUDIT REQUIREMENTS 27
J. FEDERAL FINANCIAL ASSISTANCE 28
K. SMOKE FREE PROVISIONS 28
L. HUMAN TRAFFICKING PROVISIONS 28
M. LOBBYING 29
N. MANDATORY DISCLOSURES 29
O. PUBLICATIONS 30
P. DEBARMENT, SUSPENSION OR DECLARED INELIGIBLE 30
Q. RESEARCH 30
R. SUBRECIPIENTS OR CONTRACTORS UNDER THIS SUBAWARD 30

V. PROJECT DESCRIPTION AND SCOPE OF WORK 32

A. PROJECT OVERVIEW 32
B. PROJECT ENVIRONMENT 32
C. PROGRAM REQUIREMENTS FOR ON-GOING CASE MANAGEMENT 33
D. PROGRAM REQUIREMENTS FOR SERVICE DELIVERY 36
E. ADMINISTRATIVE REQUIREMENTS 38
F. TRANSITION AND IMPLEMENTATION 41
G. READINESS REVIEW 41
H. FINANCIAL REQUIREMENTS 41
I. FEDERAL AND STATE LEGAL AND POLICY REQUIREMENTS 44
J. COST RECONCILIATON PROCEDURE 46
K. INFORMATION SYSTEM REQUIREMENTS 46
L. RETAINAGE AND PERFORMANCE MEASUREMENTS 48
M. REPORTING REQUIREMENTS (DELIVERABLES) 52
N. CAPACITY BUILDING COMPONENT 54

VI. PROPOSAL INSTRUCTIONS 55

A. PROPOSAL SUBMISSION 55

VII. COST PROPOSAL REQUIREMENTS 59

A. COST PROPOSAL 59
B. PRICES 59

Form A Bidder Contact Sheet 60

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM 61

INTRODUCTION

The Department of Health and Human Services (DHHS), Division of Children and Family Services (CFS) is dedicated to providing child welfare services in the least intrusive and least restrictive manner possible. Services offered are based on family voice and choice and designed to give families and children the opportunity to safely preserve their family whenever possible, engage with both formal and informal community resources, strengthen parents' protective capacity in order to keep children safe from harm, meet the needs of children and families as identified through the assessment process, be culturally humble, and include parents, siblings, and extended family.

The CFS continuum of services includes prevention activities and coordination, child protective services that focus on the safety, health and wellbeing of the child, parental and sibling engagement, family voice and choice in service provision, respite, resource families and independent living, adoption, domestic violence, safety, mental health, substance abuse and treatment services, as well as educational initiatives. These services are provided by CFS personnel or through contracted vendors.

CFS seeks a single external entity to provide full service case management, including the development and purchase of the full array of services to meet the needs of children and families in the Eastern Service Area of Nebraska. This service area is composed of the two counties, Douglas and Sarpy, with a combined population of 675,950 people. Douglas County is the most populous and urban county in the State of Nebraska. The Eastern Service Area has 40 percent of child welfare cases in the State of Nebraska, including a variety of families from different socio-economic and cultural backgrounds.

The Subrecipient selected to provide services to the Eastern Service Area will receive assignments based on the following process:

- Calls of reported child abuse and neglect come into the statewide reporting hotline and are screened by hotline staff. Some calls may not be accepted based on statutory requirements. Some families may be referred to the Alternate Response program. Alternative Response is a program that helps families with less severe reports of child abuse and/or neglect, connect with the supports and services they need in order to enhance the parent's ability to keep their children safe and healthy. The Alternative Response program is not a part of this RFP.

- If the report is opened for investigation, information is gathered to complete a safety assessment (within 24 hours of contact) and a risk assessment (within 30 days). The decision points of the safety and risk assessments determine if further CFS involvement is needed. If there is not a safety issue but the family has other unmet needs, CFS will refer the case to available community programs.

- If a case is opened for ongoing CFS involvement, either through court or non-court services, a referral will be made to the Subrecipient for the provision of ongoing services and case management.

- This referral will be made through a written formal document as well as a meeting to discuss the case to ensure a streamlined information exchange.

- The CFS investigative worker and the subrecipient's newly assigned case management worker will meet with the family together either at the home or at the first court hearing, to transfer case management responsibilities.

Summary of Key Roles and Responsibilities in Eastern Service Region under the subaward:

Role of CFS	Subrecipient	Courts
Abuse Hotline	Family Preservation	Assign Custody
Investigations	On-going case management	Hold review hearings
Legal Services	Service coordination	Case/custody closure
N-Focus SAQWIS System	Recruit Resource Families	
License Residential Providers	Foster Care	
	Adoptions	

Through this subaward, a Subrecipient must deliver high quality case management and child protection services, including provision of Well-Supported, Supported, and Promising Practice evidence-based models that strengthen families and build protective factors in families, in compliance with the federal Families First Preservation Services Act (FFPSA), part of the Bipartisan Budget Act of 2018 (H.R. 1892). When family preservation is not possible, the Subrecipient will ensure the recruitment and retention of culturally humble resource families to care for the child(ren), ensure the delivery of trauma-informed services, and engage and support the biological parents in the reunification process. If permanency is not attained for the child in a timely manner, then the Subrecipient will provide an array of culturally humble adoptive parents willing to provide a forever family to the child who support the engagement of the child in cultural activities and maintain sibling connections whenever possible.

GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

After Receipt of Order (ARO): After Receipt of Order.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Agreement: A contract or subaward, as defined herein, or both, as context provides.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Award: All purchases, leases, subawards, or contracts which are based on competitive proposals will be awarded according to the provisions in the RFP. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer (BAFO): In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: The offer submitted by a vendor in a response to a written solicitation.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the vendor will not withdraw the bid.

Bidder: A vendor who submits an offer bid in response to a written solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Change Order: Document that provides amendments to an executed purchase order or subaward.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade

secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Continuous Quality Improvement Culture: Behaviors and beliefs of Subrecipient personnel that constantly and consistently promote quality improvement in work and service delivered to clients.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement. See Subaward.

Contract Administration: The management of the contract / subaward which includes and is not limited to; contract / subaward signing, contract / subaward amendments and any necessary legal actions.

Contract Award: Occurs upon execution of the State document titled "Service Contract Award" by the proper authority.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Subrecipient. Contract management also encompasses contract monitoring which includes, but is not limited to, both on and offsite document and practice review focused on outcomes and objectives specified in the contract document.

Contract / Subaward Period: The duration of the contract / subaward.

Contractor: Any individual or entity having a contract to furnish commodities or services. See also Subrecipient.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the subaward.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Subrecipient.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or subaward.

Discharge: The formal act of ending a service or case.

Eastern Service Area: The geographic area of Douglas and Sarpy counties in Nebraska, designated for case management services.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals (offers made in response to written solicitations).

Evidence-Based: Well-researched interventions with clinical experience and ethics, and client preferences and culture to guide and inform the delivery of treatments and services as referenced in the Families First Prevention Services Act (FFPSA). Evidence-based models, as indicated in the FFPSA include Well-supported, Supported, and Promising Practice models.

Extension: Continuance of a subaward for a specified duration upon the agreement of the parties beyond the original Subaward Period. Not to be confused with "Renewal Period".

Federal Funding Agency: The United States Department of Health and Human Services (HHS).

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the vendor.

Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Independent Living Services: Services which prepare youth ages 14 to 19 for making the transition from adolescence to adulthood. Independent Living Services will include services who are expecting to be a parent, and parenting a child.
Installation Date: The date when the procedures described in "Installation by Subrecipient", and "Installation by State", as found in the RFP, or subaward, are completed.

Interested Party: A person, acting in their personal capacity, or an entity entering into a subaward or other agreement creating a legal interest therein.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Subrecipient to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Maltreatment: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or, an act or failure to act which presents an imminent risk of serious harm.

Mandatory/Must: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Mandatory/ Must and Shall/Will/Must.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Non-Federal Entity: As defined by 45 CFR § 75.2, a state, local government, Indian tribe, institution of higher education (IHE), or nonprofit organization that carries out a Federal award as a recipient or subrecipient.

Nonprofit Organization: As defined by 45 CFR § 75.2, any corporation, trust, association, cooperative, or other organization, not including Institutions of Higher Education, that: (1) Is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; (2) Is not organized primarily for profit; and (3) Uses net proceeds to maintain, improve, or expand the operations of the organization.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Operational Start Date: Date the Subrecipient starts managing referred child welfare case under this agreement.

Outsourcing: The subawarding out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Subrecipient fulfills any and all obligations under the subaward.

Permanency: When a child: is returned to his/her parent; legally adopted; legal guardianship has been established; or has

been placed in another permanent living situation.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Point of Contact (POC): The person designated to receive communications and to communicate.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the subaward for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the subaward.

Promising Practice: a practice shall be considered to be a promising practice if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measure of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that:

1. Was rated by an independent systematic review for the quality of the study design and execution and determined to be well designed and well executed; and
2. Utilized some form of control (such as an untreated group, a placebo group, or a wait list study. (Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.)

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serves no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to a RFP or resultant subaward, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provisionally Licensed – A time-limited, non-renewable license issued to an applicant who is unable to comply with all licensure requirements and standards, and is capable of compliance within the time period stated on the license.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Quality Assurance: A program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met.

Quality Assurance Review: A critical evaluation of a project, service, or facility to ensure that all standards of quality are met.

Quality Improvement Process: A system involving the measurement, analysis, and actions taken to improve quality in services, treatment, or care.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Subrecipient.

Release Date: The date of public release of the written solicitation to seek offers.

Renewal Period: Optional subaward periods subsequent to the original Subaward Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Information (RFI): A general invitation to vendors requesting information for a potential future solicitation. The RFI is typically used as a research and information gathering tool for preparation of a solicitation.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Resource Family: A family, subawarded through an accredited agency that has a child placing licensing license, who provides placement and permanency for children, support and education for parents, as well as supervised visitation for families whose children have been removed from the parental home due to abuse and/or neglect.

Resource Family Home: The residence in which a Resource Family lives and provides services as a Resource Family. (see Resource Family).

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Second Tier Subaward: an award provided by Subrecipient to another subrecipient for the subrecipient to carry out part of a Federal award received by the pass-through entity.

Second Tier Subrecipient: A non-Federal entity that receives a subaward from the Subrecipient to carry out part of a Federal program.

Secure Transportation: Providing for the safe, secure, and humane treatment of youth during transport to a secure facility or psychiatric facility. Transportation Secure shall include the use of the least restrictive mechanical restraint available that allows for the safety and security of the youth, while preserving the dignity of the youth transported.

Service Area: geographic area designated by the Division of Children and Family Services for case management services. The Division of Children and Family Services has five service areas in Nebraska; Eastern, Central, Northern, Southeast, and Western.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Commodity: When an item is available from only one source due to the unique nature of the requirement, its supplier, or market conditions.

Sole Source – Services: A service of such a unique nature that the vendor selected is clearly and justifiably the only practical source to provide the service. Determination that the vendor selected is justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a subaward.

State Business Days: Days of the week considered as working days by the State of Nebraska, not including weekends or State holidays.

Statutory: These clauses are controlled by state law and are not subject to negotiation.

Subaward: As defined in 45 CFR § 75.2, an award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a Federal award received by the pass-through entity. See Contract.

Subcontractor: Individual or entity with whom the Subrecipient enters a subaward to perform a portion of the work awarded to the Subrecipient. See also Second Tier Subrecipient.

Subrecipient: The non-Federal entity (as defined by 45 CFR § 75.2) that receives a Subaward from a pass-through entity to carry out part of a Federal program. See Contractor.

Substantiated: An investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by state law or policy.

Supported Practice: a practice shall be considered to be a supported practice if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one (1) study that:

1. Was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;
2. Was a rigorous random controlled trial (or; if not available, a study using a rigorous quasi-experimental research design);
3. Was carried out in a usual care practice setting; and
4. The study described established that the practice has a sustained effect (when compared to a control group) for at least six (6) months beyond the end of the treatment.(Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.)

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Subrecipient as functioning or being capable of functioning, as an entity.

Termination: Occurs when either Party, pursuant to a power created by agreement or law, puts an end to the subaward prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third Party: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and subcontractors, Second Tier Recipients, or agents, and their employees. It shall not include any entity or person who is an interested Party to the subaward or agreement.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product or service.

Utilization Management: The use of techniques that allow the Subrecipient to manage the cost of services by assessing its appropriateness before it is provided using evidence-based criteria or guidelines.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to the Subrecipient by State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, subaward, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Subrecipient regarding any such report. The vendor performance report will become a part of the permanent record for the Subrecipient. The State may require vendor to cure. Two such reports may be cause for immediate termination.

Well-Supported Practice: A practice shall be considered to be a well-supported practice if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two (2) studies that;

1. Were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed
2. Were rigorous random controlled trials (or, if not available, studies using a rigorous quasi-experimental research design);
3. Were carried out in a usual care or practice setting; and
4. At least one of the studies described established that the practice has a sustained effect (when compared to a control group) for at least one (1) year beyond the of treatment. (Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.)

Will: See Shall/Will/Must.

Work Day: See Business Day.

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

The RFP is designed to solicit proposals from qualified bidders who will be responsible for providing Full Service Case Management for Child Welfare Services at a competitive and reasonable cost.

Proposals shall conform to all instructions, conditions, and requirements included in the RFP. Prospective bidders are expected to carefully examine all documents, schedules, and requirements in this RFP, and respond to each requirement in the format prescribed. Proposals may be found non-responsive if they do not conform to the RFP.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this RFP reside with the State Purchasing Bureau. The point of contact (POC) for the procurement is as follows:

Name: Annette Walton / Nancy Storant Buyer(s)
Agency: State Purchasing Bureau
Address: 1526 K Street, Suite 130
Lincoln, NE 68508
Telephone: 402-471-6500

E-Mail: as.materielpurchasing@nebraska.gov

From the date the RFP is issued until the Intent to Award is issued, communication from the bidder is limited to the POC listed above. After the Intent to Award is issued, the bidder may communicate with individuals the State has designated as responsible for negotiating the subaward on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this RFP. The POC will issue any clarifications or opinions regarding this RFP in writing. Only the buyer can modify the RFP, answer questions, render opinions, and only the SPB or awarding agency can award a subaward. Bidders shall not have any communication with, or attempt to communicate or influence any evaluator involved in this RFP.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts, subawards or obligations;
2. Contact required by the schedule of events or an event scheduled later by the RFP POC; and
3. Contact required for negotiation and execution of the final subaward.

The State reserves the right to reject a bidder's proposal, withdraw an Intent to Award, or terminate a subaward if the State determines there has been a violation of these procurement procedures.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

ACTIVITY		DATE/TIME
1.	Release RFP	January 9, 2019
2.	Last day to submit written questions	January 23, 2019
3.	State responds to written questions through RFP "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	February 6, 2019
4.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	April 4, 2019 2:00 PM Central Time
5.	Review for conformance to RFP requirements	April 5, 2019
6.	Evaluation period	April 8, 2019 Through April 22,2019
7.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
8.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	May 15, 2019
9.	Subaward finalization period	May 14, 2019 Through June 14, 2019
10.	Award of subaward	July 1, 2019
11.	Subrecipient start date	January 1, 2020

D. **WRITTEN QUESTIONS AND ANSWERS**

Questions regarding the meaning or interpretation of any RFP provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5995 Z1; Full Service Case Management for Child Welfare Services Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Bidders should present, as questions, any assumptions upon which the bidder's proposal is or might be developed. Proposals will be evaluated without consideration of any known or unknown assumptions of a bidder. The subaward will not incorporate any known or unknown assumptions of a bidder.

It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov, but may be delivered by hand or by U.S. Mail. It is recommended that bidders submit questions using the following format.

RFP Section Reference	RFP Page Number	Question

Written answers will be posted at http://das.nebraska.gov/materiel/purchasing.html per the Schedule of Events.

E. **PRICES**

Prices submitted on the cost proposal form shall remain fixed for the first two (2) years of the contract. Any annual request for an increase in the annual Not To Exceed amount, subsequent to the first two (2) years of the subaward shall not exceed five percent (5%) of the previous annual Not to Exceed amount. Increases will not be cumulative across the remaining periods of the subaward. Requests for an increase must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current subaward year. Documentation will be required by the State to support the increase in the annual Not To Exceed amount. Documentation must show an increase in external cost outside of the control of the Subrecipient.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the subaward by the parties. Per federal law, no profit may be made from this subaward. See 45 CFR § 75.400.

F. **SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory)**

Subrecipient must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The Subreceipient who is the recipient of an Intent to Award may be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html. This must be accomplished prior to execution of the subaward.

G. **ETHICS IN PUBLIC CONTRACTING**

The State reserves the right to reject bids, withdraw an intent to award or award, or terminate a subaward if a bidder commits or has committed ethical violations, which include, but are not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilize the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from receiving a subaward with any state or federal entity:
4. Submitting a proposal on behalf of another Party or entity; and
5. Collude with any person or entity to influence the bidding process, submit sham proposals, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the bid, or prejudice the State.

The bidder shall include this clause in any subcontract or Second Tier Subaward entered into for the exclusive purpose of performing this subaward.

Bidder shall have an affirmative duty to report any violations of this clause by the bidder throughout the bidding process, and throughout the term of this subaward for the awarded Subreceipient and their subcontractors / Second Tier Subreceipients.

H. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

The requirements contained in the RFP become a part of the terms and conditions of the subaward resulting from this RFP. Any deviations from the RFP in Sections II through VI must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the subaward. Any specifically defined deviations must not be in conflict with the basic nature of the RFP, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

I. SUBMISSION OF PROPOSALS

Bidders should submit one proposal marked on the first page: "ORIGINAL". If multiple proposals are submitted, the State will retain one copy marked "ORIGINAL" and destroy the other copies. The Bidder is solely responsible for any variance between the copies submitted. Proposal responses should include the completed Form A, "Bidder Contact Sheet". Proposals must reference the RFP number and be sent to the specified address. Please note that the address label should appear as specified in Section I.B. on the face of each container or bidder's bid response packet. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The RFP number should be included in all correspondence.

Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming.

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP.

The State shall not incur any liability for any costs incurred by bidders in replying to this RFP, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this RFP.

The Technical and Cost Proposals should be packaged separately (loose-leaf binders are preferred) on standard 8 ½" by 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The Technical Proposal should not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts Second Tier Subrecipients and so forth, shall be considered in the Technical Proposal so that the bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions.

J. BID PREPARATION COSTS

The State shall not incur any liability for any costs incurred by bidders in replying to this RFP, including any activity related to bidding on this RFP.

K. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL

Violation of the terms and conditions contained in this RFP or any resultant Subrecipient, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award;
3. Withdrawal of the Award;
4. Termination of the resulting subaward;
5. Legal action; and
6. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

L. BID CORRECTIONS

A bidder may correct a mistake in a bid prior to the time of opening by giving written notice to the State of intent to withdraw the bid for modification or to withdraw the bid completely. Changes in a bid after opening are acceptable only if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

M. **LATE PROPOSALS**
Proposals received after the time and date of the proposal opening will be considered late proposals. Late proposals will be returned unopened, if requested by the bidder and at bidder's expense. The State is not responsible for proposals that are late or lost regardless of cause or fault.

N. **PROPOSAL OPENING**
The opening of proposals will be public and the bidders will be announced. Proposals **WILL NOT** be available for viewing by those present at the proposal opening. Vendors may contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website. Once proposals are opened, they become the property of the State of Nebraska and will not be returned.

O. **REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS**
The proposals will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Proposals not meeting the requirements may be rejected as non-responsive. The requirements are:

1. Original Request for Proposal for Contractual Services form signed using an indelible method;
2. Clarity and responsiveness of the proposal;
3. Completed Corporate Overview;
4. Completed Sections II through VI;
5. Completed Technical Approach;
6. Completed State Cost Proposal Template; and,
7. Completed Attachment 1: Award of Initial Funds.

P. **EVALUATION COMMITTEE**
Proposals are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions.

Q. **EVALUATION OF PROPOSALS**
All proposals that are responsive to the RFP will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
   a. the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the RFP;
   b. the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
   c. whether the bidder can perform the subaward within the specified time frame;
   d. the quality of bidder performance on prior subawards;
   e. such other information that may be secured and that has a bearing on the decision to award the subaward;
2. Technical Approach; and,
3. Cost Proposal.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any subaward entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a proposal in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this subaward, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria will be released with the RFP.

R. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The State may determine after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel, identified in their proposal, may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their proposals.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the proposals received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

S. BEST AND FINAL OFFER

If best and final offers (BAFO) are requested by the State and submitted by the bidder, they will be evaluated (using the stated BAFO criteria), scored, and ranked by the Evaluation Committee. The State reserves the right to conduct more than one Best and Final Offer. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

T. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a proposal in response to this RFP, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a proposal, withdraw an intent to award, or rescind the award of a subaward.

U. AWARD

The State reserves the right to evaluate proposals and award subawards in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the proposals, or at any point in the RFP process, the State of Nebraska may take one or more of the following actions:

1. Amend the RFP;
2. Extend the time of or establish a new proposal opening time;
3. Waive deviations or errors in the State's RFP process and in bidder proposals that are not material, do not compromise the RFP process or a bidder's proposal, and do not improve a bidder's competitive position;

4. Accept or reject a portion of or all of a proposal;
5. Accept or reject all proposals;
6. Withdraw the RFP;
7. Elect to rebid the RFP;
8. Award single lines or multiple lines to one or more bidders; or,
9. Award one or more all-inclusive subawards.

The RFP does not commit the State to award a subaward. Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Any protests must be filed by a bidder within ten (10) business days after the intent to award decision is posted to the Internet.

II. TERMS AND CONDITIONS

Bidders should complete Sections II through VI as part of their proposal. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the RFP, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this RFP. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this RFP.

The bidders should submit with their proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the subaward. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The subaward resulting from this RFP shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the RFP;
3. Questions and Answers;
4. Subrecipient's proposal (RFP and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the subaward.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Subrecipient's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
PB			

Subrecipient and State shall identify the subaward manager who shall serve as the point of contact for the executed subaward.

Communications regarding the executed subaward shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth below, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

C. NOTICE (POC)

The State reserves the right to appoint a Buyer's Representative to manage [or assist the Buyer in managing the subaward on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the Subreceipient will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the Subrecipient.

D. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this subaward, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this subaward will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this subaward on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final subaward, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final subaward are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
PB			

The bidder shall not commence any billable work until a valid subaward has been fully executed by the State and the successful Subrecipient. The Subreceipient will be notified in writing when work may begin.

F. CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The State and the Subrecipient, upon the written agreement, may make changes to the contract within the general scope of the RFP. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the subaward shall not be deemed a change. The Subrecipient may not claim forfeiture of the subaward by reasons of such changes.

The Subrecipient shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Subreceipient shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Subrecipient's proposal, were foreseeable, or result from difficulties with or failure of the Subrecipient's proposal or performance.

No change shall be implemented by the Subrecipient until approved by the State, and the subaward is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the subaward and law.

G. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

If Subrecipient breaches the subaward or anticipates breaching the subaward, the Subrecipient shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the subaward. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

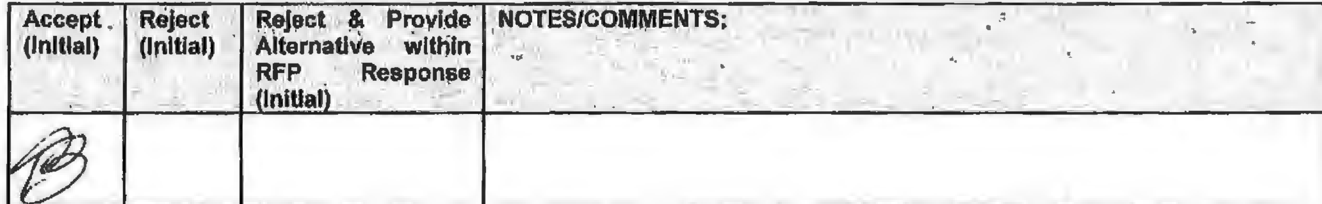
H. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the subaward in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of subaward does not waive the right to immediately terminate the subaward for the same or different subaward breach which may occur at a different time. In case of default of the Subrecipient, the State may subaward the service from other sources and hold the Subrecipient responsible for any excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Subrecipient shall retain all available statutory remedies and protections.

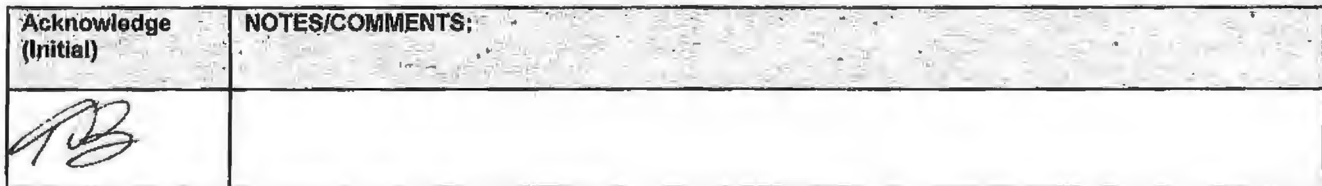
I. NON-WAIVER OF BREACH



Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

J. REMEDIES FOR NONCOMPLIANCE



Acknowledge (Initial)	NOTES/COMMENTS:

DHHS may, if Subrecipient fails to comply with federal statutes, regulations, Title IV-E state plan, or with the terms of the Subaward:

1. Impose any of the Specific Conditions listed in 45 CFR § 75.207;
2. Temporarily withhold any payments pending the correction of the deficiency by Subrecipient;
3. Disallow all or part of the cost of the activity or action not in compliance;
4. Wholly or partly suspend or terminate Subaward (see also Termination, below, and Breach, above);
5. Recommend suspension or debarment proceedings be initiated by the Federal Funding Agency; and
6. Take any other remedies that may be legally available.

If DHHS imposes items 3, 4, or 6, above, DHHS may withhold future payments, or seek repayment to recoup costs paid by DHHS, or both.

Failures to comply include, but are not limited to, Subrecipient's inability to meet or exceed the federal standards contained in FFPSA. If this, or any other failure by Subrecipient to comply with any federal statute, regulation, Title IV-E state plan, or term of this Subaward, is a proximate cause of any reduction in federal funds to DHHS, DHHS may disallow costs under this Subaward in an amount up to DHHS' reduction in federal funding.
Nothing in this section shall limit any other legal remedies available to DHHS.

K. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the subaward is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the subaward did not contain the provision held to be invalid or illegal.

L. **INDEMNIFICATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[signature]			

1. **GENERAL**
The Subrecipient agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Subrecipient, its employees, subcontractors, consultants, representatives, and agents, resulting from this subaward, except to the extent such Subrecipient liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**
The Subrecipient agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Subrecipient or its employees, subcontractors, Second Tier Subrecipients, consultants, representatives, and agents; provided, however, the State gives the Subrecipient r prompt notice in writing of the claim. The Subrecipient may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Subrecipient has indemnified the State, the Subrecipient shall, at the Subrecipient's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Subrecipient, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**
The Subrecipient shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, and, Second Tier subrecipients and their employees provided by the Subrecipient.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Subrecipient may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

M. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

In the event of any litigation, appeal, or other legal action to enforce any provision of the subaward, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.

N. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The Subrecipient will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the subaward to include any renewal and/or extension periods. The amount of the bond must be an established dollar amount $1,000,000. The bond will guarantee that the Subrecipient will faithfully perform all requirements, terms and conditions of the subaward. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the subaward.

O. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

Either Party may assign the subaward upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Subrecipient retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Subrecipient's business. Subrecipient agrees to cooperate with the State in executing amendments to the subaward to allow for the transaction. If a third party or entity is involved in the transaction, the Subrecipient will remain responsible for performance of the subaward until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this subaward and perform all obligations of the subaward.

P. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the subaward due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

Q. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

R. OFFICE OF PUBLIC COUNSEL (Statutory)

If it provides, under the terms of this subaward and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Subrecipient shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this subaward.

S. LONG-TERM CARE OMBUDSMAN (Statutory)

Subrecipient must comply with the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this subaward.

T. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The subaward may be terminated as follows:

1. The State and the Subrecipient, by mutual written agreement, may terminate the subaward at any time however, the two parties must agree, in writing, upon the termination conditions, including the effective date and, in case of partial termination, the portion to be terminated.
2. The State, in its sole discretion, may terminate the subaward for any reason upon thirty (30) calendar day's written notice to the Subrecipient. Such termination shall not relieve the Subrecipient of warranty or other service obligations incurred under the terms of the subaward. In the event of termination the Subrecipient shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
3. The State may terminate the subaward immediately for the following reasons:
   a. if directed to do so by statute;
   b. Subrecipient has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Subrecipient or of any substantial part of the Subrecipient 's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the subaward by its Subrecipient, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any Party against the Subrecipient under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Subrecipient has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Subrecipient has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Subrecipient intentionally discloses confidential information;
   h. Subrecipient has or announces it will discontinue support of the deliverable; and,
   i. In the event funding is no longer available.
4. The Subrecipient may terminate the subaward upon sending written notification to DHHS setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if DHHS determines in the case of partial termination that the reduced or modified portion of the Subaward will not accomplish the purposes for which the Federal award was made, DHHS may terminate the Subaward in its entirety. In either case, the effective date shall be as provided by the Subrecipient and may be no less than 180 (one-hundred and eighty) days.
5. All notices of termination must be consistent with 45 CFR § 75.372 and shall provide a notice period and effective date as set forth in this Subaward.

U. CONTRACT AND GRANT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

1. The following closeout procedures apply to this subaward at the end of each federal fiscal year, except for (a), which shall apply at the end of the federal fiscal year and the end of the subaward term, and (e), which shall apply at the end of the subaward term only:

a. The Subrecipient shall finalize and pay all costs for services provided under this subaward as follows:

Term	Deadline to Finalize and Pay Obligations
Initial subaward Start date through September 30, 2019	November 15, 2019
October 1, 2019 through September 30, 2020	November 15, 2020
October 1, 2020 through September 30, 2021	November 15, 2021
October 1, 2021 through September 30, 2022	November 15, 2022
October 1, 2022 through September 30, 2023	November 15, 2023
October 1, 2023 through September 30, 2024	November 15, 2024
October 1, 2024 through September 30, 2025	November 15, 2025
October 1, 2025 through September 30, 2026	November 15, 2026

These deadlines apply to all costs whether paid with state or federal funds, or both. Costs that are not finalized and paid by these deadlines shall not be reimbursed by DHHS, except that DHHS may authorize an extension, in writing, of the above deadlines. If DHHS has previously paid for an incurred cost that has not been finalized and paid by Subrecipient by the applicable deadline, DHHS may withhold additional payments to recoup that cost.

b. Consistent with the terms of the federal award, and after all reports are received, DHHS shall make any necessary adjustments upward or downward in the federal share of costs.
c. DHHS shall make prompt payments, as consistent with the terms set forth herein, for all costs allowable under the terms of this Subaward.
d. Subrecipient shall immediately return to DHHS any unobligated balance of cash advanced or shall manage such balance in accordance with DHHS instructions.
e. Within 30 days, except as otherwise stated herein, Subrecipient shall assist and cooperate in the orderly transition and transfer of subaward activities and operations with the objective of preventing disruption of services. This includes but is not limited to:

i. Transfer all completed or partially completed deliverables to the State;
ii. Transfer ownership and title to all completed or partially completed deliverables to the State;
iii. Return to the State all information and data, unless the Subrecipient is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Subrecipient's routine back up procedures;
iv. Cooperate with any successor Subrecipient, person or entity in the assumption of any or all of the obligations of this subaward;
v. Cooperate with any successor Subrecipient, person or entity with the transfer of information or data related to this subaward
vi. Return or vacate any state owned real or personal property; and
vii. Return all data in a mutually acceptable format and manner.

2. *Post-Closeout Adjustments and Continuing Responsibilities*. The closeout of the subaward does not affect any of the following:
a. The right of DHHS to disallow costs and recover funds on the basis of a later audit or other review. DHHS shall make any cost disallowance determination and notify Subrecipient within the record retention period.
b. The obligation of Contractor to return any funds due as a result of later refunds, corrections, or other transactions including final indirect cost rate adjustments.
c. Audit requirements in 45 CFR § 75 Subpart F.
d. As applicable, property management and disposition requirements in Subpart D—Post Federal Award Requirements in 45 CFR §§ 75.317 through 75.323.
e. Records retention requirements contained herein.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

It is agreed that the Subrecipient is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Subrecipient is solely responsible for fulfilling the subaward. The Subrecipient or the Subrecipient's representative shall be the sole point of subaward regarding all contractual matters.

The Subrecipient shall secure, at its own expense, all personnel required to perform the services under the subaward. The personnel the Subrecipient uses to fulfill the subaward shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Subrecipient's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Subrecipient to the subaward shall be employees of the Subrecipient, a Second Tier Subrecipient or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Subrecipient, Second Tier Subrecipient, or a subcontractor to fulfill the terms of the subaward shall remain under the sole direction and control of the Subrecipient, Second Tier Subrecipient, or the subcontractor respectively.

With respect to its employees, the Subrecipient agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Subrecipient 's employees, including all insurance required by state law;
3. Damages incurred by Subrecipient 's employees within the scope of their duties under the subaward;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;
5. Determining the hours to be worked and the duties to be performed by the Subrecipient s employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Subrecipient , its officers, agents, or subcontractors or subcontractor's employees)

If the Subrecipient intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Subrecipient shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Subrecipient to reassign or remove from the project any Subrecipient or subcontractor employee.

Subrecipient shall insure that the terms and conditions contained in any subaward or contract with a Second Tier Subrecipient or subcontractor does not conflict with the terms and conditions of this subaward.

The Subrecipient shall include a similar provision, for the protection of the State, in the subaward with any subcontractor engaged to perform work on this Subrecipient .

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The Subrecipient is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Subrecipient is an individual or sole proprietorship, the following applies:

1. The Subrecipient must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the RFP response.

2. If the Subrecipient indicates on such attestation form that he or she is a qualified alien, the Subrecipient agrees to provide the US Citizenship and Immigration Services documentation required to verify the Subrecipient's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Subrecipient understands and agrees that lawful presence in the United States is required and the Subrecipient may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Subrecipient shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Subrecipients of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Subrecipient guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of subaward. The Subrecipient shall insert a similar provision in all subcontracts for services to be covered by any subaward / contract resulting from this RFP.

The Subrecipient shall comply with all civil rights and nondiscrimination law in the provision of the services under this Subaward. This includes, but is not limited to:

1. The Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq.;
2. Federal regulations governing programs and services provided under grants from the U.S. Department of Health and Human Services (HHS) at: 45 CFR § 75.300; 45 CFR §§ 80 et seq. (nondiscrimination under programs receiving or benefitting from assistance through HHS); 45 CFR §§ 84 et seq. (nondiscrimination on the basis of handicap in HHS programs or activities receiving federal financial assistance); 45 CFR §§ 86 et seq. (nondiscrimination on the basis of sex in education programs and activities receiving or benefitting from federal financial assistance); 45 CFR §§ 87 et seq. (Equal Treatment for Faith-Based Organizations); and 45 CFR §§ 91 et seq. (nondiscrimination on the basis of age in HHS programs or activities receiving federal financial assistance).

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

Subrecipient may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Subrecipient shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Subrecipient is not required to compromise Subrecipient's intellectual property or proprietary information unless expressly required to do so by this subaward.

E. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The subaward price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Subrecipient shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the subaward. The Subrecipient must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

1. *Data.* DHHS shall own all rights in data resulting from this Subaward. The Federal Funding Agency reserves the right to obtain, reproduce, publish, or otherwise use the data produced under this subaward, and to authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes.
2. *Copyright.* As consistent with federal law, Subrecipient may copyright any of the copyrightable material and may patent any of the patentable products produced in conjunction with the Scope of Work under subaward without written consent from DHHS. DHHS and any Federal Funding Agency hereby reserve a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the copyrightable material for federal or state government purposes.
3. *Patent.* All patent rights under this subaward shall be as set forth in the clause contained in 37 C.F.R. § 401.14, and consistent with all other applicable federal law.

G. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
PB			

The Subrecipient shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Subrecipient shall not commence work on the subaward until the insurance is in place. If Subrecipient subcontracts or subawards any portion of the contract the Subrecipient must, throughout the term of the contract / subaward, either:

1. Provide equivalent insurance for each subcontractor / Second Tier Subrecipient and provide a COI verifying the coverage for the subcontractor / Second Tier Subrecipient;
2. Require each subcontractor / Second Tier Subrecipient to have equivalent insurance and provide written notice to the State that the Subrecipient has verified that each subcontractor / Second Tier Subrecipient has the required coverage; or,
3. Provide the State with copies of each subcontractor's / Second Tier Subrecipient's Certificate of Insurance evidencing the required coverage.

The Subrecipient shall not allow any subcontractor / Second Tier Subrecipient to commence work until the subcontractor / second tier subrecipient has equivalent insurance. The failure of the State to require a COI, or the failure of the Subrecipient to provide a COI or require subcontractor / Second Tier Subrecipient insurance shall not limit, relieve, or decrease the liability of the Subrecipient hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the subaward or within three (3)years of termination or expiration of the subaward, the Contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and three (3)years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Subrecipient elects to increase the mandatory deductible amount, the Subrecipient shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this subaward, the State may recover up to the liability limits of the insurance policies required herein.

1. **WORKERS' COMPENSATION INSURANCE**

   The Subrecipient shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the Subrecipient's employees to be engaged in work on the project under this subaward and, in case any such work is sublet, the Subrecipient shall require the subcontractor / Second Tier Subrecipient similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's / Second Tier Subrecipient's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

   The Subrecipient shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Subrecipient and any subcontractor / Second Tier Subrecipient performing work covered by this subaward from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Subrecipientor by any subcontractor / Second Tier Subrecipient, or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$5,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

3. **EVIDENCE OF COVERAGE**

The Subrecipient shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Health and Human Services
Attn: DHHS Service Area Administrator
301 Centennial Mall South
Lincoln, NE 68508

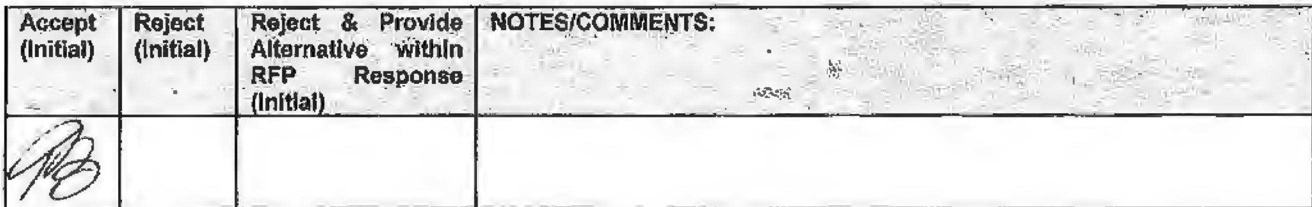
These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Subrecipient shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Subrecipient .

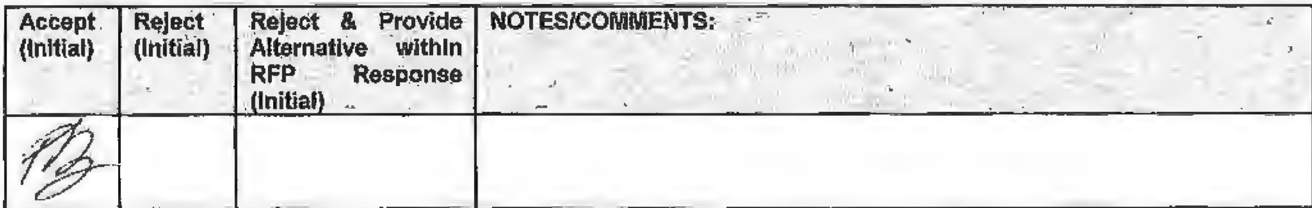
H. ANTITRUST



Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The Subrecipient hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

I. CONFLICT OF INTEREST



Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

By submitting a proposal, bidder certifies that there does not now exist a relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this RFP or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or an appearance of conflict of interest.

The bidder certifies that it will not knowingly employ any individual known by bidder to have a conflict of interest.

The Parties shall not knowingly, for a period of two years after execution of the subaward, recruit or employ any employee or agent of the other Party who has worked on the RFP or project, or who had any influence on decisions affecting the RFP or project.

J. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The Subrecipient shall be responsible for the proper care and custody of any State-owned property which is furnished for the Subrecipient's use during the performance of the contract. The Subrecipient shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

K. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The Subrecipient shall use its best efforts to ensure that its employees, agents, and subcontractors comply with site rules and regulations while on State premises. If the Subrecipient must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Subrecipient.

L. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The Subrecipient agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

M. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

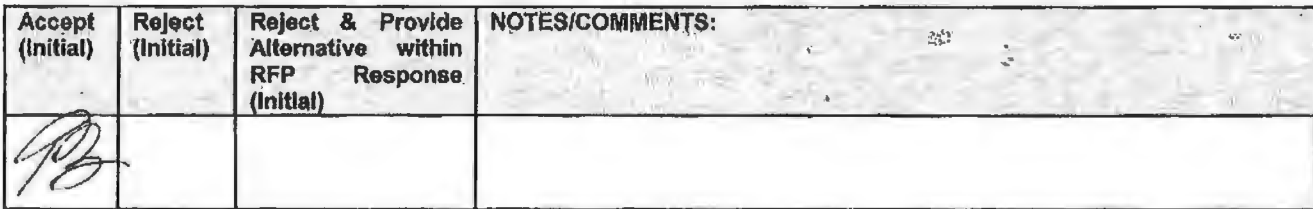
Subrecipient shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the subaward are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Subrecipient 's performance, the State may create an amendment to the subaward to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

N. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

O. DRUG POLICY



Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Subrecipient certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Subrecipient agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

IV. PAYMENT

A. COSTS

Under this subaward, DHHS shall only pay for actual and allowable costs (as defined in this section) incurred during the term of this subaward.

To be allowable, all costs must be:

1. Necessary for the performance of the subaward activities;
2. Reasonable, as provided in 45 CFR § 75.404;
3. Allocable to the federal award, as provided in 45 CFR § 75.405;
4. Consistent with all other requirements of the Cost Principles in 45 CFR §§ 75 Subpart E; and,
5. Consistent with all other law, regulation, policy, or other requirements applicable to the state or federal funds involved.

To be actual, all costs must be finalized and spent by the appropriate dates set forth in Section II.U. Contract and Grant Closeout, and as otherwise set forth herein. This may include, but is not limited to, restrictions on funds including in federal appropriations bills for the federal funds used in this subaward.

Any requirements applicable to the federal funds shall also be applied to the state funds involved in this subaward.

Per federal law, no profit may be made from this subaward. See 45 CFR § 75.400.

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Subrecipient 's equipment which may be installed in a state-owned facility is the responsibility of the Subrecipient.

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

Invoices for payments must be submitted by the Subrecipient to the agency requesting the services with sufficient detail to support payment. Subrecipient's invoice shall include the agency's name, address, contact phone number, date of invoice, and date of service. Invoices should be sent to DHHS Children and Family Services 301 Centennial Mall S. Lincoln, NE 68509. The terms and conditions included in the Subrecipient's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the subaward.

D. INSPECTION AND APPROVAL

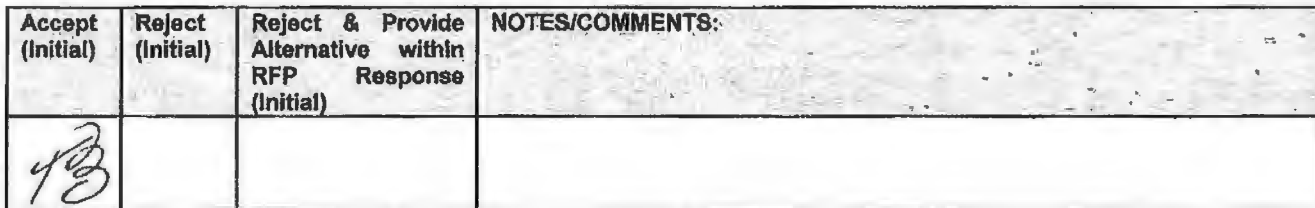
Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

Final inspection and approval of all work required under the subaward shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Subrecipient, Second Tier Subrecipient, or subcontractor duties under the subaward are being performed, and to inspect, monitor

or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT



Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Subrecipient monthly when the terms and conditions of the subaward and specifications have been satisfactorily completed on the part of the Subrecipient as solely determined by the State. (Neb. Rev. Stat. §73-506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Subrecipient to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Subrecipient prior to the Effective Date of the subaward, and the Subrecipient hereby waives any claim or cause of action for any such services.

Payments may be withheld as set forth in 45 CFR § 75.305(a)(6), as amended from time to time, as otherwise provided herein, or according to other applicable law.

F. LATE PAYMENT (Statutory)

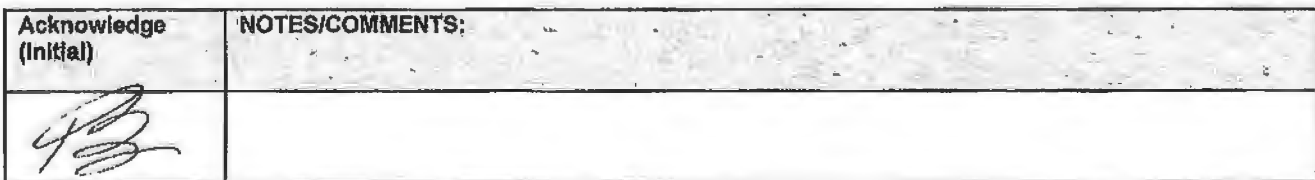
The Subrecipient may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State's obligation to pay amounts due on the subaward for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the subaward with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Subrecipient written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Subrecipient shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date for noncancelable obligations properly incurred by Subrecipient prior to termination, and costs incurred on, or prior to, the termination date.

H. ACCESS TO RECORDS



Acknowledge (Initial)	NOTES/COMMENTS:

Subrecipient shall provide access for DHHS, or its authorized representative, to any documents, papers, or other records pertinent to Subaward, in order to make audits, examinations, excerpts, and transcripts. The Subrecipient shall provide the same access to the Federal Funding Agency, the Inspectors General, the Comptroller General of the United States, or any of their authorized representatives. These rights also includes timely and reasonable access to Subrecipient's personnel for the purpose of interview and discussion related to such documents, papers

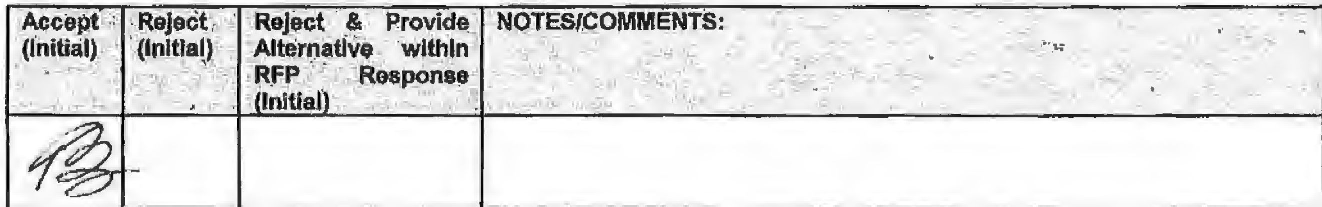
or other records. These rights are not limited to the retention periods included herein but continue as long as the records are retained by Subrecipient.

Subrecipient shall comply with all federal retention requirements as amended from time to time and shall maintain all financial records, supporting documents, statistical records, and all other records pertinent to Subaward, for three (3) years from the date of submission of the final financial report, as provided in Section V.M. .Reporting Requirements.

In addition to the foregoing retention periods, all records must be retained as specified in 45 CFR §§ 75.361 (a) through (f), as applicable. This includes, but is not limited to: if any litigation, claim, or audit is started before the expiration of the three (3) year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken.

Records that fall under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and all associated rules and regulations, including but not limited to the policies and procedures identified in 45 CFR § 164.316, shall be maintained for six (6) years from the date of their creation or date when the policy or procedures were last in effect.

I. AUDIT REQUIREMENTS



Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
[initials]			

The Subrecipient shall comply with all applicable federal audit requirements, including but not limited to those in 45 CFR § 75 Subpart F; an audit required by these regulations must be prepared and issued by an independent auditor in accordance with generally accepted government auditing standards. A copy of the audit is to be made electronically available or sent to: Nebraska Department of Health and Human Services, Financial Services, and P.O. Box 95026, Lincoln, NE 68509-5026.

Subrecipient shall comply with 45 CFR §§ 75.508 through 75.512, including but not limited to: (a) procure or otherwise arrange for the audit required by this part in accordance with § 75.509, and ensure it is properly performed and submitted when due in accordance with § 75.512; (b) prepare appropriate financial statements, including the schedule of expenditures of Federal awards in accordance with § 75.510; (c) promptly follow up and take corrective action on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan in accordance with § 75.511; (d) provide the auditor with access to personnel, accounts, books, records, supporting documentation, and other information as needed for the auditor to perform the audit required by law.

In addition to, and in no way in limitation of any obligation in this Subaward, Subrecipient shall be liable for audit exceptions, and shall return to DHHS all payments made under this Subaward for which an exception has been taken or that has been disallowed because of such an exception, upon demand from DHHS.

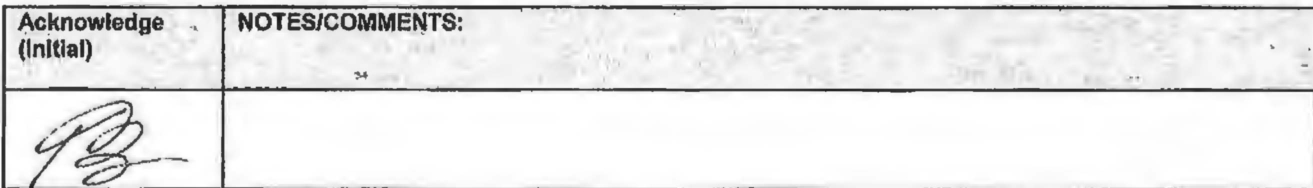
The Subrecipient shall maintain its accounting records in accordance with generally accepted accounting principles. DHHS reserves the right to require Subrecipient to submit required financial reports on the accrual basis of accounting. If Subrecipient's records are not normally kept on the accrual basis, Subrecipient is not required to convert its accounting system but shall develop and submit in a timely manner such accrual information through an analysis of the documentation on hand (such as accounts payable).

J. FEDERAL FINANCIAL ASSISTANCE

Acknowledge (Initial)	NOTES/COMMENTS:
[initials]	

The Subrecipient shall comply with all applicable provisions of 45 C.F.R. §§ 87.1-87.2. The Subrecipient certifies that it shall not use direct federal financial assistance to engage in inherently religious activities, such as worship, religious instruction, and/or proselytization.

K. SMOKE FREE PROVISIONS



Acknowledge (Initial)	NOTES/COMMENTS:
[initials]	

SMOKE FREE. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds in Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The Subrecipient certifies that the Subrecipient will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

L. HUMAN TRAFFICKING PROVISIONS

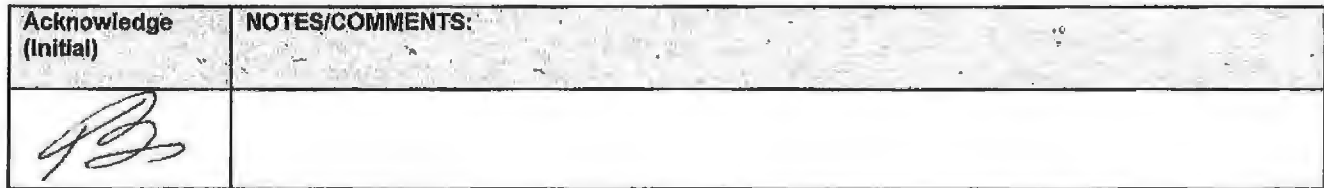
Acknowledge (Initial)	NOTES/COMMENTS:
[initials]	

The Subrecipient shall comply with and be subject to the requirements of the Trafficking Victims Protection Act of 2000, 22 USC §§ 7101 et seq.

The Subrecipient, its employees, any subcontractors or Second Tier Subrecipients under this award, and Second Tier Subrecipients' or subcontractors' employees may not:

1. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
2. Procure a commercial sex act during the period of time that the award is in effect; or
3. Use forced labor in the performance of the subaward.

M. LOBBYING



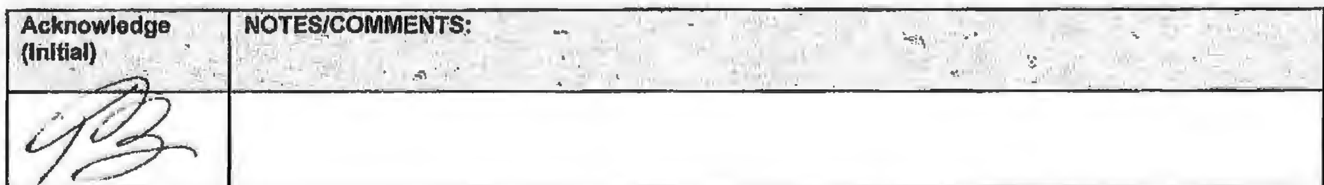
Acknowledge (Initial)	NOTES/COMMENTS:
[initials]	

1. No federal or state funds paid under this Subaward shall be paid for any lobbying costs as set forth herein.
2. Lobbying Prohibited by 31 U.S.C. § 1352 and 45 CFR §§ 93 et seq, and Required Disclosures.
   a. Subrecipient certifies that no federal or state appropriated funds shall be paid, by or on behalf of Subrecipient, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this award for: (a) the awarding of any federal agreement; (b) the making of any federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any federal agreement, grant, loan, or cooperative agreement.
   b. If any funds, other than federal appropriated funds, have been paid or will be paid to any person for influencing or attempting to influence: an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with Subaward, Subrecipient shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. Lobbying Activities Prohibited under Federal Appropriations Bills.
   a. No funds under Subaward shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any state or local government itself.
   b. No funds under this Subaward shall be used to pay the salary or expenses of any grant or subaward recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive legislative relationships or participation by an agency or officer of an State, local or tribal government in policymaking and administrative processes within the executive branch of that government.
   c. The prohibitions in the two sections immediately above shall include any activity to advocate or promote any proposed, pending or future federal, state or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale of marketing, including but not limited to the advocacy or promotion of gun control.

4. Lobbying Costs Unallowable Under the Cost Principles. In addition to the above, no funds shall be paid for executive lobbying costs as set forth in 45 CFR § 75.450(b). If Subrecipient is a nonprofit organization or an Institute of Higher Education, other costs of lobbying are also unallowable as set forth in 45 CFR § 75.450(c).

N. MANDATORY DISCLOSURES



Acknowledge (Initial)	NOTES/COMMENTS:
[initials]	

The Subrecipient must disclose to the State, in a timely manner and in writing, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting this subaward in accordance with 2 CFR

§200.113. Failure to make required disclosures can result in any of the remedies described in §200.338 Remedies for noncompliance, including suspension or debarment. (See also 2 CFR part 180 and 31 U.S.C. 3321).

O. PUBLICATIONS

Acknowledge (Initial)	NOTES/COMMENTS:

Subrecipient must acknowledge federal and DHHS funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with federal and DHHS funds. Subrecipient is required to state: (1) the percentage and dollar amounts of the total program or project costs financed with federal and DHHS funds; and (2) the percentage and dollar amount of the total costs financed by nongovernmental sources.

P. DEBARMENT, SUSPENSION OR DECLARED INELIGIBLE

Acknowledge (Initial)	NOTES/COMMENTS:

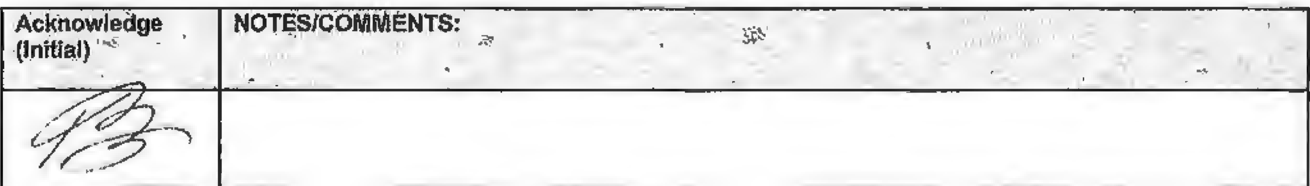
The Subrecipient certifies that neither it nor its principals are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any state or federal department or agency. The Subrecipient certifies that it is registered with the System of Award Management (SAM) (https://www.sam.gov), in good standing, and that the entity will maintain annual certification in accordance with Federal Acquisition Regulations. Failure to comply with this section, including maintaining an active registration and/or good standing with SAM, may result in withholding of payments or immediate termination of the subaward.

Q. RESEARCH

Acknowledge (Initial)	NOTES/COMMENTS:

The Subrecipient shall not engage in research utilizing the information obtained through the performance of Subaward without the express written consent of DHHS. The term "research" shall mean the investigation, analysis, or review of information, other than aggregate statistical information, which is used for purposes unconnected with this Subaward.

R. SUBRECIPIENTS OR CONTRACTORS UNDER THIS SUBAWARD



Acknowledge (Initial)	NOTES/COMMENTS:

In contracting or subawarding any portions of this subaward, Subrecipient shall follow 45 CFR §§ 75.327 through 75.335. If Subrecipient enters into a subaward (as defined by 45 CFR § 75.2) with any non-federal entity (also as defined by 45 CFR § 75.2) out any portion of this subaward, Subrecipient shall monitor the subaward as necessary

to ensure that the subaward is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward; that subaward performance goals are achieved. As applicable, Subrecipient shall follow the requirements for pass-through entities, including but not limited to 45 CFR § 75.352.

Subrecipient shall maintain copies of all procurement subawards and documentation of its compliance with the provisions cited above.

Subrecipient shall ensure that all subcontractors and Second Tier Subrecipients comply with all requirements of this subaward and applicable federal, state, county and municipal laws, ordinances, rules, and regulations.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this RFP.

A. PROJECT OVERVIEW

The State of Nebraska, DHHS is issuing this RFP to solicit proposals from qualified bidders to provide Full Service Case Management, which includes the delivery of on-going case management and a continuum of services to children and families residing in Douglas and Sarpy counties (herein referred to as the Eastern Service Area). The objectives for the subaward are:

1. Delivering high quality case management to effectively serve child protection cases;

2. Results and accountability with managing and delivering prevention services that are Well-Supported, Evidenced-Based services in the Subrecipient's service continuum that integrate a strengthening families approach to build protective factors in families in accordance with the time periods stated in FFPSA;

3. Minimizing time in care and promoting reunification and/or adoption in 12 months or less;

4. Recruiting licensed Resource Family homes;

5. Retaining Resource Families for foster and adoptive placements;

6. Utilizing practice models that maximize Federal IV-E funds, and;

7. Identifying how the State benefits by utilizing a Subrecipient to provide case management services in these two counties.

8. The Subrecipient will develop an on-going case management model that:

    a. Effectively engages 100% of families referred for service;
    b. Operates in a culture of continuous quality improvement, as evidenced by data based decision-making and utilization of performance indicators and trend data;
    c. Trains all staff to be trauma-informed, culturally humble, and to build on strengths-based and utilizes family voice and choice in planning and service provision; and,
    d. Ensures 100% of families are applying for and accepting services available through public assistance programs such as Supplemental Nutrition Assistance Program (SNAP), Medicaid, Low Income Home Energy Assistance Program (LIHEAP), child care, and services available from non-profit and community organizations prior to the utilization of State General Funding for payment of services.

9. The Subrecipient will develop a continuum of services that will ensure:

    a. Service expenditures are Well-Supported evidenced-based service in their service continuum in accordance with the time periods specified in the FFPSA;
    b. Delivery to 100% of children and families during the time that DHHS is completing the Initial Assessment;
    c. Delivery to 100% of children and families during the time the Subrecipient is delivering on-going case management, which prevents out-of-home placements and that supports reunification and permanency;
    d. 100% of children served live at home safely, achieve permanency within timeframe of federal measures, and experience improved health and well-being as indicated using the North Carolina Family Assessment Scale;
    e. Utilize appropriate funding sources, such as private pay from the family, private insurance provided by the family, Medicaid, or Behavioral Health Regions for treatment services for 100% eligible individuals;
    f. At least 50% of all prevention service expenditures will meet the criteria of Well-Supported as outlined in the FFSPA; and,
    g. A network of recruited and retained licensed foster homes, such that there is a ratio of two beds in licensed foster homes for every child in care in the Service Area.

B. PROJECT ENVIRONMENT

1. Attachment Three - Service Area Monthly Summary Reports document – Eastern Service Area data includes the number of children and families served in Douglas and Sarpy counties by placement type.

2. DHHS will utilize the Subrecipient's service array to prevent children from being placed out of the family home during the time that DHHS is conducting the Initial Assessment of safety and risk.

3. DHHS is responsible for the care of state wards served under the terms of this subaward. Such ultimate authority cannot be delegated to other parties. DHHS reserves all rights and responsibilities.

4. DHHS may make referrals for service delivery during the time DHHS is conducting the Initial Assessment.

5. DHHS will be the final authority on all decisions related to case management.

6. DHHS reserves sole authority for:

   a. Staffing and operating the Child Abuse/Neglect Hotline system for community reporting of suspected child abuse/neglect;
   b. Conducting all Initial Assessments of safety and risk;
   c. Conducting Out-of-Home Assessments on accepted reports of child abuse/neglect allegations in out-of-home settings (including foster homes, daycare, group homes, and other facilities); and,
   d. Licensing of foster homes, child care providers, group homes, and other facilities.

7. DHHS is the sole authority for:

   a. Accepting all relinquishments of parental rights;
   b. Consenting to adoptions; and,
   c. Entering into guardianship and adoption subsidies.

8. DHHS reserves the right to:

   a. Review and approve case plans and court reports prior to the Subrecipient submitting them to the courts and legal parties;
   b. Provide legal support for legal staffing and to request early hearing or other motions;
   c. Approve all requests for placement changes;
   d. Approve all requests for case management transfers from the Eastern Service Area to another Service Area;
   e. Approve all requests for courtesy supervision to be delivered in the Eastern Service Area; and,
   f. Delegate authority to Subrecipient, where allowable by law, or rescind its delegated authority previously given to Subrecipient, at the discretion of DHHS.

9. DHHS will update the Eastern Service Area Operations Manual (Attachment Two) that outlines processes and responsibilities to ensure that the day-to-day operations in the Eastern Service Area are seamless throughout the life of the resulting subaward. The current Eastern Service Area Operations Manual is available for reference as Attachment Two.

10. Title IV-E foster care funds are an important funding source for states to provide foster care maintenance payments for eligible children.

    a. DHHS seeks to make accurate and timely reimbursement claims for Title IV-E foster care maintenance payments.
    b. When the state subawards to a child placing agency to perform administrative functions of the state, the state may claim federal financial participation through Title IV-E at the rate of fifty percent (50%) for administrative expenditures necessary for the proper and efficient administration of the foster care program, in accordance with the Families First Prevention Services Act.
    c. DHHS goal is to maximize the amount of Title IV-E funds claimed in this subaward.

11. This Subaward will involve both state and federal funds. Information about the federal funding for Federal Fiscal Year 2019, as required by 45 CFR § 75.352, is contained on Attachment One Award of Additional Funds. DHHS shall provide Subrecipient further funding information for future Federal Fiscal Years.

C. **PROGRAM REQUIREMENTS FOR ON-GOING CASE MANAGEMENT**

1. The Subrecipient must operate within a culture of continuous quality improvement, with a focus on ensuring that children are safe, achieving timely permanency, and experience improved health and enhanced well-being through the Subrecipients work with the family to meet the children's needs and prevent recurrence of maltreatment. The Subrecipient must operate a continuous quality improvement program.

2. The Subrecipient shall develop, deliver and manage a model of on-going case management which:

a. Recruits and retains a qualified workforce to respond to and serve the diverse needs of abused or neglected and at-risk families.

i. The role and function of on-going case management staff and the supervision of on-going case management staff must not be subcontracted by the Subrecipient. On-going case management must be performed by direct employees of the Subrecipient.
ii. Staff delivering ongoing case management and supervising ongoing case management must have at least a Bachelor's Degree from an accredited university or college in social work, psychology, counseling, human development, education, criminal justice or other related area. Another Bachelor's Degree combined with four years of case management or human services experience is also acceptable.
iii. The Subrecipient must maintain written verification of the employee's college education.
iv. The Subrecipient must hire a diverse workforce that reflects the population being served.
v. The Subrecipient must organizationally understand, recognize and respond to the effects of all types of trauma experienced by the case management workforce.

b. Trains staff on the knowledge, skills and abilities required to conduct and supervise case management.

i. The Subrecipient shall ensure staff receive initial training in a manner that consistent with Neb. Rev. Stat. § 68-1214, and maximizes IV-E training funds for the State. This training must be approved by DHHS.
ii. After initial training, all case managers shall successfully complete the DHHS formal assessment process to demonstrate competency prior to assuming responsibilities as a case manager. The formal assessment process shall include a written and oral evaluation of the case manager's knowledge and competency in case management and support services. The Subrecipient shall maintain record of each case manager's competency assessment.
iii. The Subrecipient shall provide 24 hours of annual professional development training for staff and document training attended in the staff's training record.
iv. The Subrecipient shall provide a monthly training calendar to DHHS.
v. The Subrecipient shall use best practice guidelines, approved by DHHS, to train staff in, to include but not limited to, Trauma Informed Care and Motivational Interviewing.

c. Uses the DHHS-approved assessment model (currently DHHS uses the Structured Decision Making® (SDM) assessment model) to include, but not limited to, the implementation of Safety Organized Practice model within the Eastern Service Area.
http://dhhs.ne.gov/children_family_services/Pages/Safety-Organized-Practice.aspx

i. The Subrecipient must conduct quality assurance reviews to ensure quality and timeliness of all assessments completed.
ii. The Subrecipient must develop a training plan and it must be approved by DHHS prior to implementation.

d. Coordinates, collaborates and communicates information sharing between individuals and agencies serving the child and family. At a minimum, this includes:

i. Child;
ii. Parents (custodial and non-custodial);
iii. Safety plan participants;
iv. The child's family members;
v. Resource Family parents or other temporary placement providers;
vi. Medical and dental providers;
vii. School representatives;
viii. Behavioral health providers;
ix. Law enforcement; and,
x. Legal parties in the court.

e. Creates a case plan during the course of service that:

i. Utilizes family voice and family choice.

a) Based on the assessment approved by DHHS (currently, Family Strength and Needs Assessment (FSNA)), the child/family selects the strategies and action steps to achieve outcomes;
b) Addressing the services and supports associated with the identified needs of the child and family;
c) Monitoring progress with and updating strategies and outcomes;
d) Reviewing and updating goals throughout the life of the case;
e) Using the DHHS-approved case plan and court report template. Information will be provided to the awarded Subrecipient; and,
f) Submitting the case plan and court report to DHHS for approval at least three (3) business days prior to the date the report is due to the court.

f. Creates a court report for court-involved cases. The court report shall:

i. Utilize family voice and choice;
ii. Articulate safety or harm statement clearly;
iii. Include Structured Decision Making assessments;
iv. Outline visitation plan if child does not live with either parents or siblings;
v. Address Child Support;
vi. Outline reasonable or active efforts;
vii. Address areas of well-being to include educational, physical/developmental, emotional, mental/behavioral, as well as cultural considerations;
viii. Provide a summary and recommendations to the court; and,
ix. Be submitted along with the case plan at least three (3) state business days prior to the date the report is due to the court.

g. Links children and families with informal and formal services and supports that:

i. Are the least restrictive community-based services, in the intensity required, designed to meet the child and family's needs.
ii. Develop and strengthen connections for children and their families with caring individuals who will support the child throughout life.
iii. Identify the community resources available to meet the needs of the family preventatively and in times of crisis prior to discharge from the child welfare system.

h. Ensures that youth transitioning to adulthood are provided appropriate Independent Living services. The Subrecipient shall develop and implement a system to record and report on the following:

i. Number of youth in the Subrecipient's program that are receiving Independent Living services;
ii. Number of youth referred to a subcontractor / Second Tire Subrecipient for Independent Living services;
iii. Number of youth eligible for Independent Living services but who are not receiving Independent Living services and the reasons for not providing services;
iv. Independent Living services that each eligible youth is receiving each month;
v. Monthly summary of any community planning the Subrecipient participates in to prepare youth to become self- sufficient.
vi. Awarded Subrecipient must submit the system plan and report template within thirty (30) days after award of Subaward.

3. Referrals for on-going case management will be made by DHHS. This is a no reject, no eject subaward. The Subrecipient must:

a. Accept and serve all children and families as of the date of the referral or court order, whichever is first; .
b. Serve children and families unconditionally regardless of diagnosis, history, presenting problems, family composition or behaviors;
c. Provide case management to families with children between the ages of 0 and 19 who are either court involved or referred from DHHS for voluntary in-home services;
d. Maintain the capacity 24 hours a day, every day of the year to receive and serve children and families referred by DHHS, and;
e. Collaborate with DHHS to ensure families experience a seamless transition from the Initial Assessment Unit to On-going Case Management.

4. On-going Case Management must utilize best practice guidelines that include the DHHS-approved safety assessment model (currently DHHS uses the SDM) and the DHHS approved collaborative practice approach (Safety Organized Practice). The Subrecipient must ensure that the array of services and supports are available and accessible to children and families in the Eastern Service Area. The services and supports must have sufficient capacity to:

   a. Assess the strengths and needs of children and families;
   b. Address the needs of children and families in order to create and sustain a safe home environment;
   c. Enable children to safely remain with their parents; and,
   d. Safely reunify children as expeditiously as possible.

5. The Subrecipient must exhaust all other options prior to placing a child outside the family home. When placements outside the family home must occur, the Subrecipient shall:

   a. Document why safety planning in home is not an option;
   b. Document why placement with the other parent is not appropriate;
   c. Provide a report to DHHS using the DHHS' preferred format that summarizes the decision to place the child outside the home or current placement and provides a justification for this decision including demonstrating that all other options were exhausted prior to placing a child outside the home or current placement;
   d. Identify and consider all relatives and kin first, as possible placement options including placement with any known sibling;
   e. Ensure appropriately safe parental visitations occur on a regular and consistent basis if the child is not living with a parent;
   f. Ensure appropriately safe relative and kin foster parents complete all activities required for licensing;
   g. Place siblings together when it is safe to do so. Document safety concerns if siblings are not placed together;
   h. Ensure sibling visitations occur on a regular and consistent basis when siblings are not placed together;
   i. Ensure the continuity of family relationships and preserve connections for the child that includes but is not limited to connections with his or her parents, neighborhood, community, faith, extended family, Tribe, school, and friends;
   j. Ensure that the out-of-home placement is the least restrictive placement and most family-like setting;
   k. Ensure that placements are in DHHS provisionally licensed foster homes or licensed foster homes or licensed facilities;
   l. Ensure provisionally licensed homes receive full licensure within six (6) months of placement.
   m. Ensure that the child continues to be educated in their school of origin or the school that will support the goal of improving the child's achievement. The Subrecipient shall consult with DHHS if the child will not be attending his/her school of origin or a school that does not support the improvement of the child's achievement in school; and,
   n. Ensure that the child has the most normal and developmentally appropriate experiences that are generally afforded to children not involved with the child welfare system.

D. PROGRAM REQUIREMENTS FOR SERVICE DELIVERY

1. The bidder shall develop and submit with their bid a catalogue of in-home services available in each zip code of the Eastern Service Area. This catalogue shall be updated by the Subrecipient and provided to DHHS every quarter.

2. Services will be accessed by DHHS to support child safety through vigorous safety planning with the identified safety plan participants and promote family preservation activities, which will prevent children from being removed from the family home.
3. The service array must include Well-Supported, Supported, and evidenced-based in-home and out-of-home services and supports that integrate a strengthening families approach to build protective factors and maintain compliance with FFPSA. The Subrecipient must manage and or deliver an array of services that:

   a. Is trauma-informed, trauma-capable;
   b. Is culturally humble and linguistically appropriate;
   c. Utilizes Well-Supported, Supported or promising practices to prevent children from entering foster care;

d. At least 50% of all service expenditures related to children and families designated to be at "imminent risk of removal" will be Well-Supported evidenced-based practices as approved by the Administration of Children and Families by the end of the first year of the subaward;
e. Effectively engage those receiving the services;
f. Is delivered in the family home, neighborhood and community where the child and family reside whenever possible;
g. Utilizes data to demonstrate effectiveness;
h. Supports cross-agency collaboration with two-generational or whole family approaches; and,
i. Is consistent with any orders issued by the court.

4. The Subrecipient must ensure that a sufficient capacity of trained resource families are available to foster and adopt children in the Eastern Service Area, to include developing and implementing specific strategies to recruit resource families for historically difficult to place children (teenagers and children with medical and behavioral challenges).

   a. The Subrecipient is required to expand the availability of trained foster and adoptive families in the Eastern Service Area during the terms of the subaward, as measured by a ratio of placements to children. The baseline and performance targets will be established and mutually approved prior to subaward execution. DHHS will provide reimbursement rates for Resource Family care to the Subrecipient. Please see Attachment Three: Service Area Monthly Summary Report.

5. The Subrecipient must deliver the services and supports to help youth successfully transition into adulthood.

6. The Subrecipient must ensure that the array of service and supports can be individualized to meet the unique needs of *children* being referred in both court and non-court cases. The unique needs of the child population being referred include, but is not limited to:

   a. Children ages birth to five (5);
   b. Infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from pre-natal drug exposure, or a Fetal Alcohol Spectrum Disorder;
   c. Children who have a developmental disability or who demonstrate behaviors consistent with children who have a developmental disability, including Autism Spectrum Disorder (ASD);
   d. Children who have been exposed to domestic violence;
   e. Children who have extensive histories of trauma;
   f. Children who have limited connections with supportive adults;
   g. Youth that intersect with both the child welfare and juvenile justice systems;
   h. Youth who are pregnant or parenting foster youth;
   i. Youth identified as survivors of sex trafficking; and,
   j. Youth who are near the age of majority and preparing to transition to adulthood.

7. The Subrecipient must ensure that the array of service and supports can be individualized to meet the unique needs of the *parents* being referred. The unique needs of this population include, but are not limited to:

   a. Parents who have extensive histories of trauma;
   b. Parents experiencing stress, particularly caused by poverty;
   c. Parents who have mental health and substance use disorders or co-occurring disorders;
   d. Parents who have been impacted by domestic violence;
   e. Young parents with very limited parenting knowledge and skills;
   f. Parents who may be resistant to engaging with traditional service delivery models; and,
   g. Parents who are currently incarcerated or reside in institutional settings.

8. The Subrecipient must effectively manage a service array within a culture of continuous quality improvement to ensure that:

   a. A single point of contact for referrals to be made at all times;
   b. Sufficient service capacity is available to service the children and families being referred;
   c. Services are geographically accessible to the children and families being served;
   d. Services are delivered with appropriate frequency, intensity and duration;
   e. Collaboration occurs with community-based and other child-serving agencies, including Medicaid Managed Care Organizations, the Regional Behavioral Health Authorities, public and private schools, public health clinics, community advocates and other interested parties, to ensure that

families are able to access and engage in the services and supports they need during and after formal child welfare system involvement. The Subrecipient shall report to DHHS any Medicaid Managed Care Organization that it believes is non-compliant with case management duties, network adequacy, or ensuring appropriate care delivery to the state Medicaid Program and CFS;

f. Eligible families are assisted with accessing the services and supports offered through DHHS's Division of Children and Family Services Economic Assistance Programs such as SNAP; LIHEAP; Temporary Assistance for Needy Families (TANF) and Emergency Assistance;

g. All available and existing community resources available to the child and family must be exhausted before Subrecipient charges the costs of any activity to this Subaward;

h. An application is made through ACCESSNebraska for both public assistance and Medicaid prior to discharge of a child or family.

i. A complete and accurate application is made to Social Security and the DHHS Division of Developmental Disabilities for children or adults who are disabled;

j. Providers of services will provide information through written documentation or oral testimony for court proceedings, as requested;

k. Service array and rates associated with the service array are equal to or lower than rates paid to other providers contracted by DHHS, Current rates will be provided to awarded Subrecipient; and,

l. State and federal funds will only be expended on items within the scope of the subaward, including, but not limited to case management and services.

9. Subrecipient must provide courtesy supervision of cases that transfer from other service areas outside of the Eastern Service Area, to ensure safety and monitoring of safety plans.

E. ADMINISTRATIVE REQUIREMENTS

1. The Subrecipient shall collaborate with DHHS to ensure families experience a seamless and well-coordinated transition from the Initial Assessment unit to on-going case management.

2. The Subrecipient must provide all in-state and out-of-state transportation related to the Subrecipient's primary business of serving children and families. Please see Attachment Seven, Estimated Mileage FY 2018.

   a. The Subrecipient must ensure that it complies with all applicable Public Service Commission regulations and requirements to the extent they apply to the Subrecipient's activities in the performance of this subaward. Nebraska Public Service Commission website: http://www.psc.nebraska.gov/.

   b. The Subrecipient must make a reasonable effort to maintain consistency in the individual driver(s) providing transportation and/or a transportation escort for the child.

   c. The Subrecipient must provide secure transportation when necessary.

3. The Subrecipient shall complete a Social Security Administration Access Agreement.

4. Grievance Process

   a. The Subrecipient must develop and distribute written guidance to families and Resource Family care families on how to lodge grievances about the Subrecipient and any actions related to the performance of the subaward.

   b. The grievance process must conform to Neb. Rev. Stat. § 81-603 in that the process shall ensure that families are not dissuaded from utilizing the complaint process for fear of reprisal from the Subrecipient, Second Tier Subrecipients, or foster parents.

   c. The Subrecipient must respond to grievances within ten (10) State business days related to the performance of this subaward.

   d. The Subrecipient must maintain a file of all grievances and responses thereto related to the performance of this subaward.

5. Background Checks for Agents, Employees, Interns, Volunteers, Second Tier Subrecipients or Subcontractors:

   a. The Subrecipient must complete and maintain the initial background checks before any agents, employees, interns, volunteers, Second Tier Subrecipients or subcontractors have direct unsupervised contact with any child or family, and every two years thereafter.

   b. The Subrecipient must ensure, at a minimum, the following background checks have been completed on all agents, employees, interns, volunteers, Second Tier Subrecipients and subcontractors:

i. Nebraska Sex Offender Registry maintained by the Nebraska State Patrol;
ii. Nebraska Child Abuse and Neglect Central Registry;
iii. Nebraska Adult Abuse and Neglect Central Registry;
iv. Nebraska Department Motor Vehicles Check for License Point Status;
v. Criminal Background Check; and,
vi. Drug Test for staff providing case management, and staff providing transportation to children and families under this subaward.

c. The Subrecipient must ensure, at a minimum, the following background checks have been completed on all agents, employees, interns, volunteers, Second Tier Subrecipients and subcontractors who have been employed or resided in Nebraska for less than five (5) years if it is foreseeable that the individual may have contact with children and families in the performance of this subaward. If an individual's prior state of residence does not maintain a Sex Offender Registry, Child Abuse and Neglect Central Register, an Adult Abuse and Neglect Central Registry, or a similar registry, the Subrecipient shall complete criminal background checks in the cities, counties and states of previous residence. The Subrecipient must perform the following in the individual's prior states of employment or residence:

i. Criminal history check for each state in which the individual resided or worked;
ii. Sexual Offender Registry;
iii. Child and Adult Abuse and Neglect Central Register/try; and,
iv. State repository of driving records.

d. The Subrecipient must ensure, at a minimum:

i. When a background check results in any non-traffic record being identified, the Subrecipient shall not allow the individual to have direct unsupervised contact with any child and will develop a process to review and determine if it wants to request DHHS approval for an agent, employee, intern, volunteer, Second Tier Subrecipients or subcontractor to have direct unsupervised contact with a child or family referred by DHHS. Requests for an exception shall be made in writing to DHHS and include but not limited to, the name and background information, along with supporting documentation from the Subrecipient as to why Subrecipient believes that such person does not pose a threat to children or families. DHHS shall have ten (10) state business days to respond to such a request. Failure to respond shall not constitute approval by DHHS. All documentation related to the process is maintained in the Subrecipient's staff personnel records.
ii. All required background checks for each employee must be completed before any direct contact with children and their families, and every two (2) years from the date of hire; and,
iii. All background check documentation must be maintained in staff personnel records. This includes documentation requested and received from states other than Nebraska.

e. The Subrecipient shall be responsible for transporting children and families, and shall ensure that children and family members are transported safely and in accordance with Nebraska law, and will:

i. Ensure each employee who has the responsibility to transport children has successfully completed a defensive driving course as sanctioned by the Nebraska Safety Council or similar agency within thirty (30) business days of his or her first day of employment with the Subrecipient.
ii. Adhere to 474 NAC 5-018.06D1 Driver Standards.
iii. Provide transportation as outlined in the Provider Service Referral provided by DHHS or a Visitation Plan approved by the court.; and,
iv. Provide and use child safety restraints in accordance with Nebraska law.

6. The Subrecipient shall cooperate with performance reviews that focus on the quality of the day to day operations and financial performance of the Subrecipient.

7. Performance-Based Contracting:

a. The Subrecipient is required to enter into performance-based contracts with child welfare service providers to incentivize improved performance outcomes, including those in V.L. Retainage and Performance Measurements

b. The percent of the Subrecipient's subcontracted expenditures that are required to be performance-based will be mutually agreed upon prior to execution of subaward.

8. Subcontractors and Second Tier Subrecipients:

   a. The Subrecipient must appropriately determine whether the relationship between it and any entity is appropriately a contract with a subcontractor or a subaward with a Second Tier Subrecipient, as consistent with 45 CFR § 75.351.
   b. In subcontracting any portions of Subaward, Subrecipient shall follow 45 CFR §§ 75.327 through 75.335, as applicable.
   c. If subawarding out any portion of Subaward to a Second Tier Subrecipient, Subrecipient must also implement a competitive application process for any Second Tier Subrecipient. Subrecipient shall monitor the subaward as necessary to ensure that the subaward is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward, as well as that subaward performance goals are achieved. As applicable, Subrecipient shall follow the requirements for pass-through entities, including but not limited to 45 CFR § 75.352.
   d. The Subrecipient must ensure that information retained by any subcontractor or Second Tier Subrecipient meets state and federal legal requirements, and will be available to DHHS upon request. This includes, but is not limited to, financial information and source documentation of subcontractors or Second Tier Subrecipients for Title IV-E reimbursement and audit purposes, as well as copies of all subaward agreements and documentation, and procurement contracts and documentation of its compliance with 45 CFR §§ 75.327 through 75.335.
   e. Subrecipient must not allow a subcontractor or Second Tier Subrecipient to further subcontract for services, other than foster family care, under this subaward.
   f. The Subrecipient must ensure that subcontractors or Second Tier Subrecipients meet all background check requirements.
   g. Subcontractors and Second Tier Subrecipients must work collaboratively with the agencies identified as Nebraska's Managed Care Organizations (MCO) to provide health care benefits and services to Medicaid and Children's Health Insurance Program (CHIP) enrollees. Providers delivering treatment services must be enrolled and sustain membership with the MCO.
   h. The Subrecipient must receive prior written approval from DHHS before executing contracts or subawards with Subcontractors or Second Tier Subrecipients, and must make available, upon request by DHHS within ten (10) state business days of the request, a listing of the names of all subcontractors or Second Tier Subrecipients; the services all subcontractors or Second Tier Subrecipients provide; and the rates for all services paid by the Subrecipient to all subcontractors or Second Tier Subrecipients.
   i. The Subrecipient must receive prior written approval from DHHS before Subrecipient, subcontractor or Second Tier Subrecipients engage in the practice of assessing or collecting client fees or co-pays for services.

9. The Subrecipient shall assist and cooperate with the orderly transition and transfer of subaward activities and operations to prevent the disruption of services delivered to children and families.

10. The Subrecipient will develop and implement a transition plan in the event this subaward reaches its term. As part of the transition plan, the Subrecipient shall:
   a. Outline and implement appropriate preparations for a successor agency;
   b. Outline and implement plans for:

      i. Staffing;
      ii. Use and transition of equipment;
      iii. Transition of case management to successor agency;
      iv. Migration of any data owned by the DHHS; and,
      v. Dispute resolution between DHHS and Subrecipient in regards to cases, case loads, and reimbursement for services.

11. Subrecipient's obligations under this subaward will continue throughout the term of the subaward even if Subrecipient's actual and allowable costs exceed the Annual Do Not Exceed Amount (see Cost Proposal) These obligations include, but are not limited to, accepting new referrals from DHHS and service all children, youth, and families according to the terms of this subaward and well as a material increase in families served.

F. **TRANSITION AND IMPLEMENTATION**

1. Preliminary Implementation Plan:
The Bidder shall be responsible for submitting a preliminary implementation plan with its proposal. The plan must describe the Subrecipient's plan to comply with all the provisions of the RFP. The plan must also address staffing, facilities, and other operational issues as identified in the RFP, including tasks, deliverables and milestones necessary to implement the program.

2. Transition after Termination:
At the end of the subaward term or other subaward termination, Subrecipient will aid in the transition to any new arrangement or provider of services. The respective accrued interests or obligations incurred to date of termination must also be equitably settled. Upon termination or expiration of this subaward, DHHS will work with Subrecipient to transfer all services as efficiently as possible with the goal to have all necessary services transferred by the effective date of the expiration or termination of the subaward. However, in the event that a transfer of all necessary services is not possible, Subrecipient will continue to provide necessary services in accordance with all terms and conditions of this subaward until all necessary client services are completely transferred.

G. **READINESS REVIEW**

1. Prior to the Operational Start Date, DHHS will conduct an operational and financial readiness review of the Subrecipient, and will provide needed technical assistance. The Subrecipient must cooperate with DHHS's review process to assess the Subrecipient's operational readiness and ability to provide covered services to children and families as of the Operational Start Date. The Subrecipient will be permitted to commence operations only if the readiness review factors are met to DHHS's satisfaction.

   Based on the results of the review, DHHS will issue a letter of findings and, if necessary, request a corrective action plan from the Subrecipient.

   The readiness review may cover all provisions of the subaward with a particular focus on assessing the following areas:

   a. The adequacy of the distribution of providers for in-home and Resource Family care services;
   b. Staffing adequacy;
   c. Subcontracts / subawards;
   d. Quality assurance/continuous quality improvement;
   e. Case management;
   f. Utilization management;
   g. Financial management;
   h. Information processing and system testing;
   i. Continuity of care;
   j. Grievance and appeal process; and,
   k. During the readiness review, the Subrecipient must provide to DHHS staff access to Subrecipientstaff, operational documentation (including a demonstration of computer systems), private workspace, and the internet.

2. If the Subrecipient is unable to demonstrate its ability to meet the requirements of this subaward, as determined by DHHS, within the time frames specified by DHHS, DHHS may terminate this subaward.

H. **FINANCIAL REQUIREMENTS**

1. Cost Allocation Plan/Administrative Expenditures:
   a. The Subrecipient shall complete and submit a final Cost Allocation Plan to DHHS within ninety (90) days of Operational Start Date that outlines the administrative functions performed by the Subrecipient, and the plan for allocating the costs of performing those functions to activities or programs supported by the costs incurred. The Cost Allocation Plan and methodology shall be submitted to enable DHHS to claim federal administrative funds under Title IV-E. The document shall be in a format prescribed by DHHS. The Cost Allocation Plan will, at a minimum, include cost pools, allocation methodologies, and benefitting programs. The Subrecipient must input paid administrative expenditures that tie to its Cost Allocation Plan, and submit supporting financial documents as requested by DHHS, to include but not be limited to, payroll records, subcontracted expenditures, and operating expenditures on a monthly basis by no later than thirty (30) calendar days following the month expenditures were incurred. The Subrecipient must complete a monthly centralized random moment time study or other time tracking method as consistent with 45 CFR §§ 75 et seq. , developed and administered by the Subrecipient. The bidder shall submit a draft Cost Allocation Plan of development and implementation of their random moment time study or

other time tracking method with their proposal response. DHHS reserves the right to require the Subrecipient to implement and maintain a random moment time study.

b. The Cost Allocation Plan and methodology shall be consistent with all requirements of the Title IV-E program, and be in furtherance of all program objectives, as set forth by DHHS. Subrecipient shall modify its Cost Allocation Plan and/or methodology at least annually or within thirty (30) calendar days of written notice by DHHS of a modification or amendment that will ensure the maximization of federal dollars. DHHS will review and approve all modifications.

2. Additional DHHS Financial Requirements:

a. Monthly, DHHS will select a sample of individual expenditures and test for allowability and reasonableness, and that they are allocated to the correct funding source.

b. Annually, DHHS will complete a comprehensive on-site review of the Subrecipient's financial information; including additional expenditure testing, allocation of expenditures to the correct fund source, and review of financial and subcontract / subaward monitoring policies.

3. Source Documentation/Service Expenditures:

a. The Subrecipient and Second Tier Subrecipients must separate direct Resource Family care payments from other service delivery expenses and keep records of direct Resource Family care payments that are readily reviewable and traceable to source documentation in a format acceptable to DHHS including, but not limited to, payments to foster parents by check, electronic funds transfers, or other payment types.

b. The Subrecipient must develop and maintain a plan to track, report, and retain all information needed for Title IV-E foster care maintenance claiming. The Subrecipient shall do the following:

i. Provide all necessary documentation to establish the child's initial and ongoing eligibility for Title IV-E, including, but not limited to:

a) A completed copy of the Income and Resources Data (IM-18FC) form;

b) Financial and third party liability information related to the child, his or her parents, and all related family members living in the child's household;

c) Documentation of the child's status related to citizenship, such as a birth certificate or verification of lawful permanent residency;

d) A copy of the first court order pertaining to the child's physical removal from the parent or specified relative home;

e) A copy of the petition leading to the first court order pertaining to the child's removal, and any documentation referenced in the order; and

f) All subsequent court orders during the child's out-of-home placement.

ii. Provide all necessary documentation to establish that the service meets the criteria for a "foster care maintenance payment" in 42 U.S.C. 675];

iii. Provide all necessary documentation to establish that the placement resource meets the criteria for payment from Title IV-E funds. If the Subrecipient utilizes an out-of-state placement resource, the Subrecipient must secure and supply a copy of the license of the home or facility, if applicable, to DHHS and must cooperate with DHHS in obtaining other information needed to determine eligibility for payment from Title IV-E funds;

iv. Ensure that all requirements of Title IV-E pertaining to children for whom payment is requested are met;

v. At the request of DHHS, provide additional information, to enable DHHS to carry out its oversight and administrative responsibilities, including federal reviews and audits, state reviews and audits, and quality assurance reviews. The additional information shall be provided to DHHS within three (3) state business days of a written request by DHHS.

c. The Subrecipient shall input documentation for services provided to children and families in the DHHS N-FOCUS or successor computer system using a format prescribed by DHHS. The Subrecipient shall input documentation for all services provided, except ongoing case management activities, at its discretion but no later than forty-five (45) calendar days following the end of the month in which the service was provided. The documentation must be readily reviewable and traceable to source documentation and reconcile to Subrecipient's financial statements so as to qualify for Title IV-E claiming. The obligation to provide documentation to DHHS, including but not limited to, source documentation of all services provided shall survive the expiration or termination of this subaward. The required format will be provided to the awarded Subrecipient.

d. The Subrecipient must adjust its financial statements related to direct services if the paid claims change.

4. Foster Care Rates

a. In accordance with Neb. Rev. Stat. § 43-4215, on July 1, 2014 DHHS implemented new foster care reimbursement rates and methodology. DHHS will provide foster care rates to the Subrecipient, as well as any change in rates. The Subrecipient and Second Tier Subrecipients shall pay foster families using the rate methodology and same foster care maintenance rate paid to foster families by DHHS. Please see Attachment Five – Foster Care Reimbursement Rate Committee. The Subrecipient and Second Tier Subrecipient's shall pay child placing agencies using the same rate methodology and same administrative rate paid to child placing agencies for each child as determined by DHHS. DHHS reserves the right to revise the administrative rate to ensure that it remains a reasonable match with actual administrative costs.

b. To pay any foster parent at a rate exceeding the rates used by DHHS, Subrecipient must first submit a written request to exceed payment rates to DHHS. DHHS shall consider approving a rate higher than its foster parent rates in instances where the child has unique medical or behavioral needs, or a disability. DHHS must approve any proposed foster parent rates above the DHHS rates.

5. All other costs not listed in V.H13 below, and that are associated with the performance of this subaward, are the responsibility of the Subrecipient. This includes, but is not limited to: court ordered services for which Subrecipient is unable to secure alternate funding sources; and assistance with funeral costs, if requested by family or legal guardian, for any child who dies while in the legal custody of DHHS or while being actively served under this subaward without court involvement.

6. The Subrecipient shall follow all state and locally developed policies and protocols related to the authorization for the purchase of services for children, youth and families being served. This includes, but is not limited to, accessing other payment sources prior to utilizing child welfare or juvenile services funds. Said policies and protocols are currently available at: http://dhhs.ne.gov/children_family_services/.

7. Payment Timeliness

a. The Subrecipient shall make payment in full to the Subcontractors or Second Tier Subrecipients for all goods delivered or services rendered on or before forty-five (45) calendar days after the date of receipt by the Subrecipient of an invoice meeting the Subrecipient's requirements, as set forth in Subrecipient's written policy, protocol or contract / subaward terms with the Subrecipient. Payment to treatment Subrecipients that are delayed due to coordination of benefits with insurance providers will be paid on or before 180 calendar days after receipt of an invoice as described above. Nothing in this subaward is intended to create a third party beneficiary relationship with Subrecipients.

b. Notwithstanding the above, Subrecipient must make all payments before the final deadlines set forth in Section II.N. Contract and Grant Close-Out,

c. These provisions shall survive expiration or termination of the subaward.

8. Financial Statements

a. The Subrecipient shall provide monthly financial statements to DHHS within thirty (30) calendar days from the end of the month services were provided. The financial statements will include a balance sheet, income statement, and statement of cash flows in a format to be agreed upon during subaward negotiations. The financial statements will be prepared using the accrual basis of accounting and using Generally Accepted Accounting Principles (GAAP).

b. Thirty (30) calendar days following the end of each month, beginning thirty (30) days after Operational Start Date, an aging of accounts payable must be provided by Subrecipient to DHHS. The accounts payable aging will be consistent with the monthly financial statements provided to DHHS and list by subcontractor / Second Tier Subrecipient the amount owed to each vendor and: what portion of the amount owed has been due less than 30 days; what portion has been due between 30 days and 59 days; what portion has been due between 60 days and 89 days; what portion has been due between 90 days and 119 days; and what portion has been due 120 days or longer. In addition, a reconciliation of accrued expenses to the balance sheet must also be provided each month and year to DHHS. Nothing in this section is intended to limit access to Subrecipient's records and information as provided elsewhere in this subaward and the terms of this section shall survive expiration or termination of this subaward.

9. Equipment Costs.

   a. In addition to the requirements contained in 45 CFR § 75.439 regarding equipment, Subrecipient shall not make purchases of equipment in excess of an aggregate amount of $25,000 (twenty five thousand dollars), unless DHHS has approved, in writing, prior to the purchase. Subrecipient shall not split or divide an equipment purchase into two or more purchases under $25,000 for the purpose or intent of avoiding this requirement. Subrecipient must submit any such approval request in writing to the Director of the Division of Children and Family Services, who will respond to Subrecipient's request in writing within fifteen (15) days after receipt thereof.

10. Bonus, Gift or Other Payment of Funds to Employees

   a. The Subrecipient must obtain prior written approval from DHHS before issuing any bonus, gift, or other payment of funds beyond base pay or salary and the Subrecipient's normal employee benefit package provided to an employee, or prospective employee, which is paid from funds provided under this subaward. Subrecipient must submit any such approval request in writing to the Director of the Division of Children and Family Services, who will respond to Subrecipient's request in writing within fifteen (15) days after receipt thereof.

11. Marketing and Advertising Costs

   a. The Subrecipient specifically agrees that no advertising costs shall be paid from the funds provided under this subaward unless those advertising costs are consistent with 45 CFR § 75.421. In clarifying the application of subparagraph (b)(4) of 75.421 to this subaward, only informational or educational material regarding services being rendered or required under this subaward are allowable under said provision.

12. Dues and Membership Costs

   a. Subrecipient's dues and memberships in any business, technical, or profession organization, or any civic or community organization, must be approved by DHHS before the Subrecipient pays or commits to pay for such dues and membership, and must be consistent with the 45 CFR § 75 Subpart E. Employee dues and membership organizations are fringe benefits and should be approved according to the first paragraph of this subsection. Subrecipient must submit any such approval request in writing to the Director of the Division of Children and Family Services, who will respond to Subrecipient's request in writing within fifteen (15) days after receipt thereof.

13. Subrecipient not responsible for payment of the following:

   a. Medical and Mental Health Services paid by Medicaid, private insurance or alternative funding source for children and parents served under this subaward;
   b. Services funded by State Ward Education;
   c. Maintenance cost for youth placed in the Youth Rehabilitation and Treatment Center at Kearney and Geneva;
   d. Adoption and Guardianship Subsidies, and;
   e. Case management and extended services for a young adult who has entered into a voluntary services and support agreement under the Bridge to Independence Program, except those requirements under said program that should be performed prior to the time the young adult reaches 19 years of age and is discharged from Resource Family care.

I. FEDERAL AND STATE LEGAL AND POLICY REQUIREMENTS

1. The Subrecipient must abide by all policy requirements of Nebraska Administrative Code; applicable state and federal statutes and regulations; any other applicable codes; applicable program guidance and administrative memos; and applicable written policy directives and interpretations from, or as directed by, DHHS.

2. In addition to the federal law cited above in section III.C., Compliance With Civil Rights Laws And Equal Opportunity Employment / Nondiscrimination, Federal Laws include also include but are not limited to:

   a. Title IV of the Social Security Act, 42 U.S.C. §§ 601 – 687;
   b. Regulations regarding the Title IV-E Program at 45 CFR §§ 1355 et seq. and 45 CFR §§ 1356 et seq., 45 CFR §§ 1357 et seq.;
   c. The Health and Human Services Grant Guidance, 45 CFR §§ 75 et seq.;
   d. P.L. 114-22 Justice for Victims of Trafficking Act of 2015;

e. Preventing Sex Trafficking and Strengthening Families Act, at 5 U.S.C. §§ 552, 20 U.S.C. § 1001, 25 U.S.C. § 450b, 28 U.S.C. § 1738B and 534, 42 U.S.C. §§ 1301, 1315, 622, 627, 652, 653, 654, 654a, 659a, 664, 666, 670, 671, 673, 673b, 675, 677, 679 and 679b;
f. Child and Family Services Improvement and Innovation Act at 42 U.S.C. 1305;
g. CAPTA Reauthorization Act of 2010, 42 U.S.C. §§ 5101 et seq.; 42 U.S.C. §§ 5116 et seq.;
h. P.L. 110-351, Fostering Connections to Success and Increasing Adoptions Act of 2008;
i. P.L. 109-248, Adam Walsh Child Protection and Safety Act of 2006, codified at 34 U.S.C. § 20911;
j. P.L. 105-89, Adoption and Safe Families Act of 1997;
k. P.L. 95-608, Indian Child Welfare Act (ICWA) of 1978, 25 U.S.C. §§ 1901 – 1963;
l. P.L. 106-169, Federal Independent Living Requirements (John H. Chafee Foster Care Independence Act);
m. P.L. 103-277, Pro-Children Act of 1994, 20 U.S.C. §§ 6081 et seq.;
n. Pub.L. 114–95, Every Student Succeeds Act of 2017; and
o. Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.

3. Federal Policy includes but is not limited to:

a. HHS Grants Policy Statement, currently available at: https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf (or the current Grants Policy Statement, if a new one is issue during the term of this subaward);
b. General Terms and Conditions of Mandatory Formula, Block and Entitlement Grant Programs administered by the Administration for Children and Families, currently available at: https://www.acf.hhs.gov/sites/default/files/assets/general_terms_and_conditions_mandatory.pdf; and,
c. Any other applicable guidance from the Administration for Children and Families.

4. State Laws include but are not limited to:

a. Nebraska Juvenile Code, Neb. Rev. Stat. §§ 43-245 through 43-2,129;
b. Neb. Rev. Stat. § 68-1214;
c. Neb. Rev. Stat. § 43-4204:
   i. The Subrecipient must provide any and all necessary information, in a timely manner, requested by DHHS to complete any readiness assessment developed by DHHS. Said readiness assessment must, in part, assess the Subrecipient's readiness to execute contracts and begin preparations for any transition of case management services.
   ii. The Subrecipient shall not directly provide more than thirty-five percent (35%) of direct services required under this subaward;
d. Nebraska Indian Child Welfare Act, Neb. Rev. Stat. § 43-1502 through 43-1517;
e. Foster Care Review Act, Neb. Rev. Stat. §§ 43-1301 et seq.;
f. Court Appointed Special Advocate Act, Neb. Rev. Stat. §§ 43-3701 through 43-3720;
g. Licensing and Approval Requirements:
   i. All foster homes must be licensed or approved as defined in applicable policy, rules or regulations. DHHS will issue the license and is responsible for all licensing actions.
   ii. Subrecipient shall ensure that persons providing Resource Family Service are in compliance with applicable Nebraska law, including, but not limited to, Neb. Rev. Stat. § 71-1902; and,

h. Child Placement Practices:

   i. All placements must be documented in N-FOCUS or successor computer program within 72 hours of a child's placement except in situations beyond the control of Subrecipient. For excepted situations, Subrecipient must work with DHHS to document placement as soon as possible.
   ii. The Subrecipient shall obtain and maintain an active and ongoing Child-placing Agency license with DHHS, including the provision to license foster homes and relative foster homes.

5. Interstate Compacts

a. Interstate Compact on the Placement of Children.
   i. The Subrecipient must comply with the Interstate Compact on the Placement of Children (ICPC) process and policy regarding visiting state wards placed in other states.
b. Interstate Compact on Adoption and Medical Assistance (ICAMA).

6. Waiver Demonstration

   a. The Subrecipient must cooperate with DHHS with respect to any services or reporting required pursuant to the Title IV-E Waiver Demonstration Project Terms and Conditions and Initial Design and Implementation Report, as DHHS deems appropriate and applicable.

   b. The Subrecipient and all subcontractors or Second Tier Subrecipients must comply with provider performance improvement measures in accordance with the Title IV-E Waiver Demonstration Project Terms and Conditions and Initial Design and Implementation Report administered by DHHS. The Subrecipient must include performance measures, indicators, and outcomes in agreements with its subcontractors and Second-Tier Subrecipients that mirror those DHHS has with its Subrecipients. Any changes to the performance measures, additional agreement language that could affect the implementation of provider performance improvement measures, or any other programmatic changes with Subrecipients must be approved by DHHS, in writing, prior to implementation. The Subrecipient must oversee the implementation of provider performance improvement measures with its subcontractors or Second-tier Subrecipient's. The Subrecipient must ensure its subcontractors and Second Tier Subrecipient's enter all necessary data as prescribed by DHHS. The Subrecipient must provide all documentation and data necessary for the completion of the Title IV-E Waiver Demonstration Project evaluation.

J. **COST RECONCILIATON PROCEDURE**

1. DHHS may, in its sole discretion, require reconciliations of payments made to the Subrecipient in excess of actual and allowable costs, but not more frequently than monthly. If Subrecipient's total actual and allowable costs pursuant to this Subaward are less than the total advance payments paid to the Subrecipient for the period of reconciliation, DHHS may withhold the difference from the next payment. If the total actual and allowable costs pursuant to this subaward exceed the total compensation paid for the period of reconciliation, DHHS shall reimburse Subrecipient for the difference.
2. If this Subaward is terminated early for any reason and terminated at any point other than the end of a subaward year DHHS will conduct a final reconciliation. If the total actual and allowable costs incurred pursuant to this subaward for that partial subaward year are less than the total compensation paid for that partial subaward year, Subrecipient shall repay the excess funds to DHHS within sixty (60) days of DHHS' written demand. DHHS may also withhold payments to recoup excess funds paid to Subrecipient. If the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS shall reimburse Subrecipient for the difference.
3. At the end of the term of the subaward and at the end of each renewal term, DHHS will conduct a final reconciliation. If the total actual and allowable costs reported pursuant to this subaward are less than the total payments made, Subrecipient shall repay the excess funds to DHHS within sixty (60) days of DHHS' written demand. If the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS shall reimburse Subrecipient for the difference.
4. In no case shall any payment or the total of payments made through the cost reconciliation process exceed the total annual Not To Exceed amount.
5. This provision shall survive the expiration or termination of this subaward.

K. **INFORMATION SYSTEM REQUIREMENTS**

1. The Subrecipient must use the state-provided case management system to perform all case management activities for services provided under this subaward. Connection to the state case management system must only be accomplished through state authorized connection and encryption methodology. Subrecipient employees are granted access to information systems and information created, collected, processed and stored on behalf of DHHS under the terms and conditions of this subaward, including but not limited to the Business Associate Provisions (Attachment Four), provided herein.

2. All information collected, processed, compiled and stored by the Subrecipient on behalf of DHHS under the terms and conditions defined in this subaward is the sole property of DHHS and subject to all privacy and security safeguards defined by DHHS and applicable federal guidance.

   a. The Subrecipient must allow and provide DHHS access to any and all information and data collected related to the performance of this subaward.
   b. Data systems created, owned, and maintained by the Subrecipient for the purpose of conducting case management in support of this subaward shall be configured per the guidance of paragraph V.K.6, and must have an independent assessment of the administrative, physical, technical and privacy controls conducted at least once every three years. Reports shall be provided to DHHS upon written request and in a format and time that is agreeable between the Subrecipient and DHHS.

3. The Subrecipient must assign a security administrator for all of its sites who will act as the liaison between the Subrecipient and DHHS. The security administrator, who must be identified in the proposal as part of the key personnel (see section VI, A, 2 Corporate Overview), will be responsible for:

   a. Immediately notifying DHHS when a Subrecipient employee is hired or leaves employment;
   b. Providing appropriate documentation to DHHS for the provisioning of user accounts;
   c. Validating all Subrecipient user accounts with DHHS annual;
   d. Conducting proper background checks for new employees;
   e. Immediately notifying DHHS in the event of a security incident involving misuse of the state-provided case management system or loss of client information per the state and federal guidance outlined in V.K.6; and,
   f. Ensuring security awareness and acceptable use training is conducted and documented for all staff on initial hire and annually thereafter. Documentation shall be provided to DHHS upon written request within three (3) business days.

4. The Subrecipient shall not request access for employees of subcontractors or Second Tier Subrecipients to state-provided case management systems without the express written consent of DHHS.

5. The Subrecipient must appoint a technology coordinator as the primary contact between the Subrecipient and DHHS to address IT related issues. The technology coordinator must be identified in the proposal as part of the key personnel (see section VI, A, 2 Corporate Overview.), The Subrecipient technology coordinator is responsible for the following:

   a. Purchasing, installing, configuring and managing all hardware and software, all computer hardware support, hardware and software upgrades, the movement of all computer equipment, any needed network support, server and LAN printer support and software installation and configuration of information systems owned by the Subrecipient for the performance of responsibilities associated with this subaward. National Institute of Standards and Technology Special Publication (NIST SP) 800-53 must be used as guidance for securing network and computing resources.
   b. Understanding that wireless laptops may be permitted under the terms and conditions of this subaward. Such laptop computers must be full disk encrypted. Subrecipient agrees to implement policies that address the physical security of mobile devices, the risk of using unsecured wireless connections, and rules of behavior that govern the appropriate use and safeguards Subrecipient employees must take when using mobile devices.
   c. Immediately notifying DHHS of any lost or stolen computer hardware that may have been used to access, process, or store client information.
   d. Providing DHHS with a detailed system security plan of any network infrastructure connecting to the agency network.
   e. Understanding that remote or home office work sites may be permitted under the terms of this subaward provided each location meets the compliance requirements as detailed in publications listed in V.K.6. All agents, employees, interns, volunteers, Second Tier Subrecipients or subcontractors take reasonable and appropriate actions to ensure such work sites meet compliance requirements when accessing DHHS information.
   f. Performing and documenting annual physical site reviews for all remote office and home office locations to ensure the security controls at remote or home office are met. The site safeguard reviews must include inspection of physical, administrative, technical and privacy safeguards implemented at each location. Documentation must include any noted deficiencies, recommendations, and actions taken to address noted deficiencies. Site review documentation must be made available upon request to DHHS agents or other applicable compliance officers with jurisdiction.

6. The Subrecipient must meet compliance requirements for all applicable state and federal physical, administrative, technical and privacy safeguard standards and abide by DHHS Information Technology Policies and Standards that govern the appropriate use of, disclosure of, privacy of, and security of information provided by DHHS or compiled by the Subrecipient on behalf of DHHS under the terms and conditions defined in this subaward. Such guidance includes, but is not limited to:
   a. Health Insurance Portability Accountability Act of 1996 (HIPAA) Privacy Rule 45 CFR §§160 et seq. and §§164 Subparts A and E;
   b. HIPAA –Security Rule 45 CFR §160 and §§164 Subparts A and C;
   c. Internal Revenue Service (IRS) - Publication 1075, Tax Information Security Guidelines for Federal, State and Local Agencies;
   d. Social Security Administration (SSA) - Computer Matching Agreement;

e. Nebraska Information Technology Commission (NITC) Information Technology Policies and Standards; and,
f. Centers for Medicare and Medicaid Services (CMS) Computer Matching Agreement.

L. RETAINAGE AND PERFORMANCE MEASUREMENTS

This is a performance-based subaward. The following approach, methodology, and measures will be applied in this subaward to ensure the Subrecipient provides effective outcomes for the children and families served.

1. Overview.

a. A performance target for each measure will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.
b. DHHS shall initially withhold three percent (3%) of each monthly payment as retainage for an initial period of twelve (12) months after the Operational Start Date. After the first twelve (12) months, the percentage of retainage will be adjusted based on the Performance Measure (PM) score, as provided below. After the initial twelve (12) month period each designated period will be three (3) months.
c. If, at the end of the designated period, Subrecipient meets all of the performance measures identified in Section V.L. 2. (b) i – v, ,, the retainage amount will be returned to the Subrecipient, in full, within 45 days of the end of the designated period. If the Subrecipient cannot meet all of the performance measures identified in Section V.L. 2. (b) i – v, , DHHS shall retain the designated portion of the retainage amount until Subrecipient becomes compliant with performance measures. Each perfomance measure will constitute twenty percent (20%) of the total retainage amount.
d. Based on the PM Average, the percentage of retainage may also be adjusted upward or downward, as provided below.

2. Retainage Measures and Methodology.

a. Methodology

i. PM Average Calculation. Each Performance Measure identified in Section V.L.2.b will be assigned a PM Score, with one hundred (100) points awarded to the agreed-upon target. If the Subrecipient does not meet the agreed upon target, one point will be subtracted for every one percent (1%) deviation from the agreed-upon target. If the Subrecipient exceeds the agreed-upon target, one point will be added for every one percent (1%) deviation from the agreed-upon target. The PM Average will be the sum of each PM Score divided by five (5).

ii. Retainage Rate. At the end of each retainage period, the retainage rate shall be equal to the previous time period's retainage rate plus or minus a percentage that corresponds to a PM Average as listed in the table below.

PM Average	Percent Change
64.9 and below	0.5
65.0– 99.9	0.25
100 – 110.0	0
110.1 – 150.0	-0.25
150.1 and above	-0.5

iii. At no point during the term of this subaward shall the retainage rate be less than one percent (1%) or more than five percent (5%).

b. Performance Measures Tied to Retainage:

i. **Recurrence of Substantiated Maltreatment.** This outcome measures the rate of recurrence, expressed as a percentage, of substantiated maltreatment in a 12-month period in the Eastern Service Area, whether or not the child was involved with the court system. The Subrecipient is expected to achieve a lower % than the agreed upon target for recurrence of maltreatment.

ii. **Average Time to Successful Case Closure for Non-Court Involved Children.** This outcome measures the average time to case closure (in days) for Non-Court Involved

Children, on a rolling 12-month average, for non-court children who exited care. The Subrecipient is expected to achieve a lower % than the agreed-upon target for average length of stay for Non-Court Involved Children.

iii. **Rate of Removal of Non-Court Involved Children (In-home).** This outcome measures the average rate of removal, on a rolling 12-month average, children originally assigned to the Subrecipient as part of in-home, non-court involved cases. The Subrecipient is expected to maintain an equal or lower % than the agreed-upon target using evidence-based services designed to preserve families.

iv. **Median Months to Reunification for Court Involved Children, in foster care.** This outcome measures all children discharged from foster care to reunification who had been in foster care for 8 days or longer. The Subrecipient is expected to achieve a lower median months than the agreed-upon target for months to reunification for court involved children.

v. **Rate of Court Involved Children in Foster Care for 24 Months or More who Achieve Permanency.** This outcome incentivizes helping children with a longer than average stay in foster care achieve a positive permanency outcome. It measures the average time to achieve positive permanency (defined as Reunification, Adoption, or Guardianship) in years, on a rolling 12-month average, for court involved children. The Subrecipient is expected to achieve a lower % than the agreed-upon target..

3. Performance Measures Tied to Outcomes and Other Remedies:

a. Subrecipient performance is also measured through the Federal Data indicators which is population data. The data indicators assess operational measures for safety, permanency and well-being. The Subrecipient shall meet or exceed the following federal targets for each of the measures indicated in this RFP and for the life of the subaward:

i. **Safety Outcome – Maltreatment in Foster Care – Federal target - <7.00**
Of all children in foster care during a 12-month period, what is the rate of victimization, per day of care?

Numerator: Of the children in the denominator, the total number of substantiated or indicated reports of maltreatment (by any perpetrator) during a foster care episode within the 12 month period.
Denominator: Of the children in foster care during a 12 month period, the total number of days that these children were in foster care as of the end of the 12 month period.

ii. **Safety Outcome – Recurrence of Maltreatment – Federal target - <7.9%**
Of all children who were victims of substantiated or indicated maltreatment report during a 12 month period, what percent were victims of an additional substantiated or indicated maltreatment report within 12 months?

Numerator: Of the children in the denominator, the number who had another substantiated or indicated maltreatment report within 12 months of their initial report.
Denominator: The number of children with at least one substantiated or indicated maltreatment report in a 12 month period.

iii. **Average Rate of Removal of Non-Court Involved Children (in-home).** This outcome measures the average rate of removal, on a rolling 12-month average, children originally assigned to the Subrecipient as part of in-home, non-court involved cases. The Subrecipient is expected to maintain an equal or lower % than the agreed upon target using evidence-based services designed to preserve families.

iv. **Permanency Outcome – Permanency in 12 months for Children Entering Foster Care. - Federal target - >43.8%**
Of all children who enter foster care in a 12 month period, what percentage are discharged to permanency within 12 months of entering care?

Numerator: Number of children in the denominator who are discharged to permanency within 12 months of entering care.
Denominator: Number of children who enter foster care in a 12 month period.

v. **Permanency Outcome – Permanency in 12 months for Children in Care 12 to 23 Months. – Federal target - >46.2%**
Of all children in care on the first day of a 12-month period who had been in care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?

Numerator: Number of children in the denominator who discharged to permanency within 12 months of the first day in care.
Denominator: Number of children in care on the first day of a 12 month period who had been in care (in that episode) between 12 and 23 months.

vi. **Permanency Outcome – Permanency in 12 months for Children in Care 24 Months or more. – Federal target - >36.3%**
Of all children in care on the first day of a 12-month period who had been in care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?

Numerator: Number of children in the denominator who discharged to permanency within 12 months of the first day.
Denominator: Number of children in care on the first day of a 12 month period who had been in care (in that episode) for 24 months or more.

vii. **Permanency Outcome – Re-entry into Foster Care – Federal target - <8.3%**
Of all children who enter care in a 12-month period, who discharged within 12 months to reunification and live with relative or guardianship, what percent re-entered care within 12 months of their discharge?

Numerator: Number of children who re-enter foster care within 12 months of discharge.
Denominator: Number of children who enter care in a 12 month period who are discharged within 12 months to reunification, living with a relative or guardianship.

viii. **Permanency Outcome – Placement Stability. - Federal target - <4.12**
Of all children who enter foster care in a 12 month period, what is the rate of placement moves per day of foster care?

Numerator: Of the children in the denominator, the total number of placement moves during a 12 month period.
Denominator: Among the children who enter foster care in a 12 month period, the total number of days that these children were in foster care as of the end of the 12 month period.

ix. **Well-being Outcome – Sibling Placement.**
Children are entitled to live with other siblings in care when in the best interest of the child.

Numerator: The number of children who are placed with at least one other sibling in Out of Home (OOH) care.
Denominator: The number of children who have siblings in OOH placement on the last day of the month.

x. **Well-being Outcome – Relative/Kinship Placement.**
Children are entitled to live with relatives/kin while in care when in the best interest of the child.

Numerator: The number of children who are placed with a relative/kin while in OOH placement.
Denominator: The number of children who are in OOH placement on the last day of the month.

xi. **Well-being Outcome – Completed 12th Grade.**
Children aging out of state wardship that have completed the 12th grade.

Numerator: The number of children aging out of state wardship who have completed the 12th grade.
Denominator: Total number of children aging out of state wardship for reason of emancipation.

xii. **Well-being Outcome – School stability.**
Children are entitled to remain in their same school when in the best interest of the child.

Numerator: The number of children who are age 5 or older and attending the same school as prior to removal to OOH.
Denominator: The number of children who are age 5 or older in OOH placement on the last day of the month.

xiii. **Well-being Outcome – Early Placement Stability.**
For all children in care 6 to 12 continuous months during a designated 12 month period, the percent with two or more placement changes during their first 6 months in care.

Numerator: Number of children in care for 6 to 12 continuous months during the designated 12 month period who have changed placements 3 or more times.
Denominator: Number of children in care for 6 to 12 continuous months in the designated 12 month period.

xiv. **Well-being Outcome – Placement Stability within 1 Year.**
For all children in care 12 to 24 continuous months in a designated 12 month period, the percent with two or more placement changes during their first 12 months in care since their removal date.

Numerator: Number of children in care 12 to 24 continuous months during the designated 12 month time period who have changed placements 2 or more times.
Denominator: Number of children in care for 12 to 24 continuous months in the designated 12 month time period.

xv. **Well-being Outcome – Placement Stability for Children in Care for Extended Time Periods.**
For all children in care 18 continuous months or more in the designated 12 month period, the percent with three or more placement changes since their removal date.

Numerator: Number of children in care for 18 continuous months or more during the designated time period who have changed placements three or more times.
Denominator: Number of children in care for 18 continuous months or more in the designated 12 month time period.

xvi. **Well-being Outcome – Case Manager Stability.**
For all children in care 6 to 12 continuous months during a designated 12 month period, the percent with two or more case manager changes during their first 6 months in care.

Numerator: Number of children in care for 6 to 12 continuous months during the designated 12 month period who have changed case managers 2 or more times.
Denominator: Number of children in care for 6 to 12 continuous months in the designated 12 month period.

xvii. **Well-being Outcome – Case Manager Changes within 1 Year.**
For all children in care 12 to 24 continuous months in a designated 12 month period, the percent with three or more case manager changes during their first 12 months in care since their removal date.

Numerator: Number of children in care 12 to 24 continuous months during the designated 12 month time period who have changed case managers 3 or more times.
Denominator: Number of children in care for 12 to 24 continuous months in the designated 12 month time period.

xviii. **Well-being Outcome – Case Manager Changes for Children in Care for Extended Time Periods.**
For all children in care 18 continuous months or more in the designated 12 month

period, the percent with three or more case manager changes since their removal date.

Numerator: Number of children in care for 18 continuous months or more during the designated time period who have changed case manager three or more times.
Denominator: Number of children in care for 18 continuous months or more in the designated 12 month time period.

xix. **Well-being Outcome – Non-Court Cases**
For all children who were victims of a substantiated or indicated maltreatment report during a 12 month period and non-court services were offered what percent were victims of another substantiated or indicated maltreatment report within 12 months of closure of the non-court case.

Numerator: Of the children in the denominator, the number who had another substantiated or indicated maltreatment report within 12 months of closure of the non-court case.
Denominator: The number of children with at least one substantiated or indicated maltreatment report for which non-court services were offered in a 12 month period.

4. Performance Improvement Plan (PIP)
DHHS reserves the right to require a PIP be submitted at any point if performance measures as referenced in Section V. L Retainage and Performance Measurements are not being met.. The plan will be submitted in writing and must contain strategies to meet and maintain the identified outcome. This PIP shall be submitted within 14 Subrecipient business days of the request.

M. REPORTING REQUIREMENTS (DELIVERABLES)

1. Cost Allocation Plan

A cost allocation plan meeting the standards set forth in this RFP must be submitted to and approved by DHHS by no later than ninety (90) days after Operational Start Date. DHHS will not unreasonably withhold approval of such cost allocation plan.

2. Financial Reports

a. Financial statements must be provided by the Subrecipient to DHHS within thirty (30) calendar days of the end of each month. The financial statements must include a balance sheet, income statement, and statement of cash flows in a format to be agreed upon during subaward negotiations. The financial statements must be prepared using the accrual basis of accounting and using GAAP.

b. Thirty (30) calendar days following the end of each month, an aging of accounts payable must be provided by the Subrecipient to DHHS. The accounts payable aging must be consistent with the monthly financial statements provided to DHHS and list, by subcontractor or Second Tier Subrecipient, the amount owed to each subcontractor or Second Tier Subrecipient and what portion of the amount owed has been due less than thirty (30) days; what portion has been due between thirty (30) days and fifty-nine (59) days; what portion has been due between sixty (60) days and eighty-nine (89) days; what portion has been due between ninety (90) days and one hundred nineteen (119) days; and what portion has been due one hundred twenty (120) days or longer. In addition, a reconciliation of accrued expenses to the balance sheet must also be provided each month to the DHHS. Nothing in this section is intended to limit access to the Subrecipients records and information as provided elsewhere in this subaward and the terms of this section shall survive expiration or termination of this subaward.

3. Expenditures

a. The Subrecipient must track and report, quarterly and annually, all federal and state expenditures, including administrative costs, in a format to be agreed upon during subaward negotiations. This report shall be due on the 15th day following the end of the quarter and 15th day after the end of the subaward year. Tracking includes, but is not limited to, reconciling its monthly financial statements to invoices for services for purposes of claiming reimbursement under Title IV-E of the Social Security Act. The reconciliations must be readily reviewable and traceable to source documentation. Source documentation includes, but is not limited to: invoices, timesheets, and other billing documents; payments to foster parents and other providers by check, electronic funds transfer, or other types of payment; and contracts, subawards, and other

writings documenting the agreement of the parties relating to services and compensation. In the event that such reconciliation is not completed by the last day of the second month following the end of a reporting quarter, DHHS may elect to withhold the next advance payment until the reconciliation is completed. DHHS may also withhold the final payment necessary to effect reconciliation from any payment made.

4. State and Federal Reports

   a. The Subrecipient shall provide any and all information requested, in writing, by DHHS that is deemed necessary to complete reports required by any applicable federal or state law or regulation, including but not limited to caseloads, training, coordination with Tribes, Foster and Adoptive Parent Recruitment and Retention Plans, monthly caseworker visits, Continuous Quality Improvement, and others.

5. Outcome Measures

   a. The Subrecipient shall submit monthly reports on Outcome Measures as addressed in Section V, subsection L 2-3.

6. Performance Reviews

   a. The Subrecipient shall submit a written monthly report for performance measures indicated in Section V, subsection L, Retainage and Performance Measurements

7. Foster Care

   a. The Subrecipient shall provide a written quarterly report of licensed Resource Family (foster) homes recruited and retained during the month.

8. Training

   a. The Subrecipient shall submit a quarterly report of training that occurred for case management staff, to include but not limited to training curricula, training rosters, and hours of training.

9. Grievances

   a. The Subrecipient must provide to DHHS a quarterly report of all grievances about the performance or actions of the Subrecipient made by children, families or constituents.

10. Critical Incident Reports

   a. The Subrecipient shall immediately report (verbally) to DHHS any Critical Incident. The term Critical Incident includes, but is not limited to:
      i. Death of a child resulting from abuse or neglect;
      ii. Near fatality, life threatening condition or serious injury of a child resulting from abuse or neglect;
      iii. Suicide, or attempted suicide of a state ward or child who DHHS serves;
      iv. Death of a state ward or child DHHS is working with by other means, accidental or non-accidental;
      v. Death or non-accidental serious injury of a staff person while on the job;
      vi. Allegations or arrests of a state ward or child who is served by DHHS is involved with for serious illegal/criminal activity (i.e. homicide; manslaughter; near fatality of another person; sexual assault; assault – first or second degree; aggravated or armed robbery; etc.,
      vii. Any other event that is highly concerning, poses potential liability, or is of emerging public interest; and;
      viii. Any incident that meets the definition of sexual abuse as defined in Neb. Rev. Stat. § 28-318.

   b. The Subrecipient shall provide to DHHS a written report of the Critical Incident within four (4) hours on the DHHS-approved format.

11. Safety Standards:

    a. The Subrecipient shall immediately report any circumstances that would require a report pursuant to Neb. Rev. Stat. § 28-711 to the DHHS Hotline (1-800-652-1999), or appropriate law enforcement agency, or 911, if an emergency, in addition to the assigned DHHS personnel.
    b. The Subrecipient must provide documentation of its protocol after award of the subaward for reporting suspected abuse and neglect for staff in its employment and with any subcontractors or Second Tier Subrecipients.

12. Laws Violations by Employees

    a. The Subrecipient must report, within 24 hours, to DHHS, any non-traffic arrest or conviction of an employee who may have contact with children and families in the performance of this subaward.

N. **CAPACITY BUILDING COMPONENT**

1. DHHS will reimburse actual and allowable expenses incurred by the Subrecipient for reasonable and prudent incremental management, administrative, and support staff, as well as reasonable and prudent operating expenses incurred prior to Operational Start Date that are necessary to build capacity in Nebraska to support transition planning, staff recruitment, and service contract procurement. Such reimbursement of actual and allowable costs shall not exceed $300,000 (three hundred thousand dollars).

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "RFP for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP, agrees to the Terms and Conditions stated in this RFP unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The RFP for Contractual Services form must be signed using an indelible method (not electronically) and returned per the schedule of events in order to be considered for an award.

Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

Further, Sections II through VI must be completed and returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should describe its corporate structure. It should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized. Per Neb Rev Stat. § 43-4204, the Subrecipient must have a board of directors of which at least fifty-one percent of the membership is composed of Nebraska residents who are not employed by the Subrecipient or by a subcontractor of the Subrecipient. Failure to provide a plan that sufficiently addresses the statutory requirements, in the sole discretion of DHHS, may result in a rejection of any bid. Any new entity created will have to execute all final contractual documents, but the entity does not have to be created unless awarded the subaward. The bidder should describe how it will comply with the requirements of the governing board and financial liquidity as described in Neb. Rev. Stat. § 43-4204.

While the bidder does not have to be a "non-Federal entity," as defined by 45 CFR § 75.2 as it may be amended from time to time, the Subrecipients (if a new entity is created for the purposes of this contract) must be a "non-Federal entity" as provided in said regulation

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. **CHANGE OF OWNERSHIP**
If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

d. **OFFICE LOCATION**
The bidder's office location responsible for performance pursuant to an award of a subaward with the State of Nebraska should be identified.

e. **RELATIONSHIPS WITH THE STATE**
The bidder should describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract / subaward number(s) and/or any other information available to identify such contract(s) / subaward(s). If no such contracts / subawards exist, so declare.

f. **BIDDER'S EMPLOYEE RELATIONS TO STATE**
If any Party named in the bidder's proposal response is or was an employee of the State within the past twenty-four (24) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. **CONTRACT PERFORMANCE**
If the bidder or any proposed subcontractor has had a contract / subaward terminated for default during the past ten (10) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past ten (10) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past ten (10) years, so declare.

If at any time during the past ten (10) years, the bidder has had a contract / subaward terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

h. **SUMMARY OF BIDDER'S CORPORATE EXPERIENCE**
The bidder should provide a summary matrix listing the bidder's previous projects similar to this RFP in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include:

   a) The time period of the project;
   b) The scheduled and actual completion dates;
   c) The Subrecipient's responsibilities;
   d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
   e) Each project description should identify whether the work was performed as the prime Subrecipient or as a subcontractor. If a bidder performed as the prime Subrecipient the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. The bidder's financial management capacity including experience / ability to manage federal funds, financial stability, systems, and cost allocation plans.

iii. Subrecipient and subcontractor(s)/ Second Tier Subrecipient experience should be listed separately. Narrative descriptions submitted for subcontractors / Second Tier Subrecipient should be specifically identified as subcontractor Second Tier Subrecipient projects.

iv. If the work was performed as a subcontractor / Second Tier Subrecipient, the narrative description should identify the same information as requested for the Subrecipient above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor / Second Tier Subrecipient.

v. Bidder should describe previous experience with service the child welfare population or any other relevant experience with the child welfare population.

i. **SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH**

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the subaward resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. **SUBCONTRACTORS**

If the bidder intends to subcontract / subaward, any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the subcontractor(s) / Second Tier Subrecipient(s);
ii. specific tasks for each subcontractor(s) / Second Tier Subrecipient(s);
iii. percentage of performance hours intended for each subcontract / subaward; and
iv. total percentage of subcontractor(s) / Second Tier Subrecipient(s) performance hours.

k. **REFERENCES**

The bidder should provide three references from a non-DHHS individual familiar with the bidders' corporate experience.

3. **TECHNICAL APPROACH**

The technical approach section of the Technical Proposal should include the following items:

a. Attachment Four – Business Associate Agreement
b. Attachment Six - Business Requirements Matrix;
c. Catalogue of In-Home Services;
d. Preliminary Implementation Plan;
e. Draft Cost Allocation Plan of development and implementation of Random Moment Time Study or other time tracking method; and
f. Transitional Plan

Technical Proposal & Attachment 6

Saint Francis Ministries • 509 E. Elm Street • Salina Kansas 67401
785-825-0541 • Toll Free: 800-423-1342

CO Corporate Overview

a. BIDDER IDENTIFICATION (Bidder Information below)

Saint Francis Ministries, Inc.,
f/k/a Saint Francis Community Services, Inc.
Corporate Office
509 E. Elm Street
Salina, KS 67401-2353
Phone: 785.825.0541 / 800.423.1342
Fax: 785.825.2502
https://saintfrancisministries.org/

Saint Francis Ministries, Inc. has 10 subsidiaries *providing healing and hope to children and families* in seven (7) states and two Central American countries. Our vision is *Saint Francis will be recognized nationally and internationally for transforming lives and systems in ways others believe impossible.*

The 10 subsidiaries include the following:

Saint Francis Community Services, Inc.
Saint Francis Community and Residential Services, Inc.
Saint Francis Community and Family Services, Inc.
Saint Francis Community and Outreach Services, Inc. (Texas and International Outreach)
Saint Francis Community Services in Nebraska, Inc.
Saint Francis Community Services in Oklahoma, Inc.
Saint Francis Community Services in Mississippi, Inc.
Saint Francis Community Services in Illinois, Inc.
Bridgeway, Inc.
Saint Francis Foundation, Inc.

Section VI.A.2.a. of the Request for Proposal requires the entity that is a successful bidder and Subrecipient of the subaward to have a board of directors of which at least fifty-one percent of the membership is composed of Nebraska residents who are not employed by the Subrecipient, as required by Nebraska Revised Statutes § 43-4204. Saint Francis will comply with this statutory requirement if awarded the subaward.

Section VI.A.2.a. also provides that a bidder may create a new entity to perform the work under the subaward after the subaward is awarded. As permitted by the RFP, Saint Francis intends to create such a new entity if awarded the subaward. Saint Francis already provides Agency Supported Foster Care services for the Division of Children and Family Services in Western Nebraska and has deep connections in the state, both among child welfare professionals and in the Episcopal Church. Saint Francis has identified a number of individuals who are residents of Nebraska and are affiliated with Saint Francis, the Episcopal Church, or both with sufficient experience in child welfare, health care, and nonprofit management to serve as board members of the new entity. Upon the request of the Department of Administrative Services and the Department of Health and Human Services, either prior to or upon being awarded the subaward,

Saint Francis will be prepared to identify the Nebraska residents it has identified to serve as board members of the new entity.

b. FINANCIAL STATEMENTS – See below

c. CHANGE OF OWNERSHIP – No

d. OFFICE LOCATIONS IN NEBRASKA

Grand Island Office
1811 W. 2nd Street, Ste 105
Grand Island, NE 68801

North Platte Office
121 N. Dewey, Ste. 201
North Platte, NE 69404

Omaha Office
Have already begun exploring properties
Address to be determined

Organized: 1945

CO-1: Financial Statements and Litigation **The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.** **If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.** **The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.**	Comply: X

b. FINANCIAL STATEMENTS

The most Recent Audited Financial Reports can be found in Attachment A.

The name, address, and telephone number of the fiscally responsible representative of Saint Francis is Intrust Bank, Mark Heiman, P.O. Box 1, Wichita, KS 67201 Phone 316-383-1482.

a. BIDDER INFORMATION
Description of Organization

Saint Francis Ministries, Inc., f/k/a Saint Francis Community Services, Inc., (Saint Francis) is an independent not-for-profit 501(c)(3) organization dedicated to providing healing and hope to children, adults and families, and changing lives in ways that others believe impossible. Initially established in 1945 as a boys' home in rural Ellsworth, Kansas, Saint Francis's Child Management and Information Systems 2018 report shows that we have grown to serve over 18,000 children and families each year.

Saint Francis is dedicated to the needs of children and families as we advocate for and work to help them achieve safety, permanency, and well-being. Feeling safe and secure is vital to the growth of children and the prosperity of family. We value both traditional and non-traditional families, believing families make children's lives better. Though rooted in the Episcopal tradition, Saint Francis is an independent community organization dedicated to the protection, nurturing, and healing of all children in body, mind, and spirit. To that end, while partnering with government agencies in supporting children and families in crisis, Saint Francis honors religious freedom. Saint Francis welcomes the opportunity to provide important and life-changing services to children from all walks of life.

Saint Francis is strategically located throughout seven (7) states and two (2) Central American countries, delivering the best possible services to children and families in their home communities with accessibility to staff and services with timely responses. We are licensed to provide and currently offer child welfare services in five (5) states, including Nebraska, Kansas, Oklahoma, Texas, and Arkansas, where services are provided in urban, suburban, rural, and frontier counties. In Kansas, Saint Francis has been licensed and in good standing as a Child Placing Agency since 1970 and Joint Commission accredited since 1974, earning the Gold Seal of Approval by demonstrating compliance with the Joint Commission's national standards for health care quality and safety in behavioral health care.

Saint Francis is well positioned to meet the State of Nebraska Department of Health and Human Services' (DHHS) Division of Children and Family Services (DCFS) goal of providing full service case management, including the development and purchase of the full array of services to meet the needs of children and families in the Eastern Service Area of Nebraska. As the subrecipient, we will "deliver high quality case management and child protection services, including provision of Well-Supported, Supported, and Promising Practice evidence-based models that strengthen families and build protective factors in families, in compliance with the federal Family First Prevention Services Act (FFPSA)."

As child welfare specialists, "when family preservation is not possible, Saint Francis will ensure the recruitment and retention of culturally humble resource families to care for the child(ren), ensure the delivery of trauma-informed services, and engage and support the biological parents in the reunification process." If permanency is not attained for the child in a timely manner, then

Saint Francis "will provide an array of culturally humble adoptive parents willing to provide a forever family to the child who support the engagement of the child in cultural activities and maintain sibling connections whenever possible." Saint Francis looks forward to partnering with the State of Nebraska and collaborating with other community and network providers to offer family centered services that enhance the safety, permanency, and well-being of children.

For over seven decades' Saint Francis has provided quality child welfare services in urban, rural, and frontier settings. Our track record of performance improvement, success in meeting outcomes, and "doing the right thing" for children and families is evidenced in our long-standing relationships with our multi-state contractors. Some of our highlights are listed below.

- **We have maintained a 90% or higher rate of child placement in a family-like setting from FY10 through FY18[1].**
- **Our success in retaining foster care home families is evidenced by having a satisfaction rate of 97.4% with over 813 foster homes throughout Kansas, Nebraska, and Oklahoma.**
- **We have over 57% Reunification Permanency compared to the national average of 49%[2].**
- **In the Kansas Wichita Region, we have succeeded in finding at least one responsible adult connection for 90.6% of youth aging out of foster care in FY18[3].**

Saint Francis believes that families are the best resource for achieving and maintaining permanency for children. When children must be separated from their parents or caregivers due to safety and/or health concerns, there can be long-term consequences. Saint Francis strongly supports the use of a family-centered service delivery model to maintain children in their home communities, and we have a rich history of successfully connecting children with their families while providing for their safety and health.

Our service delivery model and methodology affirm and respect the strengths of the child and family and encourages a natural collaboration among the child, family, their support systems, community-based support systems, Saint Francis, the State, and others. The collaborative process of designing a service plan and course of action to make positive changes will lead the child and family toward permanency. Saint Francis uses elements of Family Voice and Choice (FVFC) to provide family case planning. Likewise, community-based care strengthens children, youth, families, and communities. Our extensive kinship searching methods, support system building strategies, and community engagement techniques bring communities and families together to achieve safety, permanency, and well-being for children.

Building on a quality foundation of core services and decades of experience in providing well-supported practices in child welfare services across the center of the U.S., Saint Francis continues to refine our service delivery model to meet the changing and unique needs of diverse populations. Throughout these states, Saint Francis has continuously demonstrated the ability to

---

[1] Kansas Department for Children and Families: Prevention and Protection Services, Foster Care\Adoption Case Management Contract Performance Outcomes.http://www.dcf.ks.gov/services/PPS/Pages/CaseManagementContractOutcomes.aspx

[2]Children's Bureau: *The AFCARS Report* https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf

[3]Kansas Department for Children and Families: Permanent Connection SFY2018, http://www.dcf.ks.gov/services/PPS/Documents/FY2018DataReports/FCAD_ContractOutcomes/PermanentConnectionFY2018.pdf

perform high quality case management within the parameters of government-awarded contracts in Family Preservation; Reunification, Foster Care, and Adoption (RFCA) services, including Independent Living and Another Planned Permanent Living Arrangement (APPLA) services; and recruiting and retaining kinship and foster family homes/Foster Care Home Placement. Our experience in capacity, network building and partnership, trauma-informed and evidence-based therapies, and family preservation services has contributed to our ability to develop infrastructures and tailor service delivery to specific communities.

As our service area grows, Saint Francis adapts to the changing environment of our clients, delivering high quality care that suits each family's emotional and physical situations. Our expansion throughout Kansas and into Oklahoma (2008), Nebraska (2012), Texas (2017), and Arkansas (2019) highlights our ability not only to meet the needs of the community but to establish trust within these communities as well. Additionally, our licensure to practice the Family Centered Treatment model in Nebraska will further our ability to bring lasting hope and healing to families across the country. Brief descriptions of each state are provided below.

Kansas

Saint Francis's Family Preservation, Kinship, and Reunification, Foster Care, and Adoption (RFCA) programs and services in Kansas have focused on family care and engaging communities to assist children and families in achieving safety, permanency, and well-being since 1986. Through these programs, we have decades of experience offering community-based services that are evidence-based, family-centered, and trauma-informed. Our approach is tailored to meet the individual needs of the family and incorporate the Six Protective Factors defined by the U.S. Department of Health and Human Services. Furthermore, our trauma-informed treatment and services practice model addresses the effects of trauma on individuals and families based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Six Principles of a Trauma-Informed Approach. We have provided reunification, foster care, and adoption services throughout the state of Kansas for 18 years, and Family Preservation services for 22 years. We are primed to take our community-based service delivery model and 74 years of case management experience to children and families in Nebraska's Eastern Service Area.

Saint Francis is currently contracted to provide foster care reunification, adoption, and child placement services in Kansas and has successfully held this status since 2000. Additionally, we have verified hundreds of family foster homes and supported three (3) youth residential centers for those children needing a more structured setting. During this time, Saint Francis has expanded to meet the needs of children and families in many different geographical areas, including urban, suburban, rural, and frontier areas of the state. With expert understanding of the complexities that exist within these geographic populations, our organization provides timely, family-centered services tailored to the unique environment of the family home, with direct assistance in building familial, kin, foster care, and community-based support networks. We provide direct services to children and families throughout 75 of Kansas's 105 counties and serve the remaining counties with community-based services.

Since 1998, Saint Francis's Clinical Services and Behavioral Health department has provided support to strengthen, unite and reunite children and their families through mental health counseling, psychological evaluation, testing, assessments, and substance use disorder treatment services. Saint Francis uses well established, evidenced-based mental health services for children

and their families. We provide crisis intervention, individual, family, and/or group therapy. We do so in home, school, community, our three (3) behavioral health offices, and our psychiatric residential treatment facility.

Nebraska

Saint Francis currently provides kinship/foster care home and adoption homes, family support programs, Intensive Family Preservation, Intensive Family Reunification, and Family Centered Treatment services in Nebraska. We have provided foster care services for the Nebraska Department of Health and Human Services (DHHS) since 2012 and Intensive Family Preservation Services (IFP) since 2017, adding Intensive Family Reunification services in 2018 after demonstrating positive results through IFP. We were then approached by DHHS to become the first certified Family Centered Treatment (FCT) provider in Nebraska in 2018. We are currently the only provider of this evidence-based practice model in Nebraska.

Our ability to pull from decades of experience in Family Preservation, adoption, and kinship/foster care services in Kansas enabled our organization to recognize the needs and accomplish the goals presented in Nebraska. Initially, Saint Francis worked with Nebraska DHHS to develop much needed foster care homes to prevent children from being placed out-of-state. By making our organization readily available and responsive to the needs of Nebraska's communities, Saint Francis is able to maintain 59 foster homes in rural and frontier areas where they are much needed, keeping children in their communities and closer to their families, friends, and support networks. Since providing foster care services in 2012, our goals and objectives have expanded in Nebraska to develop a family support program and include adoption services.

Our efforts to build and establish vital resources in Nebraska have allowed us to develop a professional team dedicated to recognizing the needs of different geographical environments, as well as accessing and connecting referred families to a variety of existing community resources and options. After a meeting with DHHS to discuss their goals and strategies, we ascertained that the area of greatest need was the shortage of providers in western Nebraska, particularly North Platte and Gering, as well as in Grand Island, located in the central part of the state. In successfully expanding our services to the more rural areas of the state, Saint Francis has demonstrated the ability to bring our services to families in an efficient and timely manner and our desire and ability to bring hope and healing to those in different community settings.

Oklahoma

In 2012, Saint Francis was selected as a Bridge Resource Provider in Oklahoma City, Tulsa and McAlester. A Bridge Resource Family provides temporary care, love, and nurturing to a child. They welcome children into their home at any hour, day or night, and manage a wide array of emotions/behaviors of those in their care. They successfully navigate agency regulations, policies, and paperwork and serve as mentors and social community supports, actively helping biological families improve their abilities to safely care for their children with the goal of achieving safe and timely permanency for the child. They actively assist in the child's transition and the family's transition to reunification, legal guardianship, adoption, independent living, or APPLA and work to maintain the child's connection to kin, culture, and community.

Saint Francis recruits, trains, assesses, approves, and provides on-going support services for Bridge Resource Families to maintain the least restrictive out of home care placements for children and youth in state conservatorship. Prospective families receive 27 hours of pre-service training, plus six (6) hours of orientation, as well as assistance with decision making and licensure processes. Furthermore, staff provide professional support, ongoing training and support groups, crisis intervention, and other identified services for every Bridge Resource Family, with a goal of providing a caring and stable family environment where each child is safe until permanency. Our office locations are in McAlester, Oklahoma City and Tulsa, and our service areas are Oklahoma City and contiguous counties in Northeast and Southeast Oklahoma.

Texas

Saint Francis became a Child Placing Agency in Abilene, Tx in 2016 and we have made community partnership a priority to bring families into the community-based care network and to provide resources for children in foster care. We have successfully adapted our service model to Texas' standards and become part of the provider community in Abilene to meet the needs of Texas children and families by adapting to statutes, policy procedures, and to bridge gaps to diverse demographics and resources. We have worked with the State, faith-based communities, and other providers in the development and implementation of recruitment activities to engage more qualified families. We have fully implemented the CANS 2.0 process to provide timely and efficient assessment of needs to identify the most appropriate and beneficial service plans for the children of Abilene.

Our child placing agency (CPA) in Abilene actively seeks caring homes in family-like settings to facilitate and provide the least restrictive out of home care placement for children. We recruit foster care families that provide various levels of care to children, ranging in age from 0 to 19, including respite and emergency care. Potential foster care families receive extensive training prior to child placement, in addition to assistance in decision making and verification processes with our staff. Saint Francis collaborates with the families to determine best placement strategies for children, providing ongoing professional support, training, and other services after placement. We assist relatives and fictive kin with the State's verification process so that care may be continued in a warm and caring environment where children will be safe and remain in their communities until permanency is secured.

Arkansas

In 2019, Saint Francis was awarded the Intensive In-Home Services contract for children and families in 15 counties in Arkansas to safely reduce the number of children in state conservatorship. These services will prevent children from being removed from the home and also provide essential supports to families whose children have been removed in order to facilitate successful reunification. At the time of this submission, we are in the implementation process. In these counties, we will provide intensive, long term, evidence based, and trauma informed in-home services aimed at reducing child abuse and neglect; improving family functioning; enhancing parenting skills; addressing mental health and substance abuse issues; reducing child behavior problems; connecting families to formal and informal concreate supports; and empowering families to be able to solve future problems independently. Saint

Francis's services are strength-based and tailored to the unique needs of each family; our staff develop a solid understanding of environmental, behavioral, and cognitive interventions when working with families to provide the best care possible.

Summary

Saint Francis staff live and work in the communities we serve; our connection to community and local support services is vital to our success in building new infrastructures and strengthening existing resources to change the lives of children and families in ways others believe impossible.

As successful providers of Family Preservation, RFCA and other services in the center of the U.S. for over 20 years, Saint Francis has developed significant expertise in building the necessary professional infrastructure needed to initiate work across the Eastern Service Area of Nebraska. Staff members who make up the heart of Saint Francis are competent, dedicated, and caring individuals who go the extra mile to make a difference in the lives of the children and families they serve. We actively seek to enhance parenting skills, address mental health and substance use issues, reduce child behavior problems, and empower youth and families to solve future problems independently through developing formal and informal concrete supports in compassionate and meaningful ways.

e. RELATIONSHIP WITH THE STATE

Table CO is the Nebraska State Grants and Contracts from January 1, 2009 to present.

Table CO NEBRASKA STATE GRANTS &	CONTRACTS	1/1/2009 to present
Table CO Governmental Agency Name	**Program/Type of Service**	**Contract Period**
Nebraska Department of Health and Human Services	Title IV-E - Agency Supported Foster Care (ASFC)	7/1/11-present
Division of Children and Family Services	0G-1801NEFOST	
Nebraska Department of Health and Human Services	Family Centered Treatment (FCT)	8/13/18-present
Division of Children and Family Services		
Nebraska Department of Health and Human Services	Parenting Skills and Visitation Services	9/1/12-6/30/13
Division of Children and Family Services		
Nebraska Department of Health and Human Services	Parenting Time, Visitation Services and FSW	7/6/17-present
Division of Children and Family Services	(North Platte area)	
Nebraska Department of Health and Human Services	Intensive Family Preservation Services (IFP)	9/1/12-6/30/13
Division of Children and Family Services		
Nebraska Department of Health and Human Services	Intensive Family Preservation Services (IFP)	7/1/17-present
Division of Children and Family Services	(North Platte and Scottsbluff Panhandle areas)	
Nebraska Department of Health and Human Services	In Home Safety Services	9/1/12-6/30/13

Division of Children and Family Services		
Nebraska Department of Health and Human Services	Family Support Services	9/1/12-6/30/13
Division of Children and Family Services		
Nebraska Department of Health and Human Services	Intensive Family Reunification Services (IFR)	7/16/18-present
Division of Children and Family Services	(North Platte and west to the Panhandle areas) #82636-04	
Nebraska Department of Health and Human Services	Drug Testing Services	10/2018-present
Division of Children and Family Services	(Grand Island area)	

f. BIDDER'S EMPLOYEE RELATIONS TO STATE None

g. CONTRACT PERFORMANCE

Saint Francis has not had a contract / subaward terminated for default during the past ten (10) years. We do not have any of those events as described below that would affect the viability or stability of the organization.

CO-2: Summary Matrix Similar Projects **The bidder should provide a summary matrix listing the bidder's previous projects similar to this RFP in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.**	Comply: X

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

Since 1945, Saint Francis has been fundamentally involved in protecting children, restoring families, and helping individuals live healthy lives. Our mission is to *provide healing and hope to children and families*. From a boys' home serving 12 troubled youth to an international, seven state community-based non-profit, we have continued to grow to meet the needs of 13,753[4] children and 4337 families each year. We strive to develop, implement, and maintain quality assurance and program improvement in our services to continually achieve better outcomes for the persons in our care.

Saint Francis administers family preservation, foster care, kinship care, family reunification, and adoption services throughout five (5) states. We are licensed to provide child welfare services in Nebraska, Kansas, Arkansas, Oklahoma, and Texas. Since 1970, we have been in good standing as a Child Placing Agency in Kansas.

Our experience as a Child Welfare Case-Management provider began when the State of Kansas first privatized services and awarded Saint Francis the Family Preservation Contract for the rural and frontier West Region. Saint Francis began providing reintegration, foster care, and kinship care services for the West Region in 2000, and Adoption services were added in 2005.

[4] Saint Francis Community Services Child Information System Demographics for 2018.

Our programs are delivered using a family-centered model to provide the best community-based services to achieve safety, well-being, and permanency for children and families. Our track records of performance improvement, success in meeting outcomes, and “doing the right thing” for children and families are evidenced in our long-standing relationships with our contractors. We remain dedicated to meeting performance outcomes and simultaneously building lasting and strong partnerships with many diverse community providers.

With 37 offices and over 1,200 staff members strategically located throughout our service areas, Saint Francis has demonstrated the ability to meet the needs of the families we serve in a timely manner. We fully engage communities in serving children, youth, and families. Some of our community outreach programs for family stability include behavioral health services, substance use outpatient and intensive treatment, fatherhood initiative programs, community health programs, refugee resettlement, immigrant child and family services, family support programs, workforce development, truancy prevention programs, and parenting programs. We have built trusted long-term relationships with partnering organizations that can most effectively meet this need in a manner that achieves better outcomes for children.

In addition to RFCA services, we have grown our services to continue to meet the needs of the children and families in our care. Saint Francis has three (3) residential treatment facilities in Kansas that provide 24-hour intensive care to children and teens suffering the greatest trauma; a secure residential living environment for youth ages 12-18 who have chronic runaway behaviors and have been adjudicated by the courts as children in need of care (CINC); and a psychiatric residential treatment facility; and a restorative residential therapy to minor female victims of commercial sex trafficking. Additionally, we provide residential independent living programs and employment to intellectually and developmentally disabled adults in Gulf Port and Picayune Mississippi.

In 2017, Saint Francis formed an alliance with the International Social Service-USA Branch to provide cross-border social services to children and families separated by voluntary or forced migration, adoption, abduction or human trafficking. We conduct joint information sessions for social workers, judges, lawyers and other child protection professionals, focusing on the international processes required to reunify children with their families abroad.

In 2018, we began our Refugee Resettlement program to provide initial and ongoing resettlement services to immigrants who qualify for refugee status through the U.S. government. Federal and state refugee agency grants fund programs that begin with refugees’ arrival in the U.S. through a process of acclimation to living in the U.S. Programs, including housing and employment assistance, navigating health and educational systems, and cultural orientation.

The following Prime Subrecipient Projects (See CO-2 A.) performed by Saint Francis, including all contract foster care work currently being done in Nebraska, Kansas, Oklahoma, Texas, and Arkansas demonstrates our ability to perform the Scope of Work described in the Full Service Case management RFP for Douglas and Sarpy counties.

CO-2. A. Prime Subrecipient Projects
1970
Licensed and in good standing as a Child Placing Agency (1970 –current)
1974

CO-2. A. Prime Subrecipient Projects	
	Joint Commission accredited earning the **Gold Seal of Approval (1974 –current)**
1996	
	Family Preservation Program, Kansas
	Selected as the Family Preservation provider for 53 counties in Western Kansas -Region IV (1996 – 2013) State of Kansas' Department of Children and Families (KS-DCF)
	Intensive in-home mediation and therapy to families (1996-current) KS-DCF
1997	
	Foster Care Homes, Kansas
	Established a Foster Care Homes program providing care for children and youth in foster homes (1997-current) KS-DCF (*Currently we have 813 homes throughout four states*).
2000	
	Reintegration/Foster Care Program, Kansas
	Selected as the Reintegration/Foster Care provider for 53 counties in Western Kansas (Region IV) (2000-current) KS-DCF
	Assures foster children are placed in the least restrictive environment consistent with their needs
	Oversees the Care Center to manage placement for children in Region IV in Kansas in out-of-home placements
2005	
	Reintegration/Foster Care Program, Kansas
	Includes Adoption Services (2005-current) KS-DCF
2007	
	Foster Care Homes, Kansas
	Established Therapeutic Foster Care program in Kansas (2007-current) KS-DCF
2008	
	Therapeutic Foster Care, Oklahoma
	Established a therapeutic foster care program serving children and families in western Oklahoma. State of Oklahoma Department of Human Services Child Protective Services (OK-CPS) (2008-2018)
2009	
	Family Preservation Program, Kansas
	Selected as the Family Preservation provider for 24 counties in Northeastern Kansas (Region III) for four years (2009 – 2013). The one-year of after-care ended June 30, 2014. KS-DCF
2012	
	Foster Care Homes Program, Nebraska
	Established a foster care homes program serving children and families in Nebraska. State of Nebraska's Department of Health & Human Services Division of Children and Family Services (NE-DCFS) (2012-current)
	Intensive Family Preservation Program, Nebraska
	Established an intensive family preservation program (2012-current) NE-DCFS
	Providing home and services to children and parents that will keep children in their homes with their families
	Family Support Program, Nebraska

CO-2. A. Prime Subrecipient Projects	
	Established family support services to children and their families identified by DHHS (2012-current) NE-DCFS
	Providing skill development, improved family functioning, and community engagement for support and sustainability
2013	
	Foster Care Homes (Bridge Resource Families) Program, Oklahoma
	Selected as a Bridge Resource provider in the Oklahoma City and Tulsa, Oklahoma districts which is for the recruitment and training of potential families to be Bridge resource families in 2012, OK-CPS
	Family Preservation Program, Kansas
	Selected as the Family Preservation provider for 65 counties in the West Region (2013 – current) KS-DCF Selected as the Family Preservation provider for 10 counties in the Wichita Region (2013 – current) KS-DCF
	Reintegration/Foster Care/Adoption Program, Kansas
	Selected as the Reintegration/Foster Care/Adoption provider for 65 counties in the West Region (2013 – current) KS-DCF
	Selected as the Reintegration/Foster Care/Adoption provider for 10 counties in the Wichita Region for four years (2013 – current) KS-DCF
	Permanency Clinic is a continuum of mental health services available to children, youth, and families to address the emotional and behavioral needs of the children and families served by the Saint Francis Permanency Contract
2015	
	Adoption Services, Nebraska
	Established an adoption program in Western Nebraska (2015-current) NE-DCFS
	Psychiatric Residential Treatment Facility, Kansas
	Established a new state of the art 40-bed, 28,000-square-foot residential facility providing a "healing environment" to nurture the physical, emotional, and spiritual needs of children and youth ages 6-18. (2015-current)
2016	
	Clover House, Kansas
	Established a Restorative Home for adolescent female survivors of human trafficking (2016-current) KS-DCF
	International Ministriles, Honduras & El Salvador
	Protect children, strengthen families, and search for solutions that threaten their safety and well-being in El Salvador and Honduras (2016-current)
2017	
	YRC II, Kansas
	Established a male and female Youth Residential Care (YRC II) a 24-hour group home or residential facility for teenagers DCF (2017-current) KS-DCF
	Foster Care Homes, Texas
	Received our Child Placement Agency License. State of Texas' Department of Family and Protective Services (TX-DFPS) (2017-current)
2018	
	Migration Ministries, Kansas
	Acquired Refugee Resettlement (2018-current)
	Secure Care, Kansas
	Established an 18-bed secure facility for juveniles judged to be chronic runaways with the treatment program designed around trauma informed care for females ages 12-18. (2018-current) KS-DCF

CO-2. A. Prime Subrecipient Projects	
	Family Centered Treatment
	Became the first certified Family Centered Treatment (FCT) provider in Nebraska. (2018-current) NE-DCFS
2019	
	Intensive In-Home Services, Arkansas
	Selected to provide Intensive In-Home Services to 15 rural counties in Arkansas. State of Arkansas's Department of Human Services Division of Children and Family Services (AR-DCFS) (2019-current)

For reference purposes, following table (see CO-2 B on pg. 14) are the Names and Contact Information for the contracts mentioned above.

CO-2 B. References

Current Major State	Contracts		Contacts
Governmental Agency Name	**Program/Type of Service**	**Contract #**	**Contact Person**
Kansas Department for Children and Families	Reintegration, Foster Care & Adoption Services	37677/37680	Linda Cambron
			Linda.Cambron@ks.gov
			Ph. 785-291-3251
			Fax 785-296-1158
Kansas Department for Children and Families	Family Preservation Services	37681/37683	Linda Cambron
			Linda.Cambron@ks.gov
			Ph. 785-291-3251
			Fax 785-296-1158
Nebraska Department of Health	Agency Supported Foster Care	0G-1701NEFOST	Ross Manhart
and Human Services			Ross.Manhart@ nebraska.gov
			Ph. 402-471-9732
Oklahoma Department of Human Services	Bridge Resource Family Services	93141504	Keri Peck
Division of Children and Family Services			Keri.Peck@okdhs.org
			Ph. 405-818-8528
			Fax 405-487-4783
Texas Department of Family	Foster Care	24469293	Kristan Risovi-Telfer
and Protective Services			Kristan.Risovi-Telfer@dfps.state. tx.us
			Ph. 817-792-4425
			Fax 512-276-3524
Arkansas Department of Human Services	Intensive In-Home Services	710-19-1010	Latisha Young
Division of Children and Family Services			Latisha.Young@ dhs.arkansas.gov
			Ph. 501-682-8866
			Fax 501-682-6968

The table below (See CO-2 C.) is the noted contracts originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

CO-2 C. Originally Submitted Budgets and Actual Budgets					
Governmental Agency Name	**Program/Type of Service**	**Original Scheduled Completion Date**	**Original Budget**	**Current Planned Completion Date**	**Current Planned Budget**
Kansas Department for Children and Families	Reintegration, Foster Care & Adoption S	6/30/19	$91,226,479	6/30/19	$91,226,479
Kansas Department for Children and Families	Family Preservation	6/30/19	$5,504,643	6/30/19	$5,504,643
Nebraska Department of Health and Human S	Agency Supported Foster Care	6/30/19	$1,449,649	6/30/19	$1,449,649
Oklahoma Department of Human Services	Bridge Resource Family Services	6/30/19	$1,503,452	6/30/19	$1,503,452
Division of Children and Family Services					
Texas Department of Family and Protective S	Foster Care	6/30/19	$49,899	6/30/19	$49,899
Arkansas Department of Human Services	Intensive In-Home Services	1/1/19	$837,612	6/30/19	$837,612
Division of Children and Family Services					

Over the past 74 years, Saint Francis has experienced tremendous growth in services provided to an ever-increasing number of children and families. Visionary leadership, trained personnel, strategic planning, and continuous performance improvement provide the foundation for success across all Saint Francis departments and programs. We approach each program we develop with an unwavering vision of providing opportunities for growth and healing to each child and family we serve in an environment of accountability and responsibility.

Kansas: Saint Francis began providing Kansas contracted Family Preservation services in 1996, Permanency Services (Reintegration, Foster Care, and Kinship Care case management) in 2000, and Adoption services in 2005. Saint Francis has successful met and continues to meet Children and Family Services Review (CFSR) outcomes including safety and placement stability.

Below are descriptions, by state, of some of the relevant services currently provided by Saint Francis (pg.16).

CO-2 D. Kansas Relevant Services
Family Preservation Contract with State of Kansas
Foster Care Homes Program
Reintegration/Foster Care/Adoption Contract with State of Kansas
Adoption
Permanency Clinic
Kinship
Therapeutic Foster Care
Salina West Psychiatric Residential Treatment Facility (PRTF)
Salina West Youth Residential Center (YRC II)
Clover House
Secure Care
Fostering in Faith
Immigrant Child and Family Services

Family Preservation

Through our Family Preservation contracts with the State of Kansas, Saint Francis provides home and community-based services to children and parents to keep children in their homes and with their families. The local Department for Children and Families (DCF) offices refer families who are in imminent danger of having a child removed from the home. Upon referral, assessments are completed, a plan is created, and services are initiated. Behavioral Health Clinicians and Family Support workers meet with the family to strengthen parenting skills, enhance family communication and problem-solving skills, develop structure and guidelines within the family, locate and access resources, and improve the family's ability to respond to a variety of situations. Services to the family are provided for one year, with the anticipation of those services abating as family functioning improves. The goal is to reestablish and safeguard family safety and well-being.

Foster Care Homes

The Saint Francis Foster Care Homes program recruits, trains, and supports licensed foster families to provide the least restrictive out-of-home placement for children and youth in State custody. Saint Francis actively recruits families to provide various levels of foster care service to children from ages 0 to 18, including respite, emergency care, and adoption. Prospective foster families receive 30 hours of pre-service training in addition to assistance with the decision-making and licensure process. Continual training opportunities in a vast array of subjects are made available to foster families.

FCH staff provide professional support, ongoing training and support groups, crisis intervention, and other identified services for every foster family. A Saint Francis Families website assists foster families in communicating with staff and retrieving information about children in their care. Foster families take an active role in deciding which children will blend best within their household, with the goal being to provide a caring and stable family environment where each child will be safe until permanency is achieved.

Reunification/Foster Care/Adoption

As one of two State of Kansas Contractors in Kansas, Saint Francis provides comprehensive case management/permanency services to children and families. Local DCF offices refer children in

need of out-of-home placement. Each child's and family's situation and needs are immediately assessed. Children are placed in the least restrictive environment possible while maintaining connections with family, kin, school, and home communities. Efforts are made to engage both parents. Staff members work with birth parents to strengthen parenting skills, improve home conditions, and identify and access community-based services to achieve reunification. Most children are reunited with their birth families; however, those who cannot be reunified move on to adoption, permanent custodianship, or independent living.

Adoption

Saint Francis provides adoption services for children in out-of-home care with permanency goals of adoption. Children become legally available for adoption after the relinquishment or termination of parental rights through the courts. Saint Francis staff prepare children for adoption; identify/recruit adoptive resources for children; complete adoption family assessments; and support the adoptive parent and child through legal finalization and aftercare.

Permanency Clinic

RFCA/PC is a continuum of mental health services available to children, youth, and families to address their emotional and behavioral health needs. Most of the services are available at any stage of the foster care, reintegration, and adoption process. The services include mental health medication management, psychological and other mental/behavioral health testing/evaluation, in-home family therapy, and specialized, child-focused therapies. Saint Francis RFCA case management teams refer children and families based on need. Referrals are submitted to Saint Francis Mental Health Liaisons in Wichita or Salina (as assigned). Maintaining family ties is extremely important for all children and families. When children are removed from their birth family homes and placed in out-of-home care, placement with relatives or kin is given first priority. It is in the best interest of children to be placed with relatives or kin who can provide healthy and safe homes. Kin is defined as any family member or person who has a significant relationship with the child or child's family.

Kinship

Kinship care is the full-time care, nurturing and protection of children by relatives, members of their tribes or class, godparents, or any adult who has a kinship bond with a child.

The Kinship program helps locate family and kin using X-Treme Recruiters. Once a relative or kin are found, a Kinship Specialist assesses the family to ensure the home is safe for the child. Background checks are completed on all family members 10 and older, fingerprints are completed on all family members 14 and older, and an environmental walkthrough of the home is completed. A formal interview process and assessment is also completed.

Kinship Support Workers are assigned to help support the home as soon as a child is placed. Kinship Workers help the families maneuver the complex child welfare system, help them locate resources, and advocate for the family's needs. The Kinship Support Worker remains working with the family until the child returns to his/her biological family, achieves adoption, the family takes guardianship, or the child is moved to a non-kinship placement.

Therapeutic Foster Care (TFC)

TFC is a family-based program whose overall purpose is to improve the mental health status, emotional and social adjustment of youth requiring out-of-home placement; particularly youth

who display criminal behaviors or thinking. TFC utilizes Cognitive Behavioral Therapy training and intervention tools, which have been successful for youth with criminogenic characteristics, to improve and teach the youth decision making skills, coping skills, social skills, and to address underlying problems which are negatively affecting the youth's ability to live successfully with their family or in the community. Therapeutic foster parents are an integral part of the team, are viewed as colleagues, and are active agents of interventions and change. Therapeutic foster parents are trained in Cognitive Behavioral skills and techniques and are provided weekly support by TFC staff.

The program serves youth ages 10 through 22, with the optimum length of placement being a minimum of six months. Other key components include staff trained in Cognitive Behavioral Therapy, a pre-placement interview and assessment with the youth, the program's ability to meet the youth's needs, and development of a treatment plan with input from the professional team.

Psychiatric Residential Treatment Facility

Saint Francis provides trauma-informed treatment services for youths ages 6-18 who have a profile of mental illness and chronic behavior problems, placing themselves or others in danger of being harmed. The program includes services and staff equipped to treat seriously disturbed youth who might have additional problems with sexual abuse and alcohol or drug use/abuse. Treatment is daily and intensive with a trauma-informed approach including individual, group, and family therapy, activity therapy, relationship development, emotion regulation skill building, life skill building, psychiatric evaluations, and consummate medication. Youth who have stabilized emotionally are transitioned to a community-based environment which includes their family, or in the case of youth in state custody, a foster or group home.

Youth Residential Center (YRC II)

YRC II is a secure residential living environment for youth ages 12-18 who require a structured daily living routine. Individualized care plans are created for each client that include goals, objectives, and services that are designed to encourage progress during the client's stay. A variety of different services are provided through outpatient and in-house services, including, but not limited to, substance use treatment, individual and group therapy sessions, family therapy, case management services, psychiatric evaluations, medication management services, individual counseling, social work services, education services, independent/basic living skills groups, and various psycho-social groups designed to meet the youth's individualized needs and promote an overall balanced and healthy living environment.

Clover House

Our restorative residential home for minor survivors of sexual exploitation/human trafficking is one of only a handful of similar programs in the nation and is unique in its approach to supporting survivors. Based on evidence and research around vulnerabilities, protective factors and resiliency, Clover House provides the resources necessary for youth to move from severe trauma to healing to wholeness. Our intensive and intentional staffing pattern allows our youth to receive individual attention and support, so that restorative, healing relationships can be built. Education, mental health, substance abuse treatment, life-skills training, and case management services are integrated into the program. Clover House is designed to provide an intensive, individualized approach to supporting an adolescent's healing journey.

Secure Care

Secure Care is a secure residential living environment for youth ages 12-18 who have chronic runaway behaviors and have been adjudicated by the courts as children in need of care (CINC). Individualized care plans are created for each client that include goals, objectives, and services that are designed to encourage progress. A variety of services are provided though outpatient and in-house services, including - but not limited to - substance use treatment, individual and group therapy sessions, family therapy, case management services, psychiatric evaluations, medication management services, individual counseling, social work services, educational services, independent/basic living skills and various psycho-social groups.

Fostering in Faith

Through our Fostering in Faith program, Saint Francis reaches out to the faith-based community to share the needs of our older youths without identified resources (with the youth's permission) with a wide network of churches throughout the nation. Congregations put our children's stories in their bulletins and flyers, and members actively pray for their permanency and well-being. This outreach can lead to lifelong connections for youth, their families and have inspire a church member to become a foster or adoptive parent through ongoing information about the need for caregivers.

Immigrant Child and Family Services

Saint Francis's Immigrant Child and Family Services program assesses the needs facing the immigration experience and engages a comprehensive approach to meeting these needs. In addition to helping ensure culturally and linguistically appropriate services, Saint Francis is recognized by and employs staff accredited by the Board of Immigration Appeals, providing immigration support services and legal assistance, as well as case management support to effectively serve the needs of immigrant clients.

Nebraska: Initially, Saint Francis worked with Nebraska DHHS to develop much needed foster care homes in rural communities to prevent children from being placed out-of-state. By making our organization readily available and responsive to the needs of Nebraska's communities, Saint Francis was able to keep children in their communities and closer to their families, friends, and support networks. Since providing foster care services in 2012, Nebraska has requested Saint Francis expand our services to meet additional child welfare needs. Most recently, we implemented Family Centered Treatment (FCT) in Nebraska in October 2018.

CO-2 E. Nebraska Relevant Services
Saint Francis Supported Foster Care (Scottsbluff, North Platte, Grand Island, Lincoln)
Intensive Family Preservation (North Platte, Grand Island)
Intensive Family Reunification (North Platte, Grand Island)
Family Support & Visitation Services (North Platte, Grand Island)
Drug Screening (North Platte, Grand Island)
NE Juvenile Service Delivery Project (Scottsbluff, North Platte, Grand Island)
Family Centered Treatment (Scottsbluff, North Platte)
Adoption Home Studies

Below are descriptions of some of the key child and family programs offered in Nebraska that are not already detailed above.

<u>Saint Francis Supported Foster Care</u>

Saint Francis recruits, trains, licenses, and supports foster parents who accept placement of children referred by Nebraska's Department of Health and Human Services (DHHS). Saint Francis provides active and ongoing efforts to solicit families who are invested in meeting the unique and special needs of the children and youth served by DHHS. Saint Francis makes targeted and diligent efforts to locate foster families for specific children upon the request of DHHS. Recruitment efforts include engaging communities across the state through outreach and education, with emphasis on the need for foster parents who reflect the ethnic and racial diversity of the children served by DHHS.

With regard to Agency Supported Foster Care, Saint Francis works collaboratively with DHHS local staff to develop Foster Care Recruitment and Retention Plans that are reflective of the types of foster parents needed to meet the unique and special needs of children referred by DHHS, and who are reflective of the ethnic and racial diversity of children served in the Service Area. Saint Francis trains all affiliated foster homes on the Reasonable and Prudent Parent Standard and provides ongoing training. Saint Francis works to ensure that relative and kinship foster parents referred by DHHS complete licensing activities in order to maximize IV-E federal funding. Saint Francis completes all foster care home studies in accordance with DHHS policy, updating home studies for licensed homes every two years, and for all homes when there is a change in circumstance within the foster care home.

Saint Francis is readily accessible and responsive to foster parents in meeting their needs and intervening as necessary to stabilize crisis episodes and prevent placement disruptions. Support includes providing face-to-face visits in the foster parent's home a minimum of once per month, and more frequently as needed based on the needs of the foster parent and or the child, as determined by the Family Strength and Needs Assessment Tool. More frequent contact may be necessary to maintain communication and develop ongoing rapport.

<u>Intensive Family Reunification</u>

The goal of Family Reunification is to work intensively with the family in their home to reunify a child currently in out-of-home care. Intensive Family Reunification utilizes a dyad (two core case team members) approach with a therapist and skill builder to provide pre-reunification as well as support services after the child returns home.

<u>Family Centered Treatment® (FCT)</u>

FCT is an evidence-based model of intensive in-home treatment services for youth and families using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children's physical, mental, emotional, and educational well-being through family value changes. Service provision includes therapeutic interventions and family sessions to address chronic family functioning behavior in response to the youth's mental health needs. FCT interventions are provided typically, but not limited to, the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned home from an out-of-home

placement. FCT has had successful outcomes in several states and jurisdictions working with families who have had multi-generational system involvement. Instead of addressing the symptoms of a behavior and obtaining compliance with a family plan, the foundation of the model is to treat systemic trauma that a family may have experienced and to treat the underlying cause of the family's issues.

Oklahoma: Saint Francis has experience in providing therapeutic foster home services since 2009 through our subsidiary corporation Saint Francis Community Services in Oklahoma, Inc., with offices in McAlester, Oklahoma City, and Tulsa. In addition to Oklahoma, Saint Francis has been successful in providing foster home services in Nebraska, Texas, and Kansas.

Through our Oklahoma Therapeutic Foster Care program and culturally competent staff, Saint Francis has demonstrated its knowledge of the Oklahoma child welfare programs and specifically of resource family recruitment, assessment, training, and support to make Bridge resource families successful.

CO-2 F. Oklahoma Relevant Services
Bridge Resource Families (Tulsa, Oklahoma City, McAlester)

A Bridge Resource Family provides temporary care, love, and nurturing to a child. They welcome children into their home at any hour of the day or night, manage a wide array of emotions and behaviors, and cope with the agency's regulations, policies and paperwork. They serve mentors, actively helping the biological family improve their ability to safely care for their children, while staying connected and assisting in the child's transition to reunification, legal guardianship, or adoption to another family. As foster parents, they work to maintain the child's connection to kin, culture, and community.

Saint Francis recruits, trains, assesses, approves, and provides on-going support services for Bridge Resource Families to provide the least restrictive out-of-home placement for children and youth in state custody. Prospective families receive 27 hours of pre-service training plus six hours of orientation, as well as assistance with the decision making and licensure processes. Staff provide professional support, ongoing training and support groups, crisis intervention, and other identified services for every Bridge Resource Family. Bridge Resource Families take an active role in deciding which children will blend best within their household, with a goal of providing a caring and stable family environment where each child will be safe until permanency is achieved. Our service area is Oklahoma City and contiguous counties, Northeast and Southeast Oklahoma.

Texas: In 2017, Saint Francis became a licensed Child Placing Agency in Texas. That same year we began providing Foster Care Homes in Region 2.

CO-2 G. Texas Relevant Services
Foster Care Homes (Region 2)

Within Region 2 of Texas, Foster Care Homes facilitates and provides the least restrictive, out-of-home placement for children by placing them in a caring, family-like atmosphere. Foster Care Homes actively recruits foster care families to provide various levels of care to children birth through 19, including respite (part-time) and emergency care. Potential foster care families receive extensive training prior to child placement, in addition to assistance with the decision-making and verification process. Foster care families take an active role in deciding which children will blend best with their families.

Saint Francis provides ongoing professional support, training, and other identified services. In addition to foster families, Saint Francis assists relatives and fictive kin with the verification process and the continued care of children already placed in their homes. The goal is to provide a warm, caring environment where children can be safe and remain in their home communities until permanency is secured.

Arkansas: In 2018, Saint Francis was awarded the Intensive In-Home Services contract for 15 rural counties in Arkansas.

CO-2 II. Arkansas Relevant Services
Intensive In-Home Services

The Intensive In-Home Services program is a home and community-based diversion and reunification program that utilizes the Family Centered Treatment (FCT) model. The goal of the program is to safely reduce the number of children in care by providing intensive, long term, evidence based and trauma informed in-home services aimed at reducing child abuse and neglect, improving family functioning, enhancing parenting skills, addressing mental health and substance abuse issues, reducing child behavior problems, connecting families to formal and informal concrete supports, and empowering families to be able to solve future problems independently.

The family intervention specialist (FIS) takes a systematic approach and involves school teachers, family members, friends, community members, etc., to help the family develop a healthy social support network. Essential components of the FIS treatment strategy include therapeutic coaching; providing parenting skills education; facilitating educational achievement; offering special strategies concentrating on issues of sexual problem behaviors and substance abuse; teaching age appropriate personal habits and social skills; and helping the family access community resources.

ii. Financial Management Capacity

Saint Francis Ministries, Inc. (hereinafter "Saint Francis" within this section) has a 74 year history of assuring financial stability to it diverse programs that span seven (7) states. Over those 74 years, Saint Francis has demonstrated financial stability and solvency to carry out its mission. Saint Francis believes it continues to have the ability to fulfil the requirements of this procurement.

Financial Condition

Below is a summary of Saint Francis's consolidated balance and operating results for fiscal years ended 2017 and 2018 along with the financial position and results for the period ended February 28, 2019.

Audited financial statements for FY 2017 and FY 2018 have been included in the packet.

Saint Francis has a line of credit with a Wichita, Kansas-based bank in the amount of $10 million. The line is secured by investments, annuities and a mortgage on Saint Francis's psychiatric residential treatment facility (PRFT) in Salina, KS. The line of credit's maturity has been extended to June 30, 2019.

Financial Condition Summary

ASSETS	February 28, 2019	June 30, 2018	June 30, 2017
Current Assets			
Cash	2,182,812	323,138	599,563
Accounts receivable	14,797,561	13,908,775	17,470,508
Other current assets	1,316,999	1,037,841	873,632
Total Current Assets	**18,297,373**	**15,269,754**	**18,943,703**
Property, Plant and Equipment	**12,366,602**	**11,906,381**	**12,908,960**
Other assets			
Investments	11,232,343	10,798,512	8,808,971
Other	854,306	854,306	852,377
Total Other Assets	**12,086,649**	**11,652,818**	**9,661,348**
TOTAL ASSETS	**42,750,625**	**38,828,953**	**41,514,011**

LIABILITIES AND NET ASSETS	February 28, 2019	June 30, 2018	June 30, 2017
Current Liabilities			
Accounts Payable	7,480,049	7,091,851	7,500,350
Line of credit	8,759,492	5,337,732	2,100,000
Accrued expenses	5,441,308	4,137,912	2,899,383
Other current liabilities	18,257	14,419	16,663
Total Current Liabilities	**21,699,105**	**16,581,914**	**12,516,396**
Long-term Obligations	**85,137**	**90,408**	**107,204**
Deferred Operating Revenue	**1,341,883**	**1,660,695**	**1,317,072**

Total Liabilities	**23,126,125**	**18,333,017**	**13,940,672**
Net Assets	**19,624,500**	**20,495,936**	**27,573,339**
TOTAL LIABILITIES AND NET ASSETS	**42,750,625**	**38,828,953**	**41,514,011**

STATEMENT OF ACTIVITIES	For the Eight Months Ended February 28, 2019	For the Year Ended June 30, 2018	For the Year Ended June 30, 2017
Changes in Net Assets from Operations			
Operating revenues	**88,905,846**	**115,881,690**	**108,261,665**
Operating expenses			
Program services	**77,614,032**	**107,370,618**	**95,449,553**
Fundraising	**843,333**	**1,210,632**	**1,345,737**
Management and general	**14,364,993**	**17,573,168**	**15,510,543**
Total operating expenses	**92,822,358**	**126,154,418**	**112,305,833**
Total changes in net assets from operations	**(3,916,512)**	**(10,272,728)**	**(4,044,168)**
Nonoperating Change			
Gifts and Bequests	**585,634**	**1,042,604**	**826,426**
Other Income (Expense)	**2,330,408**	**2,152,721**	**1,085,737**
Total Nonoperating Changes - Net	**2,916,043**	**3,195,325**	**1,912,163**
Total Changes in Net Assets	**(1,000,470)**	**(7,077,403)**	**(2,132,005)**

Budgeting and Financial Systems

Budgeting System

Saint Francis is in the process of upgrading its current Excel worksheet-based budgeting system to Adaptive Insights, Inc.'s (hereinafter Adaptive) cloud-based budgeting and reporting system. Adaptive system links with Saint Francis's underlying accounting system (Black Baud's Financial Edge) and provides the ability to build custom models and reports allowing for immediate feedback and planning based on actual results. Adaptive will be used for reporting beginning in May 2019 and budgeting for FY 2020.

Accounting System

Saint Francis uses Financial Edge accounting software for general ledger, fixed assets and accounts payable processing. The Controller and Director of Accounting Services maintain Financial Edge setting up new Saint Francis programs, departments, entities, corporations, and accounting codes as needed. The Director of Accounting Services also establishes the security for the application and users by assigning each employee a set of permissions as designated for the specific employee. Each user is given rights only for the functions used in his/her workflow. IT staff install updates to the software as necessary and backs up the system daily.

Accounting staff in the Corporate Financial Services department produce monthly financial reports for the parent and eight (8) subsidiary corporations. The consolidated financial statements include the accounts of Saint Francis and its wholly-owned subsidiaries. All significant intercompany transactions are eliminated in the audited consolidated financial statements, but not on the monthly internal statements.

Accounting staff code expenses using a descriptive chart of accounts following U.S. generally accepted accounting principles and compliant with applicable governmental regulations. The account structure used enables Saint Francis to produce financial statements for up to 999 cost centers in separate "entities" (contract category or major operational group) within a corporation. The Financial Services department currently produces monthly financial reports for over 175 different cost centers.

Accounting staff use Financial Edge's fixed asset module to track the property and equipment for each corporation. Depreciation expense is recorded in the general ledger directly from the fixed asset module by the accountant responsible for updating capital records. Property and equipment acquisitions are recorded at cost, if purchased, or at fair market value on the date of the gift, if donated. Software development costs to develop software are used to meet internal needs and cloud-based applications. Saint Francis capitalizes property and equipment with a useful life greater than one year and cost in excess of $4,000.

Accounts payable transactions are posted continuously by the Accounts Payable Supervisor or designee. The Accounts Payable Supervisor or designee also generates corrections to the accounts payable postings as those are detected. The Accounts Payable Department receives all invoices and scans them into the accounts payable module using PaperSave software. PaperSave provides a paperless workflow for approvals and coding invoices. The Accounts Payable Department currently processes around 500 ACH payments and 300 manual checks weekly. Saint Francis encourages vendors to have payments directly deposited into their bank accounts via ACH. ACH payments typically post to vendor's bank account on Friday. Vendors are notified of payment by email using EFT-O-Matic software. Manual checks are usually mailed each Friday unless a payment outside of the regular processing schedule is required.

Saint Francis generates payments for foster homes through CIS/CMS, an internally developed client management software. CIS/CMS captures placement history for Saint Francis clients which includes placement in homes licensed by Saint Francis, homes licensed by other agencies and also non-licensed homes. Along with calculating payments required to the foster family, CIS/CMS calculates revenue expected by Foster Care Homes from Saint Francis's Reintegration/Foster Care/Adoption (RFCA) programs. The system along with Contract Services Department personnel routinely review the prior month's changes and adjust payments and revenue as needed.

CIS/CMS software will be replaced when a newly developed cloud-based system, which is under development, is completed. Workflow and functionality will generally remain the same as described herein.

A Contract Services accountant approves foster care payments in CIS/CMS. After reviewing for errors and/or irregularities and resolving matters noted for follow-up, the Contract Services accountant approves payments which are then directly imported into Financial Edge by Accounts Payable staff. Once a payment has been approved, it cannot be re-produced in the CIS/CMS Foster Care Payment system. Payment adjustments can be made by first recouping the original claim and then generating a new payment. A Saint Francis sponsored foster home can view payments on the Family Matters website, a secure foster care homes website that provides foster homes limited access to CIS/CMS data, after they become an authorized user.

When processing payments for Saint Francis sponsored homes, the Foster Care Payment system will create an AP/AR spreadsheet which summarizes the Foster Care Homes revenue by office and the Reintegration/Foster Care expenses by general ledger expense account. Accounts Payable and Accounts Receivable use this information to record the expense/revenue for the payment between the programs.

Foster parent payments are issued on a bi-weekly and monthly schedule. Monthly payments are made on the Friday closest to the 15th of each month. Payments to foster parents follow this schedule and include reimbursements for respite, mileage, etc. If necessary, the proccss can be run at other times to correct payment errors.

Contract Services Department staff are responsible for processing client-related expenses for all contracts and submitting them to Accounts Payable for payment. Data related to contract programs is stored in the CIS/CMS database. CIS/CMS tracks expenses, case activity, and other data by client. The information contained in CIS/CMS generates foster family payments and payments for other client-related expenses. Payments are processed through CIS/CMS, which validates the payments against authorizations entered in the system and assigns the general ledger account coding. Payment information can be directly imported into Financial Edge by Accounts Payable staff for further processing.

Examples of these payments include placement costs, kinship payments, daycare, financial assistance, mileage reimbursement, birth certificate applications, and payments for drug testing. There are specific guidelines for each payment type.

1. <u>Placement Costs to Child Placing Agencies</u>
   Placement costs are paid for children in out-of-home placement. Placement costs paid to agencies other than Saint Francis are guided by the Provider and Procedure Manual produced by the Care Center. The Care Center authorizes payment in the CIS/CMS system placement history of each client.

   Agencies submit billings for placements to Financial Services. The CIS/CMS payment system generates a payment for each client's placement. Contract Services accountants review payments and compare them to the agency submission. Differences in rates and service dates are verified by the Care Center or field staff prior to payment. Contract Services accountants can make changes, as necessary, to the payment generated by the CIS/CMS payment system. Contract Services corrections are the result of the other agency charging a lesser rate than the authorization. Payments will not be made to

placements not billed by the outside agency. After completing the review, the Contract Services accountant approves payments to be directly imported into Financial Edge by Accounts Payable for further processing.

Once a payment has been approved, it cannot be re-produced in the CIS/CMS payment system. Payment adjustments are made by first recouping the original claim and then generating a new payment.

Agency payments are reviewed monthly to ensure that payments were properly paid and overpayments, if any, have been recouped. This review checks for discrepancies, if any, caused by changes in CIS/CMS data made after payment was approved.

2. Kinship Payments

Kinship payments are for children in out-of-home placement who are in unlicensed homes of relatives or non-related kin. Kinship placements are initially setup as unpaid until Saint Francis receives a direct payment determination from the applicable State agency, at that point the Kinship director will approve a stipend depending on the State agency's determination.

These homes are unpaid placements until payment is authorized. The Kinship Supervisor or Kinship Director determine the daily-rate and payment frequency. The Care Center authorizes payment through the CIS/CMS placement history of each client. CIS/CMS can process monthly or bi-weekly payments.

CIS/CMS generates a payment for each kinship placement based on procedure codes designating a monthly or bi-weekly payment cycle. Payments are reviewed by the Contract Services accountant. After completing the review and resolving matters, if any, for follow-up, the Financial Services accountant approves the payments to be directly imported into Financial Edge by Accounts Payable for further processing.

Once approved, a payment cannot be re-produced in the CIS/CMS payment system. Payment adjustments are made by first recouping the original claim and then generating a new payment.

3. Daycare

Daycare payments are guided by the Daycare Policy and Procedure Handbook produced by the Care Center. The Care Center establishes approved daycare providers in CIS/CMS and authorizes payments for each client. The Daycare Provider submits a signed Daycare Provider Timesheet to Contract Services for billing. The Contract Services clerk verifies the timesheet against the authorization, re-calculates the units due, and checks for duplicate submissions. Payment is based on the authorized rate and the amount of units submitted that do not exceed the authorized maximum frequency.

A Contract Services clerk enters claims based on a signed daycare timesheet in an CIS/CMS SmartSpreadsheet. The CIS/CMS system validates these entries against the authorization. The Contract Services accountant reviews the entries and approves them for payment after issues identified, if any, are resolved. Approved payments are directly imported into Financial Edge by Accounts Payable for further processing.

4. Financial Assistance to Clients

When a need arises for a Reintegration/Foster Care/Adoption (RFCA) client, Case Management team members will submit a supervisor approved Request for Financial Assistance Form to the Care Center. Requests for client financial assistance must include receipts and/or statements and a complete payee address. Field staff must also present a viable explanation for the expense and document, if applicable, how they attempted to find other community resources.

The Care Center enters an authorization in the CIS/CMS payment system and notifies the Contract Services clerk when payment can be made. Claims are entered into the CIS/CMS SmartSpreadsheet by the Financial Services clerk. CIS/CMS validates these entries against the authorization information. The Contract Services accountant reviews the entries and approves them for payment. Approved payments are directly imported into Financial Edge by Accounts Payable.

5. Mileage to Foster Homes

Foster homes are reimbursed for certain types of mileage when transporting clients. Policies for reimbursement are based on the type of foster home:

- Unlicensed,
- Saint Francis sponsored
- Sponsored by another agency.

All foster homes are reimbursed at the same rate unless an alternative agreement is made with the sponsoring agency.

Saint Francis foster homes and unlicensed homes are reimbursed for transporting clients to activities requested by the case management team, such as case plans, family visits, court and other case-related meetings. Transportation related to medical appointments should be reimbursed by Medicaid. In certain instances, to meet specific client needs, the case management team can approve an exception to the regular mileage policy. Once notified by the field, Care Center staff enters an authorization in CIS/CMS for a mileage exception.

Foster families sponsored by other agencies are only compensated for transporting clients over 60 miles round-trip. The mileage must be for case-related activities and cannot be for medical reasons. All reimbursements require an authorization in CIS/CMS prior to payment. Field staff submits the request to the Care Center for authorization. Mileage without prior authorization will be denied payment.

Foster parents complete a mileage log form and submit it to their Saint Francis worker, to request reimbursement. Saint Francis staff reviews and approves the log before sending it to Contract Services. A Contract Services clerk reviews the log, evaluates the reason for transport, and calculates the reimbursement. The Financial Services clerk denies any mileage submitted after the designated 180-day time limit. If the mileage is deemed unreasonable for the destination described on the log, Financial Services will re-calculate the mileage and reduce the reimbursement.

Saint Francis foster homes have the option of completing the mileage log form on the Family Matters website, a secure foster care homes website that provides foster homes with limited access to CIS/CMS data. The on-line form requires the same information as

the paper form. Once completed, the form is electronically sent to the Foster Care Home staff for approval. Once approved, Contract Services is notified, and the Financial Services clerk reviews the form as described above. The family will receive a notice as to what mileage was denied and why with their check or remittance advice from AP.

Claims are entered into the CIS/CMS SmartSpreadsheet by the Contract Services clerk. The CIS/CMS system validates these entries against the authorization information. If there is no authorization, CIS/CMS will check for duplicates and ensure that the service dates fall within the referral dates of the client. The Contract Services accountant reviews the entries and approves them for payment. Approved payments are directly imported into Financial Edge by Accounts Payable for further processing.

6. Birth Certificate Applications

Birth certificate applications are processed by the Contract Services clerk. Field staff complete an application for the appropriate state and submit it to Contract Service; the Contract Services clerk then reviews the application and collects the required paperwork. The clerk is expected to stay current and knowledgeable about each state's regulations.

Payment is submitted with each application, and, accordingly, a claim is entered into the CIS/CMS SmartSpreadsheet by the Contract Services clerk. Since there is no authorization, Contract Services clerk checks for duplicates and ensure service dates fall within the client referral dates. The Contract Services accountant reviews the entries and approves them for payment. Approved payments are directly imported into Financial Edge by Accounts Payable for further processing.

Birth certificates are mailed to Contract Services from state vital records. Contract Services mails the birth certificate to the employee who made the original request. Birth certificate applications are tracked to insure Saint Francis receives all requested certificates.

7. Payments for Drug Testing

Contract Services processes payments to vendors for drug testing clients and families. These clients can be from Reintegration/Foster Care/Adoption or Family Preservation. Only those services not paid directly by the State or Medicaid are processed for payment.

The Contract Services clerk creates a spreadsheet summarizing charges applicable to each client. Claims are then entered into an CIS/CMS SmartSpreadsheet. Because there is no authorization, CIS/CMS will check for duplicates and ensure that the service dates fall within client referral dates. The CIS/CMS entries are reviewed and approved by the Contract Services accountant against the original statement. Once approved, the Contract Services accountant forwards the forms to Accounts Payable for PaperSave auto-entry into Financial Edge.

8. Other Authorized Payments

Other payments not described above can be required for services to Reintegration/Foster Care/Adoption clients. These payments are authorized by the Care Center through CIS/CMS. The authorization and any invoices and/or statements are submitted to Contract Services for processing.

Claims are entered into authorizations typically with a small number entered via the CIS/CMS SmartSpreadsheet by the Contract Services clerk. The CIS/CMS system validates these entries against the authorization information. The Contract Services accountant reviews the entries and approves them for payment. Approved payments are directly imported into Financial Edge by Accounts Payable for further processing.

PDS Cortex (PDS) accounts receivable software is used to process balances due from clients (typically but not in every case) submitted to insurance companies and to generate accounts receivable entries. The Director of Accounting Services reconciles the entries to the general ledger. Separate journal entries for each program are imported into the general ledger monthly. Client accounts receivable are tracked through PDS. Account Receivable (AR) staff receive information on forms for patient status, provider agreements, new admissions, discharges, changes in level of care, and moves in foster homes on a daily basis. New accounts are set up in the billing program as required. Spreadsheets are maintained reflecting the daily census and units of service for various programs. The account aging updates daily as payment is received and is reviewed regularly to determine follow-up action required and to minimize account aging. Correspondence from insurance and agency payers is addressed as it comes into the AR Services office.

Non-account receivable cash receipts are prepared daily by the Treasury Accountant. These are imported into the system throughout the month by an accountant.

Ultipro, the payroll software, generates the payroll entries from time records submitted by hourly employees and payroll data it maintains for salaried personnel. The Payroll Accountant runs reports from Ultipro to prepare a journal entry that is imported into the general ledger. The accountant reconciles this entry to the Ultipro payroll records after each payroll. An accrued payroll entry is done at the end of each month. This entry includes an accrual for Earned Time Off. The Controller or designee reviews and approves payroll and accrual entries before being posted into the general ledger. All payroll activities are centralized in one corporation through a common paymaster and the disbursement of expense to all other corporations is managed through intercompany due to/from accounts.

Corporate/Parent Guarantee

Saint Francis currently is affiliated with ten subsidiary corporations in Nebraska, Arkansas, Illinois, Mississippi, Oklahoma and Texas. Each corporation actively operates as a private, non-profit organization granted 501(c)(3) status by the Internal Revenue Service and operates under its own board of directors, as well as under the guidance of the parent corporation board of Saint Francis. The parent corporation hereby unconditionally guarantees performance by the respondent of each and every obligation, warranty, covenant, term and condition of the contract.

CO-3 MANAGEMENT OF THE PROJECT The bidder should present a detailed description of its proposed approach to the management of the project. The bidder should identify the specific professionals who will work on the State's project if their company is awarded the subaward resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified. The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.	Comply: X

i. PERSONNEL/MANAGEMENT APPROACH

A diverse ten-member volunteer board of directors governs Saint Francis Ministries. Within the ten (10) subsidiaries there are diverse boards who govern their operations. Members represent both a national and international perspective and have a wide range of professional experience in the church, business, heath care, legal/judicial and academic fields. Board members meet three times each year. Board members are voting members of the Corporation and have full power and authority to amend the Articles of Incorporation, elect members, and perform all other acts required or permitted under the law for members of a not-for-profit corporation.

Saint Francis has a four-member senior executive team directed by our Dean, President and Chief Executive Officer (CEO), The Very Reverend Robert Nelson Smith. Members of the senior executive team include the President and Chief Operating Officer (COO), Tom Blythe; President and Chief Public Policy and Community Engagement Officer (CPP), Dr. Page Walley; and President and Chief Development Officer (CDO), The Very Reverend David Hodges. Answering to the President and COO are the Chief Compliance Officer(CCO), Chief Technology Officer (CTO), Chief Financial Officer (CFO), and Chief Clinical Officer (CCO). Reporting to these chief officers are a number of vice presidents, associate and assistant vice presidents, and directors who oversee a staff of over 1,200 employees.

The Very Reverend Robert Nelson Smith assumed leadership of Saint Francis Community Services in July 2014, becoming the ministry's sixth President. As the Dean and President/CEO he leads the largest social welfare ministry founded in the Episcopal tradition. Rev. Smith provides overall strategic direction, financial viability and corporate vision, and valuates effects of external forces on Saint Francis and affiliate corporate entities with operational budgets in excess of $140 million. He ensures attainment of strategic goals and objectives occur through recruitment, selection, development, motivation, evaluation and retention of qualified staff. The Very Rev. Fr. Smith also keeps board and senior staff informed about current trends, issues, opportunities, threats and activities related to the child welfare arena and marketplace; he encourages the integration of Saint Francis within the community(s) served by overseeing an

effective communication and public relations program; and works with appropriate legislators, regulators, and representatives of child welfare sector, industry, civil, legislative, and church leaders to develop legislative initiatives and social policy statements which will improve child welfare services and behavior health programs.

Fr. Smith earned a Bachelor of Arts from Eastern Illinois University and a Master of Arts in Business from Webster University in St. Louis. He has 20 years of healthcare administrative experience, having served in executive leadership positions in healthcare organizations in Wisconsin and Illinois. Prior to that, he worked on Capitol Hill as a legislative assistant for a member of the House of Representatives.

Reporting to the Rev. Smith is Tom Blythe, President and COO, who provides strategic direction for residential programs and child and family services programs. In addition, he oversees administrative and support functions including Administrative Services, Finance, Technology, Compliance, Clinical, Mental Health and Substance Use Disorder Services, Innovation, Consulting and International Ministries.

Mr. Blythe holds a bachelor's degree in business administration from Drake University and a master's degree in human resources management from Webster University in St. Louis. His career has spanned a variety of management positions for hospitals and health systems in Illinois. Before joining Saint Francis Community Services in 2015, Blythe was System Vice President for Human Resources at St. Mary's Good Samaritan, an organization that included 1,900 health care workers and two acute-care hospitals, serving 300,000 people in a nine-county area of Illinois.

James T. Wicks is Saint Francis Ministries' Chief Compliance Officer and General Counsel, reporting to CEO and President Rev. Robert N. Smith and COO Tom Blythe. He is responsible for overseeing Saint Francis's litigation, transactional, risk, compliance, intellectual property, government contracting, and corporate governance issues. He supervises the Legal Services division of the Legal Department, which, through a team of staff attorneys, provides services in child and family welfare cases in Kansas and other jurisdictions and trains staff in core legal issues and court procedure and decorum. Mr. Wicks supervises the Director of Risk Management and provides council for various internal clients, including Human Resources, The Saint Francis Foundation, and international operations.

Mr. Wicks is a graduate of the Harvard Law School and of the College of the University of Chicago. He began his law practice in New York City with Cahill Gordon & Reindel, where he concentrated on First Amendment and Antitrust litigation. He subsequently practiced in New York with the law firms of Stanley S. Arkin, P.C. and Chadbourne & Parke, where his practice involved white collar criminal defense and high-net-worth matrimonial law. Before joining Saint Francis, Mr. Wicks was Counsel in the Kansas City, Missouri office of Bryan Cave LLP, where he specialized in complex commercial litigation and class action defense.

Kevin Carrico is a child welfare lawyer and currently serves as the Vice President of CINC Legal Services, reporting to the Chief Compliance Officer. Mr. Carrico has served Saint Francis for the past 19 years. In 1994, Mr. Carrico graduated from Creighton University School of Law in Omaha, Nebraska. After four years as a lawyer in private practice, he joined Saint Francis. He initiates daily communication with Saint Francis program and administrative leadership on the programs and services being delivered particularly as they relate to social work delivery, legal risks, courtroom dynamics, and practice expectations. Mr. Carrico also engages regularly with

Saint Francis Social Workers and Support Staff to discuss staff performance improvement and quality assurance with the goal toward improving services to children and families.

To provide quality services, Mr. Carrico attends root cause analysis meetings and/or performs timely legal file reviews. To increase the legal knowledge base of front line Saint Francis workers, he coordinates and conducts on-going quarterly legal trainings for staff. To ensure that Saint Francis workers are knowledgeable about court expectations and know the identity of the local Saint Francis Field Staff Attorney, Mr. Carrico works with other departments to have newly-hired workers from selected departments meeting with the Saint Francis attorney within 90 days of their start date. To improve operational efficiency, he meets with the Saint Francis Legal Department Attorneys on a monthly basis to discuss timely permanencies and outcome measures related to service delivery.

William Whymark, Ph.d, Chief Information Officer, provides oversight for all aspects of information technology and leads the strategy and development of all data science programs for Saint Francis. Dr. Whymark reports directly to CEO and President Rev. Robert N. Smith and COO Tom Blythe, and is over the IT team including the Technology coordinator and Security Administrator for our Nebraskan programs.

Dr. Whymark holds a Ph.d in the marketing sciences and he brings over 20 years of experience leading analytics at companies such as General Electric, GE Capital, American Airlines, and IBM. While at IBM, Whymark created mega off-shore data science hubs to drive IBM Watson Artificial Intelligence solutions to diversified industrial markets. Further, Whymark has done extensive work partnering with governmental agencies to design complex data science solutions to optimize organizational processes, saving states and municipalities millions of dollars. He has extensive knowledge regarding all areas of data science with a specialty in applying artificial intelligence and machine learning protocols to solve organizational problems.

The Vice President of Administrative Services, Tracy Hervey, reports to the President and COO and provides leadership over critical support functions within the Saint Francis ministry that include human resources, training and development, compensation and benefits, organizational excellence, marketing, communications, facilities, safety, and strategic planning. A lifelong human resource professional, Ms. Hervey has always applied her skills to the service of children, beginning with the Kansas Children's Service League more than 20 years ago. Joining Saint Francis in 2007, she served as Director of Human Resources for our offices in Wichita and throughout western Kansas, Mississippi, Nebraska, Texas, Arkansas, and Oklahoma.

Ms. Hervey has a bachelor's degree in business administration from Wichita State University and a master's degree in human resources management from Webster University in St. Louis. She also holds a PHR and SHRM-CP certification.

Saint Francis's Quality Assurance and Performance Improvement, program implementation and maintenance will be led by the Vice President of Innovation and System Improvement, Matt Stephens. Mr. Stephens reports to Mr. Blythe, President and COO. Saint Francis's commitment to quality is evidenced by its pursuit of the Malcolm Baldrige National Quality Award and the systematic use of Lean/Six Sigma as the process improvement methodology focusing on elimination of waste and decrease in variance. Mr. Stephens holds a green belt in Lean/ Six Sigma and has served as a Kansas Quality Award Examiner (2017). Mr. Stephens has worked in social services for over 20 years in a variety of roles and organizations. Mr. Stephens was a

Child Welfare Scholar Recipient awarded by the State of Kansas; upon completion of a bachelor's level social work degree from Kansas State University, Mr. Stephens worked as a Child Protection Social Worker for the State of Kansas. Before joining Saint Francis Community Services in 2016, Stephens was a licensed adult care home operator at Neuvant House an assisted living community in Lawrence KS.

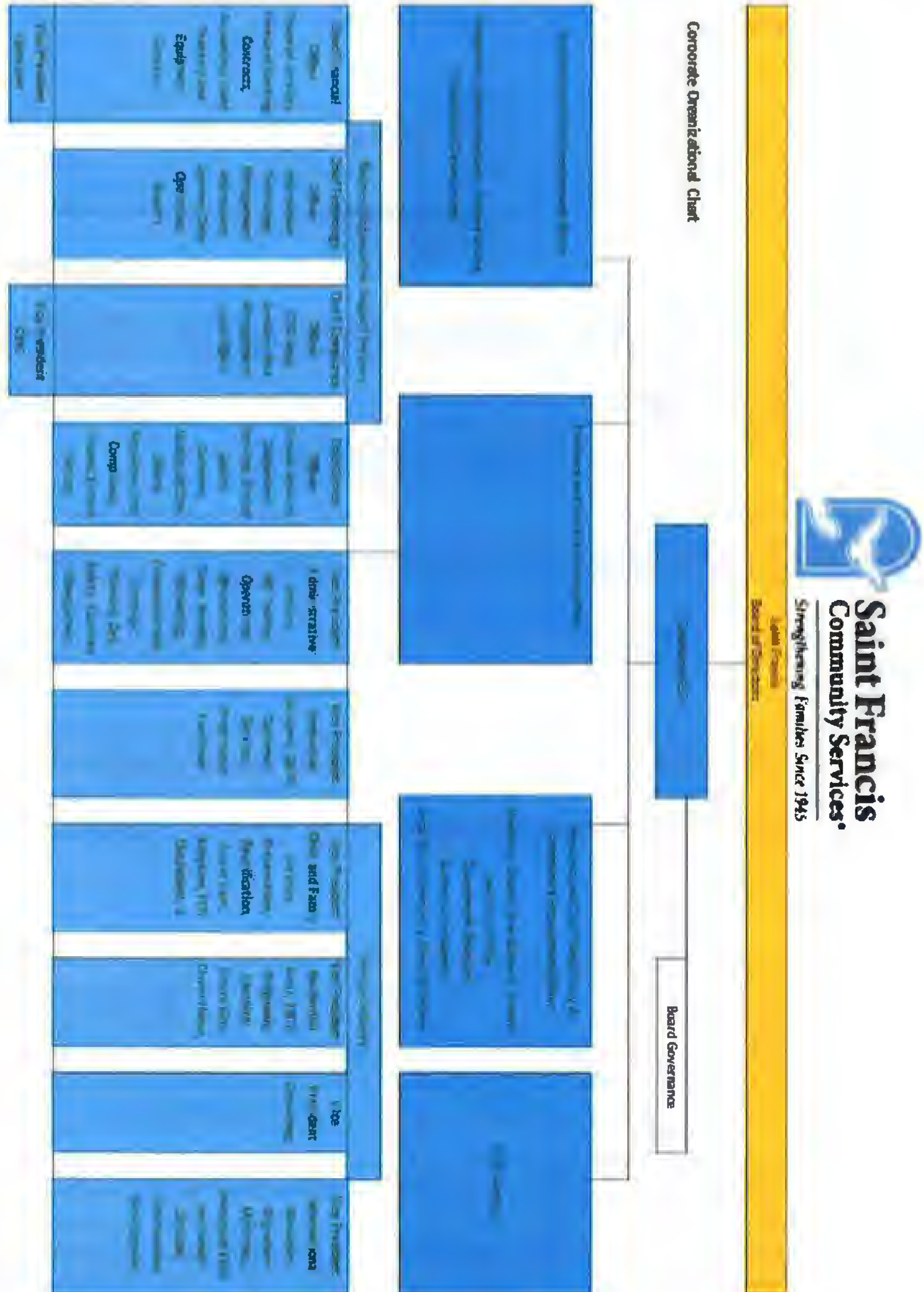
His current work includes oversight of quality assurance, data management, and facilitating process improvement efforts.

The Vice President of Children and Family Services, Diane Carver, reports directly to the President and COO and oversees the Assistant Vice President of Services for Nebraska Eastern Service Area. Mrs. Carver has over 40 years of child welfare experience, serving first in the public state system as a regional and central office administrator before serving with Saint Francis. Mrs. Carver has provided leadership for all aspects of child welfare including prevention, protection, reintegration, adoption, and independent living services. Responsibilities of her position includes leadership, planning, coordination, implementation, administration and continuous improvement of program operations. Her work involves direction of a large professional and paraprofessional workforce, allocations, program planning, community development, information management, policies and procedures. Mrs. Carver has served on numerous community and professional work groups which supports system improvements.

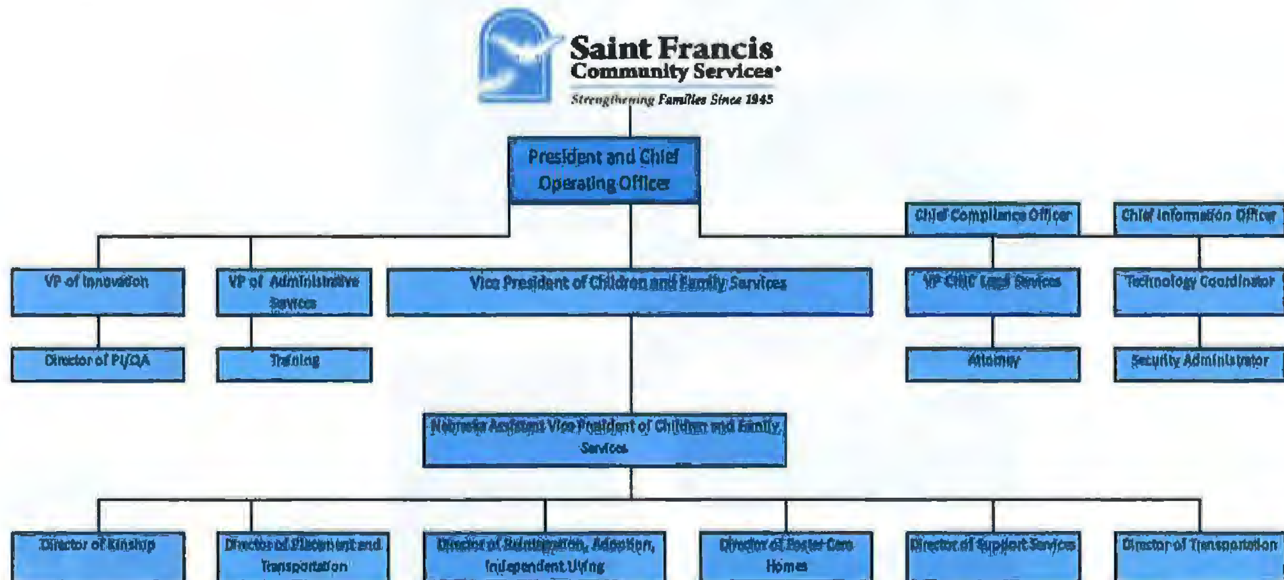
The Assistant Vice President of Services for Nebraska Eastern Service Area, To Be Hired, will hold a master's degree in social work or related degree, and have five (5) years minimum child welfare direct service experience. They will report to the Vice President of Children and Family Services. They are responsible for administering and managing the Regions service delivery and contract outcomes. Some of their interface and support functions will include design, develop and implement the child welfare programs according to DHHS contracts. Monitor program to assure compliance with contract, regulatory, licensing and accreditation standards. Advise the Vice President of critical trends, problems or events in assigned areas.

The Assistant Vice President will be over the directors of Kinship; Placement and Transportation; Reintegration, Adoption, and Independent Living; Foster Care Homes; Support Services; Family Preservation; and Transportation. A Director of Family Preservation will be added to the Organizational Chart when awarded. A full Staffing Matrix can be found on pgs. 93-96.

A Corporate Organizational Chart highlighting Executive Leadership and the areas of focus for each is provided below.



A Nebraska Eastern Service Area Organizational Chart highlighting the team leadership, and reporting relationships is provided below. A Director of Family Preservation who will report to the Nebraska Assistant Vice President of Children and Family Services will be added to this Organizational Chart.



Key resumes, and references may be found in Attachment R and job descriptions may be found in Attachment J.

Saint Francis is dedicated to the protection, nurturing, and healing of children and families in body, mind, and spirit. We respectfully provide services to people of various cultures, races, ethnic, disability status, orientation, gender and religious backgrounds in a manner that recognizes, values, affirms, and respects the worth of the individual, protecting and preserving their dignity.

j. SUBCONTRACTORS.

Saint Francis has developed relationships with many Nebraskan stakeholders including subcontractors through our work in noted in **Table CO**: Nebraska State Grants and Contracts 1/1/2009 to present. We will continue to build upon existing relationships as well as establish new subcontracts with local stakeholders that will provide services for children and families in the Eastern Service Area. Details of Saint Francis's strategies to develop and maintain these relationships can be found in Community Engagement ENG-1 and ENG-2.

The initial step in the development of Saint Francis's provider network has been to forge partnerships with potential providers throughout the Eastern Service Area. These meetings were designed to assess the strengths and challenges of children and family services, as well as placement opportunities in the community. Saint Francis is committed to partnering with providers whose commitment to community-based, collaborative, and outcome-driven service is matched by their commitment to quality child-focused, family-centered, and trauma-informed care.

During start-up, Saint Francis leadership will establish the infrastructure needed to deliver timely services in the area. Saint Francis will enter into affiliate agreements with care givers and subcontractors for placement and establish service providers for behavioral health needs, physical and dental health services, and other entities necessary to deliver required services in new counties.

Providers who wish to join the Saint Francis provider network in providing paid foster care and/or purchased services in Region 1 will enter into more formal discussions with Saint Francis once the contract award has been announced. Prospective providers will be required to supply documentation of their qualifications that meets the criteria to join the Saint Francis provider network, including professional credentialing, as a prerequisite to providing services. The provider's current standing with DHHS is an important qualifier for inclusion in the Saint Francis provider network, and Saint Francis will consult DHHS further should DHHS staff voice concerns about any providers applying to the network.

We utilize a structured application and monitoring process for assessment of quality of services. A provider manual which outlines expectations, regulations, and monitoring processes is maintained and distributed to all child placement agencies. It challenges caregivers and subcontractors to provide services that support the healing process as a part of the permanency goal and will include supervision, food, shelter, age appropriate daily living skills instruction, transportation, recreation, and supporting parent/child interactions. Placement providers are expected to participate in and support the execution of case plan activities and objectives.

Our processes for the credentialing of on-site assessments are outlined in the table CO-3 A.

CO-3 A. Saint Francis's Steps of Credentialing On-Site Assessments
All new providers go through an application process that is vetted by Saint Francis in addition to the current Nebraska regulatory oversight agencies
Application packets include enrollment application, copies of all applicable licenses, copies of any accreditations, certifications and DHHS provider agreement, copies of all liability insurance certificates, mission and program descriptions, and a completed W-9 form
Documentation is reviewed, site visit occurs, and if passing inspection, the following occurs:
• Draft agreement
• Copy of the Saint Francis Provider Manual (includes claims submission and processing manual, Saint Francis Critical Incident policy, Saint Francis Emergency Contact Phone Listing, and the Monitoring Tool developed by Saint Francis utilized to conduct quality reviews) is provided
• Rates and term negotiations are conducted
Contract agreed upon and signed
The process includes:
• A list of all critical incidents over the past year is reviewed by Provider Relations staff to pull trends
• Review of any resolved concerns and actions plans for the last year
• Review of any active concerns
• On site review of the environment, case reads of 10% of files, interviews
• Conversation over any situations in the last year

CO-3 A. Saint Francis's Steps of Credentialing On-Site Assessments
Following the site audit, provider receives a formal audit summary. The sum scores of file reads must result in a 90% or greater score; if below 90%, an Action Plan is created with the provider to complete to resolution.

During the on-site visit, providers must provide the following documentation to pass file review:

- DHHS License
- Profession and General Liability Insurance
- Copies of:
    - Insurance Card for each vehicle transporting Saint Francis youth
    - Policy and Procedure manuals
    - Youth Handbook
    - Posted Behavior Management System
    - Previous month's activity schedule
    - Previous month's food menu
    - Fire drill logs and posted evacuation route
    - Tornado drill logs and posted tornado shelter area
    - Current floor plan

Upon agreement, the name, address, and telephone number of the subcontractor(s)/Second Tier Subrecipient(s), with specific tasks for each subcontractor(s)/Second Tier Subrecipient(s), will be provided to DHHS. When the majority of percentage of subcontractor(s)/Second Tier Subrecipient(s) for the Eastern Service Area has been determined, performance hours intended for each subcontract/subaward and total percentage of subcontractor(s)/Second Tier Subrecipient(s) performance hours will be presented.

Continually monitoring the providers caring for the children in conservatorship is essential to ensuring they receive the best possible care. To monitor the performance of subcontractors, we review indicators such as: disruptions, missed appointments, runaways, legal charges involving youth, and work towards permanency. It is the expectation that the subcontractor submits a monthly report on each child, and this is carefully reviewed by the Case Managers to see how the child is doing and if there are any issues. We also do a thorough monthly Worker/Child visit in the home or facility and visit with the child about any issues.

We monitor the capacity of services and placements of our network by tracking the length of time it takes to find a placement or to get a child in for services, the utilization of emergency or shelter placement, and feedback from children, families, and providers. If placement trends indicate that we are placing children in certain offices or counties consistently away from their community, we know to evaluate the reasons for these decisions to see where gaps exist, such as if there is a shortage of placements; we then look at ways to boost referrals for new foster homes.

k. Saint Francis Community Services, Inc. REFERENCES

Nebraska State Purchasing Bureau
c/o Saint Francis Community and Family Services, Inc.
Corporate Office
509 E. Elm Street
Salina, KS 67401-2353

It is my, Timothy J. Wood, LPC, Executive Director of the Family Centered Treatment Foundation Inc.'s., privilege to provide Saint Francis Community and Family Services, Inc. a letter of reference for the Nebraska Full Service Case Management for Child Welfare Services Request for Proposal: Solicitation Number RFP 5995 Z1.

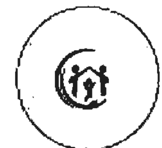
The Family Centered Treatment Foundation (FCTF) provides FCT Licensing, training and oversight for the Family Centered Treatment® (FCT) evidence-based, in-home family therapy model to Saint Francis Community and Family Services, Inc. Speaking on behalf of FCTF, since early 2018, our collective experience working with Saint Francis has been excellent. Saint Francis as an organization has demonstrated attention to detail in quality service delivery and implementation science best practices of the FCT project. Objectively, Saint Francis has met or is on pace to meet implementation science standards for provision of the FCT Model and has demonstrated a good understanding of how to build programs for sustainable success. Both through subjective discussions with state stakeholders and through objective assessment of implementation assessments of FCT, the quality of services with Saint Francis has been excellent. We at the Foundation feel confident about the relationship working with Saint Francis now and into the future.

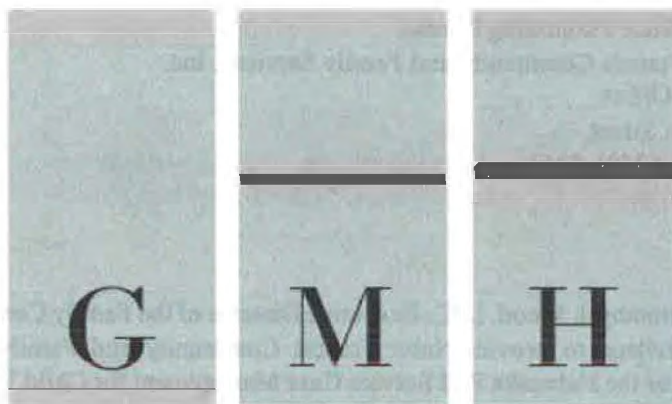
Saint Francis has a long history of providing high quality case management services to children and families in child protection cases. They deliver a continuum of evidence-based prevention services that strengthen families. They also promote the best possible care of a child including reunification, when possible, foster care and/or adoption. They are an excellent candidate for the case management services needed in Douglas and Sarpy counties and I highly recommend them.

If you would like additional information about Saint Francis, you can telephone me at 704-787-6869.

Sincerely,

Timothy J. Wood, LPC
Executive Director
Family Centered Treatment Foundation, Inc.





SOCIAL SERVICES CONSULTING

It is my privilege to provide Saint Francis Community and Family Services, Inc. a letter of reference for the Nebraska Full Service Case Management for Child Welfare Services Request for Proposal; Solicitation Number RFP 5995 Z1.

I have worked alongside St. Francis Community and Family Services as a Child Welfare professional for the last twenty years in Kansas. Most recently, I was the Secretary for the Kansas Department for Children and Families in Kansas, and St. Francis was one of our primary partners.

St. Francis has been providing quality child welfare services in Kansas since the beginning of their organization. They have provided quality residential care, family preservation and strengthening programs, foster care case management and adoption services among other services.

Saint Francis has a long history of providing high quality case management services to children and families in child protection cases. They deliver a continuum of evidence-based prevention services that strengthen families. They also promote the best possible care of a child including reunification, when possible, foster care and/or adoption. They are an excellent candidate for the case management services needed in Douglas and Sarpy counties and I highly recommend them.

If you would like additional information about this organization and its fantastic leadership, I am happy to answer questions. I can be reached at 7857605961.

Sincerely,

Gina Meier-Hummel, LMSW
President, GMHUMMEL LLC

PHYLLIS GILMORE
286 N. Overlook Street
OLATHE, KS 66061
913-238-9983

March 16, 2019

Nebraska State Purchasing Bureau
c/o Saint Francis Community and Family Services, Inc.
Corporate office
509 East Elm St
Salina, Kansas 67401 - 2353

To Whom it may concern:

It is my, Phyllis Gilmore, former Secretary of the Kansas Department for Children and Families, privilege to provide Saint Francis Community and Family Services, Inc. a letter of reference for the Nebraska Full-Service Case Management for Child Welfare Services Request for Proposal; Solicitation Number RFP 5995 Z1.

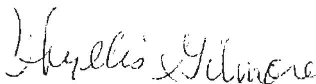
Saint Francis has served in the area of child welfare in Kansas for many years. When I became Secretary in 2012, they were the contractor for one of our regions. During my tenure which ended in 2018, that was expanded to serving two regions. They provided services in the area of foster care, adoption and prevention. We found them to be willing to listen to what we wanted them to do and tried hard to comply with our directives. I remember specifically one case involving the constituent of a state senator who was quite involved in the situation. The constituent, a grandparent, was quite unhappy about the way the case was being handled. When we intervened and spoke with Saint Francis about this, they were able to turn the situation around. Both the grandparent and the state senator were quite satisfied with the outcome.

We also found when we asked Saint Francis to speak with an employee about a case, they were willing to do so, even to the point of placing an individual on leave while investigating the situation. I especially appreciated their willingness to comply with our wishes without argument in most instances.

Saint Francis has a long history of providing high-quality case management for children and families in child welfare cases. They use a delivery system of evidence-based prevention services that has proven to strengthen families. They also work diligently to establish reunification of a child with his family whenever possible. If that is not possible, they endeavor to provide good foster care and or adoption in a timely manner. Saint Francis is a very capable candidate for the case management services needed in your state and I highly recommend them to you.

If you would like to contact me further about this matter, you are welcome to do so.

Sincerely,



Phyllis Gilmore
Former Secretary

TI Transition and Implementation

TI-1 Preliminary implementation plan. Description of Saint Francis's plan to comply with provisions of RFP 5995 Z1, including staffing, facilities, and other operational issues such as tasks and deliverables necessary to implement the program.	Comply: X

Response:

To ensure the transition of quality service delivery to children and families, Saint Francis will use the Intensive Family Preservation (In Home Services) and Reintegration, Foster Care, and Adoption (RFCA) service delivery models in conjunction with the implementation plan to provide the appropriate services during the transition and throughout ongoing case management services (see pgs. 57 and 58 for models). We will collaborate with DHHS staff to develop joint operational processes and Eastern Service Area-specific protocols to implement the Saint Francis Service Delivery Models. These protocols and joint operational processes will include, but are not limited to, establishing methods and frequency of communication, jurisdictional expectations, and clarification of DHHS's and Saint Francis's respective roles and responsibilities

The transition for Saint Francis into the Eastern Service Area will be very similar to the transition Saint Francis implemented when it was awarded the Wichita Region in Kansas in 2013. The Eastern Service Area presents similar challenges to those in Kansas's Wichita region, and is similarly composed in size, the number of children in out-of-home care, and demographics when comparing the blend of urban and rural composition. For FY17, Kansas's Wichita Region had an average 1,454 children in out-of-home placement[5], and the Eastern Service Area had 1,559 in out-of-home placement as of June 2018[6].

As with Kansas's Wichita Region, our most recent large-scale contract commencement for RFCA and Intensive Family Preservation Services, our initial plan is to serve the Eastern Service Area out of one strategically located office. For the Wichita Region, however, Saint Francis was given less than six months to plan, hire staff, prepare offices, update our data system, and work with community stakeholders while developing a comprehensive provider network. On July 1, 2013, every child in the case load was transitioned to our organization in a single day. At that point, Saint Francis was responsible for all placements, all legal and court work, all case plans, weekly visitation with the parents, all services for the family and child, as well as all adoption work, including Points of Severance for termination hearings, finding adoption resources,

[5]Kansas Department for Children and Families Prevention and Protection Services: *FY 2017 Removals, Exits and Out of Home Summary (FACTS),*
http://www.dcf.ks.gov/services/PPS/Documents/FY2017DataReports/FCAD_Summary/FACTSRemovalsExitsOOHSFY17.pdf

[6]Attachment Three RFP 5995 Z1 Full Service Case Management,
http://das.nebraska.gov/materiel/purchasing/5995/5995%20Z1%20Attachment%203%20Service%20Area%20Monthly%20Summary%20R%20agency.pdf

choosing the appropriate family for the child, and then working with the adoptive family in preparation for the adoption. Saint Francis was responsible for picking up each child within 4 hours of the referral, regardless of the time of day and then assuring the child had a placement. During our six (6) years of serving the Wichita Region, Saint Francis has never missed or refused a single referral, and we were able to implement the seamless transition of these services within a timely manner.

Our previous experience in the development and implementation of service delivery while ensuring a seamless transition of case management services to children and families in other areas and other states will enable Saint Francis to strategically define and successfully carry out tasks, deliverables, and milestones necessary to implement the Eastern Service Area's Full Service Case Management Program as defined in RFP 5995 Z1. Our Service Delivery Model is established and has been successfully adapted to serve children and families in a variety of geographical and cultural settings for over 22 years.

Saint Francis will not minimize the preparation process and will exercise due diligence in defining and executing each stage and strategy in the implementation plan. This includes stages and strategies for establishing the office location, community engagement with stakeholders and service providers, staffing including engaging DHHS staff or qualified staff from current child welfare agencies in the area who may be misplaced by an incoming child welfare provider, subcontracting for services, and ensuring service provision. The six month preliminary implementation phase and subsequent readiness review by DHHS will allow for thoughtful planning for each aspect of the contract and successful implementation of services.

Saint Francis is prepared to manage the transition from DHHS to Saint Francis in the Eastern Service Area, as well as the transition between staff and other community stakeholders currently providing services. Saint Francis has extensive experience transitioning cases and our staff understand the difficulty of this process for all involved.

Our key transition team members collaborating with DHHS will most likely be the Vice President of Children and Family Services; Assistant Vice President of Children and Family Services; Assistant Vice President of Children and Family Services for the Eastern Service Area, Executive Director of Western Nebraska; Vice President of Administrative Services; Vice President of Innovation; Director of Performance Improvement and Quality Assurance; Chief Compliance Officer; Chief Information Officer; and the Technology Coordinator. This team will collaborate with DHHS to begin building the infrastructure needed to ensure quality service delivery.

Saint Francis will enter into affiliate agreements with care givers and subcontractors for in home services and placement, and we will establish service providers for behavioral health needs, physical and dental health services, and other entities necessary to deliver required services. Saint Francis will communicate with providers, foster parents, judiciary officials, and other community members through a series of stakeholder meetings, sharing the proposed timelines associated with the transfer of placement responsibilities. We will engage in ongoing transition meetings with DHHS State partners in the Eastern Service Area.

Saint Francis has extensive experience building and maintaining the infrastructures necessary to support the full continuum of child welfare services and purchased services for children and will do so for the children and families in the Eastern Service Area. This infrastructure includes

locating our office space in a strategic locations capable of providing services across the catchment area, hiring appropriate and qualified staff, and identifying and coordinating required purchased service providers. The infrastructure will ensure placement capacity for referrals and availability of services to be delivered to the child in their home community at Operational Start Date, with emphasis on providing a family-like setting in the least restrictive placement to minimize the number of moves children make while in care. This infrastructure will be developed with community partnerships to enhance the local resources already available to children and families and thus avoid service disruption.

a. Community Engagement/ Meetings with Stakeholders

We have included a draft Community Engagement Plan in ENG-1 to ENG-2. This plan outlines our initial methods and strategies for locating and engaging community resource providers and other stakeholders. During the preliminary start up phase, Saint Francis staff will continue to utilize these strategies and build upon this plan, working with DHHS and other stakeholders to define and implement a community engagement process that will fully meet the needs of children and families in the Eastern Service Area.

After the contract award, Saint Francis will host stakeholder meetings in defined population hubs to reintroduce our organization to the community, request input about community concerns, request input about activities and tactics for long-term community engagement, identify local networks/coalitions, and identify needed outreach to nontraditional partners. Throughout this transition phase, Saint Francis will involve community stakeholders, formally and informally, as we build processes and protocols to meet desired outcomes. Saint Francis legal teams will begin building relationships with courts in Douglas and Sarpy counties in order to better understand the details of the legal system in that area.

b. Provider Relationships/Eastern Service Area Network

Development strategies are community-based and begin with establishing relationships with providers. After the contract award, Saint Francis staff will continue to build upon and solidify connections with local providers and others in the Eastern Service Area network. We will assess needs to build capacity and reach out to partners to support and enhance current services. Our refined Quality Assurance Process Improvement (QA/PI) department measures outcomes, and this data is distributed to levels of the organization to inform ongoing assessments of service delivery and to improve the beneficial impact of services on those in our care.

During the start-up phase, Saint Francis staff and transition team members will introduce our information sharing processes and communication of needs to partnering CPAs that they previously met during the development of this proposal. Information Sharing meetings will focus on developing a routine for disseminating monthly capacity needs reports to facilitate the process of recruiting foster care homes, including reports on the demographics of children in care, the number of placements outside the child's county of origin, and a separated siblings report.

Saint Francis will also begin recruiting foster homes and enacting our foster home recruitment plan detailed in PLC-1 to PLC-3. At this time, the Saint Francis Recruitment Department will work with our Marketing and Communications Department to efficiently utilize diverse forms of media and person-to-person interaction with the public to widely disseminate the needs of Eastern Service Area children in conservatorship and inspire the local community to engage in becoming foster resource families. Our Marketing and Communications staff will work with

transition team members and recruitment staff to identify and implement targeted marketing strategies, including the use of paid media outlets.

In the development of this proposal, key Saint Francis staff made connections to and created relationships with Eastern Service Area community-based organizations, CPAs, GROs, mental health and IDD providers, parent and maternity support programs, parenting class providers, churches, faith-based organizations, CASA, psychiatric treatment facilities, IL providers, and higher education partners. We will leverage these relationships and those with other stakeholders to promote and highlight recruitment needs throughout Eastern Service Area communities (see ENG-1 in the Community Engagement section of this proposal).

c. Staffing/Workforce Development

Recruiting and maintaining qualified and skilled staff is essential in providing quality services to children and families. Beginning at award announcement, Saint Francis will begin recruiting and training staff to perform the scope of work detailed in RFP 5995 Z1 and within this proposal.

The table of anticipated Key Staff, their experience, and qualifications can be found on pgs. 93-96 in WRK-1. Job descriptions are available in Attachment J, and an organization chart is on pg. 35-36. Table WRK-1.A details the number of staff to be hired for the positions necessary to immediately begin providing services to ensure families experience a smooth and non-disruptive transition. Saint Francis will ensure that the appropriate number of professionals will be hired to fill the necessary positions to maintain quality service delivery and positive outcomes.

Saint Francis values the experience and knowledge base of current provider staff and other local child welfare professionals who have served in the community, and we will prioritize recruitment of these professionals during implementation of the start-up phase and beyond. For more information on how we recruit, train, and retain a qualified workforce, please WRK-1 in the Workforce section of this proposal.

During the start-up phase, Saint Francis will begin training staff on the necessary evidence-based and trauma-informed practices, policies, and protocols. This will include training staff on joint processes agreed upon in collaboration with DHHS and updating the Eastern Service Area Operations Manual.

d. Technology and Information Systems

At the initiation of the start-up phase, Saint Francis's administrative and IT teams will begin to collaborate with DHHS to create protocols for the electronic transfer of information from Saint Francis's client management system (CMS) to N-FOCUS. Before the Operational Start Date, Saint Francis's IT team, consisting of (but not limited to) a Security Administrator and a Technology Coordinator, will work with DHHS to ensure that our client management system (CMS) is capable of accommodating imports to N-FOCUS and exports from N-FOCUS. In order to successfully integrate the N-FOCUS system with our practices, Saint Francis proposes to send a task force of IT and case management employees as soon as the contract is awarded to complete the following steps:

1. Identify current workflows in the N-FOCUS system
2. Assess the system's compatibility with Saint Francis software and hardware
3. Understand current database architecture and historical data management
4. Understand communication and alert systems

5. Provide an outline of how N-FOCUS will integrate with owned systems
6. Execute any changes necessary to integrate successfully with DHHS systems

For more information on our technology and information protocols and processes, please see IST-1 in the Information Systems Requirements section of this proposal.

e. Readiness Review

Saint Francis is aware that DHHS will conduct an operational and financial readiness review of our organization prior to the Operational Start Date and will provide technical assistance if necessary. Saint Francis will cooperate the DHHS review process; during the readiness review, Saint Francis will provide DHHS staff access to Saint Francis staff, operational documentation (including a demonstration of computer systems), private workspace, and internet connection. We understand that Saint Francis will be permitted to commence operations only if the readiness review factors are met to DHHS's satisfaction. DHHS will issue a letter of findings based on the results of the review and, if necessary, request a corrective action plan from Saint Francis.

The readiness review may cover all provisions of the subaward with a particular focus on assessing the following areas:

- The adequacy of the distribution of providers for in-home and Resource Family care services
- Staffing adequacy
- Subcontracts / subawards
- Quality assurance/continuous quality improvement
- Case management
- Utilization management
- Financial management
- Information processing and system testing
- Continuity of care
- Grievance and appeal process

Saint Francis has experience in establishing child welfare services from the ground up in a variety of geographical areas; this includes developing foster care homes, family preservation, reunification case management, foster care, adoption services, and Independent Living (and APPLA) permanency services. We have highly qualified, trained, coordinated, and licensed staff who work efficiently to ensure the best possible outcomes for those in our care, and will continue to build and train this staff in the Eastern Service Area. Saint Francis will deliver the required services outlined in RFP 5995 Z1, and in this proposal, upon completion of the readiness review and subsequent implementation of services.

f. Time Table

The time line, table TI-1.A below (pg. 47) has been developed to provide a visualization of how we plan to meet these responsibilities within the next 12 months. Saint Francis leadership will devote resources to the project, and our first step will be to hire an Assistant Vice President of Services for the Eastern Service Area. Resource development will include procuring office space, developing fleet management systems, and initiating human resource recruitment and training.

TI –1.A. Saint Francis Eastern Service Area Timeline	4/19	5/19	6/19	7/19	8/19	9/19	10/19	11/19	12/19	1/20	2/20	3/20
Submit Proposal	✔											
Intent to Award Posted		✔										
Subaward Finalization Phase			✔									
Award of Subaward				✔								
6 month Start Up Phase				✔	✔	✔	✔	✔	✔			
Readiness Review								✔	✔			
Subrecipient Operational Start Date										✔		
IL system to record and report services finalized				✔								
Final Cost Allocation Plan Submitted to DHHS						✔						
Recruit staff in new contract area		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Training Plan Developed/ Approved				✔								
Continual Staff Training					✔	✔	✔	✔	✔	✔	✔	✔
New Policy, Statutory Changes					✔	✔	✔	✔	✔	✔	✔	✔
X-Treme Recruiting (new hires, booster)					✔	✔	✔	✔	✔	✔	✔	✔
Strengthening Families					✔	✔	✔	✔	✔	✔	✔	✔
Update /train staff on DHHS policy changes					✔	✔	✔	✔	✔	✔	✔	✔
SDM/ MI/ NCFAS/ ASQ / FCT/ CROPS/ CSDC					✔	✔	✔	✔	✔	✔	✔	✔
Safety Planning					✔	✔	✔	✔	✔	✔	✔	✔
Engage communities & hold stakeholder meetings; convene regular quarterly stakeholder meetings	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Legal Dept. begins building relationships with courts in new counties				✔	✔	✔	✔	✔	✔	✔	✔	✔
Begin to locate and acquire office space				✔	✔	✔	✔	✔				
Initiate Foster Care Recruitment in New Counties				✔	✔	✔	✔	✔	✔	✔	✔	✔
Update MIS System				✔	✔	✔	✔	✔	✔	✔	✔	✔
Obtain affiliate agreements and subcontractor contracts in new counties / DHHS approval				✔	✔	✔	✔	✔	✔	✔	✔	✔
Use N-FOCUS system for data management										✔	✔	✔
Accept new Referrals for ongoing case management (in home and out of home)										✔	✔	✔
Monitoring Fidelity to EBP Models				✔	✔	✔	✔	✔	✔	✔	✔	✔
Begin submitting monthly report on:											✔	✔
Outcome measures											✔	✔
Performance Measures											✔	✔
Financial Statements											✔	✔
Aging of accounts payable											✔	✔
Begin Submitting Quarterly report on:												✔
Expenditures												✔
Catalogue of Services												✔
Training to case management staff												✔
Recruited foster care homes												✔
Grievances												✔

FIN Financial Requirements

FIN- 1: Submit a draft Cost Proposal Plan that Summarizes the methods and procedures that the bidder will use to allocate costs to various programs, services, subcontracts and agreements. The draft Cost Allocation Plan will, at a minimum, include cost pools; allocation methodologies; and benefitting programs	Comply: X

Response:

The Saint Francis Cost Allocation Plan calculates and spreads agency-wide indirect costs to departments that receive a service from other departments and is based on the Direct Allocation method described in OMB Circular A-122.

At each month end, the indirect costs are allocated based on the actual Direct Expenses by each program.

Direct Expenses are accounted for on the General Ledger by specific project codes and are coded directly to those specific project codes when invoices/expenditures are received.

The cost pools identified within Saint Francis are:

- Clinical Services
- Customer Care
- Marketing
- Financial Services
- Communications
- Corporate Operations
- IT Technology
- New Business Development
- Human Resources
- Training
- Office of the President
- Advocacy
- QA/PI
- Legal
- Employee Wellness
- IT Software Development
- Grant Writing

The Saint Francis draft Cost Proposal for RFP 5995 Z1 is submitted as Attachment C.

FIN- 2: Plan of how Saint Francis will implement a Random Moment Time Study or other time tracking method consistent with 45 CFR §75 et seq. with employees in order to maximize Title IV-E Funding.	Comply: X

Response:

Appropriate organization case management staff will participate in Random Moment Time Studies (RMTS) through email. Saint Francis knows that case management staff will be randomly selected to complete RMTS samples. We understand the RMTS system is an approved alternative to workers maintaining time records of 100% of paid time and is part of DHHS's cost allocation plan used to claim federal funds.

Our organization will continue to utilize a designated staff person as the RMTS Coordinator and one staff member as an alternate who will serve as back up, to carry out the duties of maintaining and submitting employee rosters.

Case management staff who will complete RMTS samples receive training during employee orientation prior to completing an RMTS. Online training is available and will be developed as needed for ongoing guidance. Our RMTS Coordinator will provide guidance and assistance for staff as needed.

FIN- 3: Describe how Saint Francis will comply with the requirements of the governing board and financial liquidity as described in Neb. Stat. § 43-4204.	Comply: X

Saint Francis will comply with the requirements of the governing board and financial liquidity as described in Neb. Rev. Stat. § 43-4204 to complete a readiness assessment as developed by DHHS to determine the lead agency's viability and as mentioned in RFP 5995 Z1 V.I.4.c.i. The readiness assessment shall evaluate organization, operational, and programmic capabilities and performance. As mentioned in RFP 5995 Z1 V.G.1, Saint Francis will provide any and all necessary information, in a timely manner, to complete the readiness assessment developed by DHHS to assess, in addition to other items, Saint Francis's financial management. During the readiness review, Saint Francis will provide to DHHS access to Saint Francis staff, operational documentation, private workspace, and the internet to conduct the financial assessment.

For more information on Saint Francis's financial management capacity, including but not limited to our budgeting and accounting systems, please see pg. 22 above.

IST Information System Requirements

IST- 1: Describe a plan of how Saint Francis will adopt and use the state-provided case management system to perform all case management activities for services provided under this subaward. Connection to the state case management system must only be accomplished through state authorized connection and encryption methodology. Subrecipient employees are granted access to information systems and information created, collected, processed and stored on behalf of DHHS under the terms and conditions of this subaward, including but not limited to the Business Associate Provisions (Attachment Four). The bidder should describe their plan to comply with these requirements.	Comply: X

Response:

Saint Francis Ministries will use the DHHS SAQWIS system (N-FOCUS) to track case management activities under this award. A secure connection can be maintained between each Saint Francis device and the N-FOCUS system using an encrypted VPN. Saint Francis Ministries uses Cisco AnyConnect to ensure this and provides remote users with secure IPsec (IKEv2) or SSL VPN connections to the Cisco 5500 Series Adaptive Security Appliance (ASA). This is industry-standard VPN encryption technology that ensures security and safety of data transfer.

a. Start-up

In order to successfully integrate the N-FOCUS system with our practices, Saint Francis Ministries proposes to send a task force of IT and case management employees as soon as the contract is awarded to complete the following steps:

1. Identify current workflows in the N-FOCUS system
2. Assess system's compatibility with Saint Francis software and hardware
3. Understand current database architecture and historical data management
4. Understand communication and alert system
5. Provide an outline of how N-FOCUS will integrate with owned systems
6. Execute any changes necessary to integrate successfully with DHHS systems

b. HIPAA Compliance, Privacy, and Security

Saint Francis is up-to-date on HIPAA compliance and holds the security and privacy of data in the highest regard. Physical safeguards include limited facility access and control, with authorized access in place. All covered entities, or companies that must be HIPAA compliant, must have policies about use and access to workstations and electronic media. This includes transferring, removing, disposing and re-using electronic media and electronic protected health information (ePHI). Technical safeguards require access control to allow only the authorized to access electronic protected health data. Access control includes using unique user IDs, an emergency access procedure, automatic log off, and encryption and decryption. Audit reports, or tracking logs, are implemented to keep records of activity on hardware and software. This is especially useful in pinpointing the source or cause of security violations. Technical policies should also cover integrity controls, or measures put in place to confirm that ePHI hasn't been altered or destroyed.

IT disaster recovery and offsite backup are key to ensuring that any electronic media errors or failures can be quickly remedied, and that patient health information can be recovered accurately and intact. Network (or transmission) security is the last technical safeguard required of HIPAA compliant hosts to protect against unauthorized public access of ePHI. This concerns all methods of transmitting data, whether it is via email, Internet, or even over a private network.

c. Staffing

Saint Francis Ministries will appoint one of its senior network administrators as the Security Administrator for this project. This employee has over 15 years of experience in the field and

will oversee all of the sites working on this DHHS contract through this award. He will be assigned the following job duties:

- Direct oversight of network configuration
- Bi-annual evaluation of network security weaknesses
- Software and Hardware maintenance
- User training and security and network interface
- Allocating data science and IT resources
- Notifying DHHS when an employee is hired or leaves employment
- Providing documentation for DHHS user accounts
- Conducting background checks for all new employees
- Notifying DHHS immediately in the event of a security incident involving misuse of the state's case management system or loss of client information
- Ensuring security awareness and acceptable use training is conducted and documented for all staff on initial hire and annually thereafter, providing documentation for DHHS upon request within three (3) days

Saint Francis will appoint a senior data scientist to be the Technology Coordinator for this project. This employee has over 20 years of experience in the Technology sector and oversees the Saint Francis's hardware. He is also in charge of cloud management and is familiar with the fourth revision of NIST Special Publication 800-53. He will be assigned the following job duties:

- Purchasing, installing, configuring, and managing all hardware and software, all computer hardware support, hardware and software upgrades; movement of all computer equipment; needed network support; server and LAN printer support; and software installation and configuration of information systems owned by Saint Francis for the performance of responsibilities associated with this award
- Understanding the requirements for use of wireless laptops under this award under the conditions that the disk is encrypted and the appropriate safeguards are in place
- Notifying DHHS of any lost or stolen hardware that may have been used to access, process, or store information
- Providing DHHS with a detailed security plan of any network infrastructure connecting to the agency network
- Understanding that remote or home office sites may be permitted provided each location meets compliance requirements, ensuring all agents, employees, interns, and subcontractors take reasonable actions to ensure such worksites meet these compliance requirements when accessing DHHS information
- Performing and documenting annual physical site reviews for all remote office and home office locations to ensure the security controls are met, and documenting any noted deficiencies, recommendations, and actions taken to address noted deficiencies, making this information available upon request to DHHS

d. Storage

Case management data is highly confidential, and it is critical that data is available at all times to facilitate smooth processing. We recently moved our database to the Microsoft Azure cloud

environment. Migrating to a cloud platform helps to keep data safe, secure, and ensures availability for use at all times, therefore enabling activities to run smoothly throughout any kind of disaster. Saint Francis has policies and procedures in place for protecting confidential information, a data back-up plan, and a disaster recovery plan.

Saint Francis's use of the cloud platform for our user-interfaces, which captures data into a data lake with the ability to attach documents and maintain case files, supports many popular disaster recovery architectures. With data centers in regions all around the world, the Azure cloud platform provides a set of cloud-based disaster recovery services that enable rapid recovery of data. Electronic data, documents, case files, behavioral assessments, raw data captures, and programs or software utilized for the purposes of this contract will be available to DHHS for review. Expansion of electronic storage and exchange of information is possible with the cloud-based data lake structure in Microsoft Azure, which contains security precautions and measures related to data security, leakage, loss, and theft, including unified security management and threat detection/protection.

Our data storage architecture consists of Microsoft Azure Cloud, an on-premise data center, and Amazon Web Service. Data is encrypted at both cloud and offsite data center portals, connected through VPN (Cisco AnyConnect, providing remote users with secure IPsec [IKEv2] or SSL VPN connections to Cisco 500 Series Adaptive Security Appliance [ASA] and Azure Express Router. All desktops are password and firewall protected with two-factor authentication and rigorous password requirements. Additionally, our database interfaces feature automatic log-off settings. Our databases and systems are HIPAA compliant, which requires all hosts with electronic protected health information (ePHI) to implement physical and technical safeguards, listed below. Whenever possible, information will be sent to DHHS electronically.

Cloud-based data storage is regular, invisible, and virtually immune to server crashes which could impact the ability to access vital information regarding a child's case. Data back-up occurs every 20 minutes, therefore if a server goes down locally, the maximum amount of work that can be lost is the last 19 minutes of work entered into any of our systems. Data is stored at two geographic locations, preventing a natural disaster from destroying all data since the other server hosting the cloud would remain intact. See Table IST-1.A. below.

Benefits	Cloud Service for Data Recovery — Table IST-1.A
Fast Performance	Fast disk-based storage and retrieval of files.
No Tape	Eliminate costs associated with transporting, storing, and retrieving tape media and associated tape backup software.
Compliance	Fast retrieval of files allows you to avoid fines for missing compliance deadlines.
Elasticity	Add any amount of data, quickly. Easily expire and delete without handling media.
Secure	Secure and durable cloud disaster recovery platform with industry-recognized certifications and audits.

e. Data Collection and Case Management

Saint Francis currently utilizes an electronic Child Management and Information Systems (CIS/CMS) for data collection of placements and trend management, including placement needs.

This custom-designed, intuitive, and user-friendly data management system is a cloud-based system that assures security and access, regardless of location, across diverse geographies. The CIS/CMS system is ideal for staff out in the field, as the system can be easily utilized via portable devices, and digitized forms will provide easy migration to other data systems, such as N-FOCUS, for ease of reporting for compliance with DHHS requirements and for the completion of court reports. Saint Francis's Information Technology team is currently developing a secure, state-of-the-art electronic data management system for our services that is expected to launch mid-2019.

The Saint Francis Information Technology team, in conjunction with our Quality Assurance and Performance Improvement Departments, are able to modify our reporting system to comply with the standards and expectations of the State of Nebraska, this RFP, and N-FOCUS reporting methods. This allows Saint Francis staff to capture information regarding case planning, service delivery, assessments, case review, and other needs, as well as communicate contract specific outcomes and provide a culture of Continuous Quality Improvement (please see CQI-1 for more details).

CSM Case Management

CSM-1: Saint Francis's philosophy on case management and the on-going case management model we plan to utilize to effectively serve all populations involved with child protection cases. Include any Well-Supported, Supported, or Evidence Based models that are used. The bidder should describe its understanding or statutory requirements related to the provision of case management. The bidder should describe its knowledge of and ability to coordinate services across various state and community programs available to children/families.	Comply: X

Response:

Saint Francis is dedicated to meeting the needs of children to help them achieve safety, permanency, and well-being. We value both traditional and non-traditional families, believing families make children's lives better, and we seek to strengthen families to achieve these goals. Saint Francis's Reunification, Foster Care, and Adoption (RFCA) and our Family Preservation service delivery models reflect this philosophy. Over the past 22 years, Saint Francis has successfully utilized these models to help children and families achieve positive outcomes, adapting and applying them to address the specific cultural and geographical demographics serve to provide evidence-based and trauma informed practices to meet individual needs.

We have the expertise and experience to develop and implement Full Service Case Management for Child Welfare Services in Nebraska's Eastern Service Region, as specified in RFP 5995 Z1 scope of work. Our ongoing case management model will meet the objectives of the RFP, which include the following:

- Delivering high quality case management to effectively serve child protection cases

- Managing and delivering prevention services that are timely, well-supported, and evidence-based through a service continuum that integrates a strengthening families approach to build protective factors in families in accordance with FFPSA
- Minimizing time in care and promoting permanency, especially reunification and/or adoption when in the best interest of the child.
- Recruiting resource, foster, and adoptive families
- Retaining families for foster and adoptive placements
- Utilizing practice models that maximize Federal IV-E funds

Furthermore, this case management model provides strategies to effectively engage families referred. It cultivates and operates within a culture of continuous quality improvement, maintains a professional and qualified staff who are trained to be trauma-informed, culturally humble, and connect families to community and government based supports, and thereby promotes reunification and family preservation.

Saint Francis's case management service delivery models are well suited to accept referrals from DHHS when the state agency identifies a safety threat for children and the need for Safety Planning (with in-home or out-of-home services). Our Family Preservation Service Delivery Model provides quality case management services for those children and families requiring in-home services, and our RFCA Service Delivery Model provides quality case management services for those children and families requiring out-of-home services.

Saint Francis's Family Preservation Service Delivery Model (pg. 57 below) and RFCA Service Delivery Model (pg. 58 below) illustrate these family-centered, community-based, evidence-based, strengths-based, culturally humble, and trauma-informed services. Each aspect of service delivery, from referral to case closure, is focused on providing quality on-going case management services, from Family Preservation in home services, to reunification and other forms of permanency that achieve safe, timely permanency based on the best interests of the individual child. Saint Francis understands that each state and catchment area poses unique challenges that can impact the design of an FPS or RFCA model; we will use our expertise to anticipate these challenges and work with the DHHS to adapt the model and methodology to best serve the needs of the population.

Using the RFP Number 5995 Z1 Full Service Case Management for Child Welfare Services, the Family First Prevention Services Act (FFPSA), and the California Evidence-Based Clearinghouse for Child Welfare (CEBC), the evidence-based practices outlined on pg. 60 below were chosen for their "best fit". Knowing that final guidance to support Nebraska in identifying promising, supported, or well-supported practices that may be eligible for Title IV-E funding is DHHS' discretion under the Family First Prevention Services Act (FFPSA), our Family Preservation and RFCA programs would be open to negotiating relevant contract amendments reflecting an adjustment in evidence-based practices at such time as DHHS may elect additional or alternative practices under the state option.

a. Trauma-Informed Treatment and Services

Saint Francis's overall practice model addresses the effects of trauma based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Six Principles of a Trauma-Informed Approach. These principles include 1) Safety; 2) Trustworthiness and Transparency; 3)

Peer Support; 4) Collaboration and Mutuality; 5) Empowerment: Voice and Choice; and 6) Cultural, Historical and Gender Issues. This approach is driven by principles allowing Saint Francis staff to assess and match the strategy to the specific needs of a family.

Staff training, both general trauma training and intervention specific, assures that our workforce understands the prevalence and widespread impact of trauma, particularly for the families served. The routine trauma screening and assessment process identifies signs and symptoms of trauma, as well as family resilience. Staff use this information with families in case planning and pinpointing the trauma-specific interventions that will meet the family's needs. Interventions have been selected based on the best available evidence of each related to the application to child welfare and the efficacy in the remission and abatement of trauma-related symptoms.

Additionally, Saint Francis responds to secondary traumatic stress experienced by staff through multi-level supports including (but not limited to) the following: supervision, employee assistance support, and staff support groups utilizing the Resilience Alliance model designed specifically for the child welfare workforce (please see WRK-1).

b. Motivational Interviewing (MI)

MI is listed in the CEBC-CW as a *well-supported practice* with *medium child welfare relevance*. Our staff are experienced in this client-centered, directive method designed to enhance client motivation for behavior change that can be used by itself or in combination with other treatments. MI focuses on exploring and resolving ambivalence by increasing the intrinsic motivation to change and has been utilized in pretreatment work to engage and motivate clients for other treatment modalities. The goals of MI are to enhance internal motivation to change, reinforce this motivation, and to develop a plan to achieve change. Emphasis is placed on the importance of the change and confidence that the change can be accomplished. Please see Table CSM-1.A and CSM-1.B below for required/formal and supplemental assessments, respectively.

c. Court Responsibilities

Our Legal Department trains staff to have a thorough knowledge of their local court system, to submit reports as required, to attend court hearings, and to be prepared to testify in court. Information is provided via reports to the court and testimony in court. Our staff submit reports to the court with copies to DHHS, the County/District Attorney, the GAL, and other attorneys involved in the case, according to timelines established by the court and in collaboration with DHHS. Supervisors review and approve court reports for content prior to submission to the court and other involved parties. Court reports are sent through the court portal, faxed, e-mailed or hand-delivered to the court to ensure that timelines and court expectations are met. Our staff submit reports to the court.

d. Transportation

To meet transportation challenges, Saint Francis will utilize our current model of coordinating transportation with a team dedicated to ensuring that children are provided timely services to placements and appointments when appropriate or necessary to their Case Plan. Families may receive transportation to appointments as well. The Placement Director will oversee a Transportation Coordinator located in each office, who will schedule a fleet of drivers for that office's service area. The transportation team focus is to complete trips as safely and economically as possible. Drivers are assigned trips based on a child's placement or

destination. By keeping loaded miles greater than unloaded, it helps to eliminate wasted deadhead miles, saving both vehicle and maintenance costs.

Saint Francis will also utilize ride sharing with children traveling in the same general direction, which creates efficiency by maximizing passengers, while keeping a focus on the personal safety of children and understanding when ride sharing may not be appropriate due to a child's special needs or behaviors. This is accomplished by borrowing drivers between offices to assure that all transportation needs are met. It is our policy that transportation should never be a barrier to a parent or child attending visitation, an appointment, court, or any other case plan activity.

In addition to each office's transportation team, Saint Francis leases vehicles and hires drivers to transport children and families for visitation to take them to medical and behavior health appointments, court, and any other important events.

As transportation challenges can arise in any setting, this practice occurs whether the office and services are in an urban or rural/frontier area. Providing timely service to children and families is imperative in case management. Saint Francis drivers receive extensive employment and background checks prior to hire, and once they have received orientation, receive training in trauma-informed practice and other areas mentioned in RFP 5995 Z1, to effectively respond to our clients.

e. Program Oversight

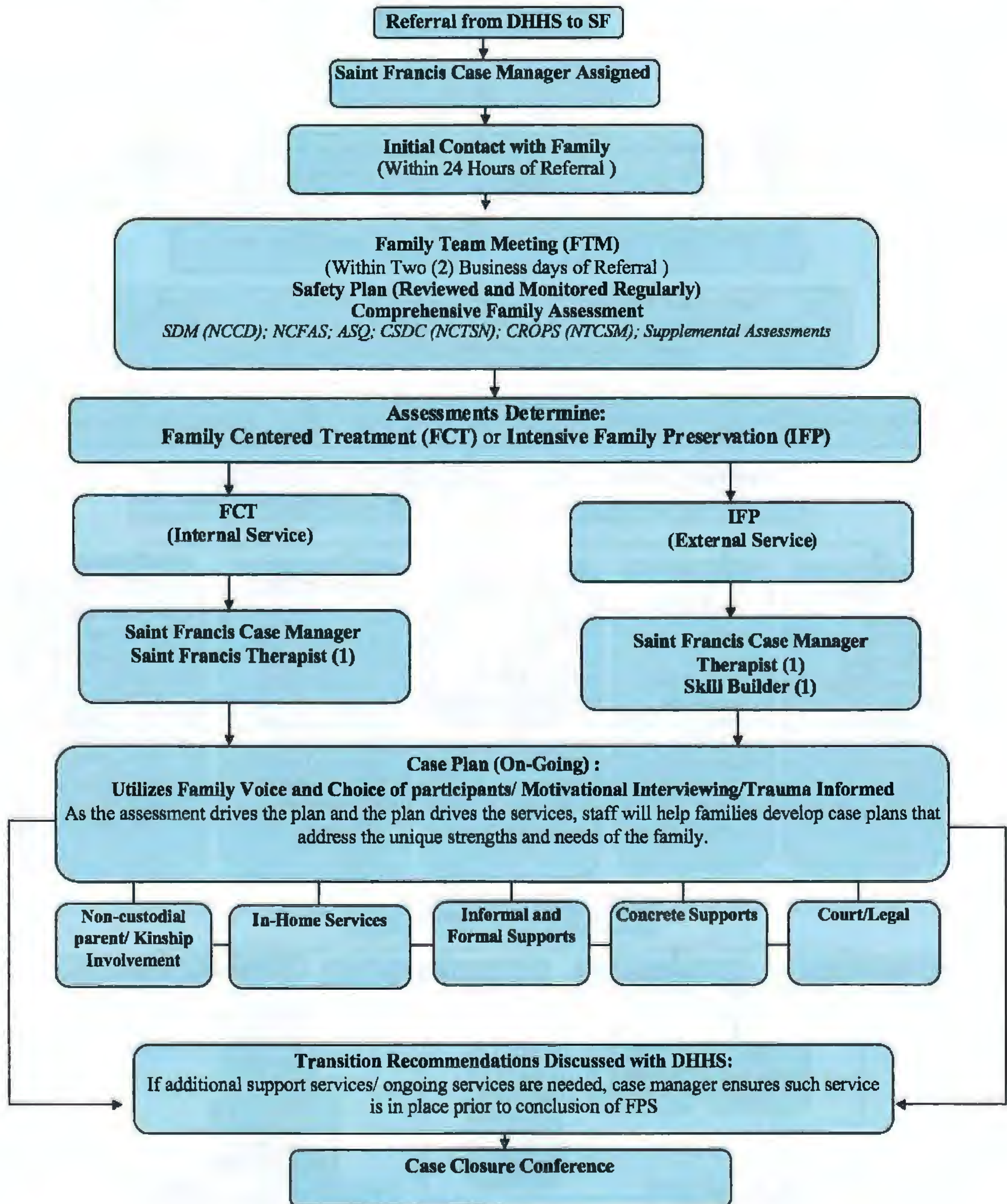
Saint Francis will track and monitor Program Outcomes as well as utilization of services. Additionally, we will complete Clinical Utilization Reviews. A Clinical Utilization Review is completed on a random sample of cases as directed by the Clinical Director of Family Preservation. Cases are reviewed for compliance to program guidelines, use of standard clinical practice, and completeness of documentation. Furthermore, our comprehensive risk management program tracks critical incidents involving children and foster care placement/providers.

The Quality Assurance and Performance Improvement Department (QA/PI) tracks data and contract outcomes in service departments, alerting case management of safety issues as well as using data to inform continuous quality improvement of safety and other outcomes. The Saint Francis QA/PI department analyzes data received by case management dyads to track the impact of services, case progress, and other contract specific outcomes. The QA/PI department alerts case management dyads if data indicates a case is not progressing towards the permanency, safety, and well-being of the child. This allows staff to modify strategies to reach desired goals and help the team anticipate changes to the permanency plan.

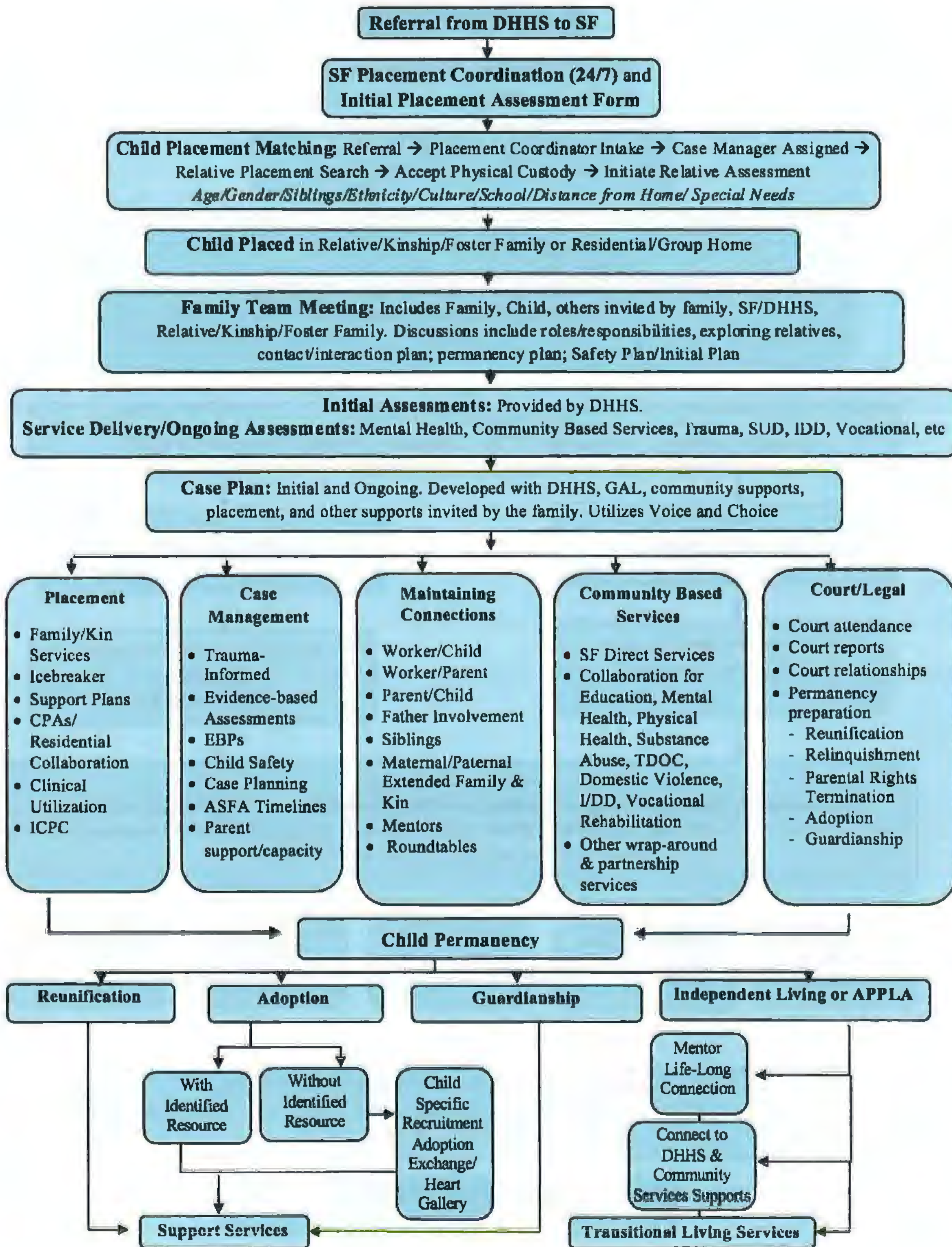
Furthermore, providing information on referral demographics to directors and community engagement teams can help Saint Francis build programs and develop resources that directly address specific issues in the community. This creates a circle of information and feedback that is easily communicated to other departments, allowing them to in turn provide solutions that increase the positive impact of our services in a variety of community settings (urban, suburban, and rural/frontier).

Please see UTZ-1 Utilization Management section, as well as CQI-1 in the Continuous Quality Improvement section, of this proposal for more details.

Saint Francis Family Preservation (In Home Services) Service Delivery Model



Saint Francis RFCA Service Delivery Model



Family Preservation Services (In-Home-Services)

a. Case Management Service Delivery

Case Managers assigned to Family Preservation cases will have a variety of responsibilities including, but not limited to, engagement, case planning, safety planning, non-custodial involvement, court responsibilities, and linking families to formal and informal supports. Saint Francis sees safety planning, non-custodial involvement, and linking families to formal and informal supports as a shared opportunity with the family as well as those providing the Intensive Family Preservation programs.

Engagement begins with the initial contact with the family and continues through the family's involvement in the assessment, in designing the Case Plan and services to be provided, participation in services, and in the evaluation of those services. New referrals are assigned to a Case Manager who makes initial contact with the family within 24 hours of our receipt of the referral. During initial contact staff introduce themselves, explain the reason for the contact, review referral information, explain the home visit and encourage the parent to involve others including the non-custodial parent if applicable, and other community supports involved with the family. The Case Manager and family determine a date and time to hold the Family Team Meeting (FTM) with the family's schedule taking precedence.

The FTM is held within 72 hours of the referral (or as agreed upon by Saint Francis and DHHS). During the FTM, roles and responsibilities are reviewed for participants, the reason for the DHHS referral is noted, and the family's understanding for the referral is explored including level of services and commitment required. Staff provide the family with emergency contact information, the *Benefits of Father Involvement,* and/or the *Benefits of Co-Parenting* material. A Safety Plan is created as appropriate and the family is provided a copy. Needed releases of information are obtained. Medicaid and other insurance information is gathered.

The Case Manager will utilize a comprehensive family assessment to evaluate the needs of the family across multiple domains. The assessment tools included in the comprehensive family assessment assist the family in identifying safety concerns, functional challenges, trauma-related issues, and substance use concerns. Families will then be empowered to use their voice and choice to make selections on service providers to meet their unique needs. In addition, the Case Manager will screen for referral to one of two (2) types of Intensive Family Preservation programs: Family Centered-Treatment (FCT) or Intensive Family Preservation (IFP). Both programs are outlined in later sections of this document. Referral into FCT or IFP is based on a combination of factors including program qualifications, SDM scores, and NCFAS scores. Please see table CSM-1.A. below for list of required assessments.

CSM.1.A. Table of Required Assessments (In-Home and Out-Of-Home)

Structured Decision Making – an assessment that promotes safety and well-being; offering workers a framework for consistent decision making; and a way to target in-demand resources toward those who can benefit the most (NCCD). Risk and safety assessment will be completed when services start and at critical points specified in DHHS policy.
North Carolina Family Assessment Scale - an evidence-based tool to assess family functioning in domains for Environment, Parental Capabilities, Family Interactions, Family Safety, and Child Well-being.
Ages and Stages Questionnaire – developmental screening tool for infants and young children (ASQ: Ages &Stags Questionnaires), children ages 0-3.
Child Stress Disorder Checklist – an observer report measures to screen for childhood traumatic stress symptoms (NCTSN), children ages 0-18.
Child Report of Post-Traumatic Symptoms – a self-report measure for children and adolescents that assesses a broad range of post-traumatic symptoms which can be used to measure changes in symptoms over time (NCTSN), children ages 6-18.

Supplemental assessments will be made available to Case Managers to assist with identify further needs in the areas of individual functioning (please see pg.73 below).

Our case management staff conduct quality in-person alone time with each child in the family, prior to the Case Plan and at minimum once a month thereafter. For children over 12 months of age and/or verbal, a portion of one monthly visit will be with the child alone. The purpose of the visit is to assess safety, stability, and well-being. The visit will include developing/reviewing Case Plan goals and tasks or discussing progress in achieving goals and addressing issues, as age appropriate.

More frequent alone time will be based on the worker's determination of necessity to ensure the child's safety, stability, and well-being. Additional visitation with each child in the family home will be determined based on the circumstances of the case, such as risk and safety concerns present during the service delivery period, the age and vulnerability of the children, and the reason for the agency's involvement with the family.

Staff arrange the case plan meeting around the family's schedule to allow the family's support persons to participate, including the non-custodial parent and DHHS staff. The Case Plan is built from an understanding of the family's strengths and recognition of how they have resolved problems in the past, with the objective of addressing current concerns and returning the family to stability quickly. Case plans are completed in accordance with State regulations.

Our Case Managers are trained to use principles of Family Voice and Choice (FVFC) in case planning. Families are empowered to choose their own tasks/activities and interventions, so the family has ownership of their Case Plan. Case Plan objectives and activities are written in a manner that captures individuals' and/ or families' words and ideas. As the assessment drives the

plan and the plan drives the services, staff will help families develop a Case Plan that address the unique strengths and needs of the family. Each family member is asked to identify individual tasks/activities to achieve their goal of maintenance of the intact family. The child and family are assisted in accessing community supports and services to help achieve the family Case Plan.

The Case Manager will assist the family in overcoming barriers to achieving the objectives and activities contained within their Case Plan. Assistance could include helping a family find access to concrete supports in times of need such as flex funds, transportation, daycare, and other resources. Additionally, staff will have the *Motivational Interviewing* skills to assist a family in moving towards the *Action Stage of Change.* As the goal of Family Preservation services is to have the family functioning in a safe and healthy way, specific efforts are made to connect the family to community resources to support long-term success.

b. Safety Plans and Family Safety Networks

The Safety Plan is a temporary, short-term plan to keep the child and other members of the family safe while more permanent safety provisions can be put in place. The Safety Plan should be used whenever the plan will enhance family safety and only when it is reasonable to believe safety can be achieved through the plan. For families whose presenting concern to the agency was for a reason other than abuse or neglect, the plan should only be used to address safety issues affecting the family, such as behavior of a child or youth that can be harmful to self or others.

In order to be effective, individuals who are necessary to the Safety Plan must be able and willing to cooperate in carrying out the plan and should be involved in the planning. A Safety Plan empowers the family to remain responsible for their lives, avoids resistance by the family to externally imposed conditions, and can be used as an assessment tool to help the staff and the family decide together whether change is possible. Families who have the access and availability to reach out to natural supports are more likely to do so and are less likely to engage in abusive or neglectful behaviors.

The Safety Plan is monitored and reviewed regularly by staff. Safety and risk are assessed at contacts with the parents and caretaker, child, and youth. It is documented for in-person contact. The documentation logs guide the staff to assess past and current safety and risk concerns. Safety and risk are discussed in monthly supervision meetings to ensure concerns are being addressed, parties involved in the plan are following through with tasks, and the safety concern is mitigated.

c. Case Management/ Linking Families to Formal and Informal Supports

Saint Francis fully understands the target population for our services will include children who are neglected, abused, dependent, or otherwise in need of services. Family needs generally include some combination of the following: communication; limit setting; effective relations; monitoring of the child's peers; interactions with the school; marital relations; problem solving skills; support from extended family and community; and concrete needs. The Case Manager will assist parents in accessing services from other providers that will address psychiatric problems and medication monitoring, substance abuse prevention, domestic violence, and an overall commitment to parenting.

The Case Manager will assist families in developing support systems and linking families to formal and informal supports. These support systems are critical for sustaining families during times of crisis and buffering against future stress. This includes, but is not limited to, accessing services for medical, dental, developmental, and mental health, as well as substance use, vocational rehabilitation, disability services, education, or other identified needs. Staff assist families in utilizing health care benefits such as private insurance, Medicaid, or Medicare. We confirm access to available services and supports for children. When these resources are not already in place, staff assist caregivers in applying for benefits. If the family is expected to pay for services, staff work with the family to budget for the expense, accessing resources with sliding fee scales and identifying community funding sources for the needed services. For more information on the types of services available to Nebraska families, please see PPF-1 to PPF-5.

Workers are trained in helping families to identify both relative and non-relative supports, such as those with personal ties to the family who are invested in their safety and well-being. Families are asked to identify individuals whose support will be beneficial to their Case Plan, and those individuals are asked to commit to be a support to the family.

Non-custodial parents, when a positive influence on the family's unification, safety, and well-being, are asked to participate in in-home services (please see CSM-3 for more details). This may mean being involved in case planning meetings, being contacted by parents for advice, or providing positive feedback to family members throughout the life of the case.

Creating a supportive social network for positive reinforcement and accountability is an important factor in developing a family's resilience to ineffective and/or unsafe parenting behaviors. The Case Manager will help families develop a social support network within their natural environment from extended family and close friends, schools, neighbors, fellow church members, and others.

Saint Francis Family Preservation has a process in place for locating these connections, which allows the worker and family to connect or reconnect with other family members to establish long term relationships. The Case Manager will work to maintain important connections to relatives, kin, and communities throughout the life of the case. Once relatives and other social connections have been identified, they are assessed for safety and matching of the family's needs.

Saint Francis works continuously to develop relationships and collaborate with community organizations, human services agencies, state and local government agencies, and those providing valuable resources to families. The Case Manager is educated on the repertoire of these agencies to make informed recommendations to families, and act as stewards of Saint Francis when connecting families to these services. When a family is introduced to a community support, the Case Manager will act as their representative and will assist them, at the level of involvement desired by the family, to secure services. Linking to formal and informal supports is a shared responsibility with those providing service delivery for Family Preservation referrals.

d. Case Transition and Closure

The desired outcome is that the family will need no further intervention aside from possible necessary long-term services such as medication management/therapy. If long-term service is needed, the Case Manager will help the family ensure that such service is in place prior to the conclusion of Family Preservation Services.

The goal of every referral is the safe maintenance of the child in the family home. The Case Manager will close the family's case at the end of the service period or when Case Plan goals and activities have been successfully achieved prior to end of service period.

There will be occasions when a family needs ongoing support to build new skills or practice existing skills. Our Case Manager will discuss transition recommendations with DHHS prior to a case closure conference to assure that connections to community resources, behavioral health services, or treatment services have been made prior to case closure. The Case Manager will work closely with the family and DHHS to ensure that the family's needs to achieve safety and well-being have been met, and that their concerns for the future are addressed prior to case closure. Recommendations for ongoing treatment to assure the safety and well-being of the family are based on family strengths, services provided throughout Family Preservation, the family's response to the services provided, assessment results, goals achieved, and activities completed on the Case Plan.

If a child is removed from the home during Family Preservation, Saint Francis will coordinate efforts with DHHS to see that the family's case is transitioned to the appropriate level of service if they are to remain in Family Preservation, or that case closure procedures are followed as dictated by DHHS if Family Preservation is no longer appropriate to the family's needs.

Saint Francis will work with DHHS to establish a case closure timeline, including but not limited to the point in the treatment at which the degree of therapist involvement with the family diminishes over time, a detailed closure procedure, as well as reasons a case may be closed early beyond the control of our organization. Should this occur, we will coordinate with DHHS to the best of our efforts to supply any transitional support to the children, family, and DHHS, and to ensure that the case is closed in a timely manner.

Examples of early case closures due to reasons beyond the control of our organization may include: 1) If the family refuses services and DHHS' effort to re-engage the family are not successful; 2) The family moves out of state or places children out of state; 3) The family moves their children to another caregiver's residence within the state, after consultation with DHHS regarding a potential referral for new caregiver. Services can be resumed if the family and/or children return to Nebraska during the referral period.

Saint Francis Family Preservation: Internal Referrals

a. Family Centered Treatment (FCT)

FCT is an evidence-based treatment program designed to find simple, practical and common-sense solutions for families faced with disruption or dissolution of their family. This model of intensive in-home treatment services for youth and families utilizes psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop health and nurturing relationships, and increase children's emotional, physical, mental and educational well-being through changes in family values.

Using a joining process that works with highly-resistive families, FCT operates under the premise of Family Preservation and Keeping Families Together and can be utilized for families with children of all ages.

FCT does not simply treat behaviors but, viewing problematic behaviors as symptoms and outward expressions of deeper-rooted traumas, addresses the emotions and emotional responses

behind behavior as the point of intervention. In so doing, FCT adapts to the needs of the family, including those experiencing past or present trauma, sexual or otherwise. FCT is purposefully constructed as a generalized model designed to incorporate a variety of presenting problems and is therefore inclusive of client/family focused interventions. Furthermore, this approach teaches the family and the individual to recognize how and where change can and should occur, thus facilitating more functional patterns of behavior. Once the new skills are internalized and adopted into the family value system, the family can recognize when behaviors are inappropriate and implement a more effective manner of dealing with crisis situations.

FCT is currently rated as a *promising practice* on the California Evidence-Based Clearinghouse for Child Welfare (CEBC-CW), with a rating of *high child welfare relevance.* A high rating in this area indicates that "the program was designed, or is commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services." FCT is known for its proven outcomes and continues to grow its research base, making it likely to move up on the clearinghouse ratings released.

When compared to other major evidence-based practices, FCT has a significantly lower implementation cost. As the Family Centered Treatment Foundation website explains, FCT can positively influence other aspects of the program including "marketing and collateral relations, clinical goal planning and documentation, team effectiveness and staff retention, utilization review of necessity for services, hiring motivated clinicians, and improving data collection, research and distribution"[7].

The expected length of Family Centered Treatment is approximately 180 days and offers 24/7 on-call crisis support for families with their clinical staff.

b. FCT Team Structure

All services to a family will be delivered by a single worker, a Saint Francis Therapist. Each Saint Francis Therapist will be supervised weekly, on an individual and team basis, by a Clinical Supervisor/Licensed Independent Mental Health Practitioner. A Clinical Supervisor (CS) has a team of no more than eight (8) Saint Francis Therapists, with each managing a case load of no more than 4-5 families. Clinical Supervisors will report directly to the Program Director. The Program Director overseeing Saint Francis's Family Preservation program will report directly to the Assistant Vice President of Children and Family Services.

Our services shall be available twenty-four (24) hours a day, seven (7) days a week for emergency crisis intervention. The Saint Francis Therapist shall provide Family Centered Treatment, with both individual and family meetings (as needed), in the family's home or natural environment and at times that are convenient and reasonable for the family. The Saint Francis Therapist will meet with the family approximately two (2) times a week for multi-hour sessions, which may include daytime, evenings, and weekends. Saint Francis will ensure coverage by other team members when the scheduled therapist is unavailable.

Family Preservation Services: External Referrals

a. Intensive Family Preservation

[7] Family Centered Treatment: The FCT Foundation, http://www.familycenteredtreatment.org/fctf-mission

External referrals will be made for Intensive Family Preservation (IFP) services, which are six (6) weeks in duration. Services will be provided to families in crisis, whose children are at imminent risk of removal and placement or for families who have recently had a child placed out of home. Intensive Family Preservation aims to keep children at home in a safe, stable, and nurturing family environment, improve parenting capacity and family functioning, improve children's well-being, and prevent unnecessary placement and/or safely facilitate the reunification of children with their families. Services are provided by a therapist and skill builder.

This service is designed to create rapid, sustainable change in the family unit by focusing on interventions that build on family strengths in order to eliminate safety threats and/or reduce the risk of child maltreatment.

Frequency of home visits will be based on assessed family needs and risks, as well as Case Plan goals and activities. Direct service hours are a combination of a therapist and skill builder hours spent with the family. Direct service is defined as in-person visits, phone calls, and HIPAA compliant video conferencing. At a minimum, 50% of all direct service hours provided by the therapist must be in-person visits with the family. Likewise, 50% of all direct services provided by the skill builder must be in-person visits with the family. IFP should be a minimum of 8 hours per week of direct service time for all families served during the length of the referral period.

b. Team Structure: IFP External Referrals

The IFP dyad of one (1) assigned therapist and one (1) assigned skill builder caseload size will not exceed 4-6 families. An IFP Supervisor will supervise a maximum of six (6) case management dyads.

Therapists providing services must be either a fully Licensed Mental Health Practitioner, or a provisionally Licensed Mental Health Practitioner under the supervision of a fully License Mental Health Practitioner. The contractor may also consider individuals who are MSE (Master's Degree Counseling) Level and have completed all of the required classes but are currently obtaining internship hours with the contractor. Interns must be supervised by a fully Licensed Mental Health Practitioner.

The skill builder must have obtained a bachelor's degree in human services, such as a degree in Social Work, Psychology, Sociology, Early Childhood Development, or a related field. The skill builder may also be enrolled in college and be within two (2) semesters of completing a bachelor's degree in human service or a related field. A person who is on semester, summer, or other break, who was enrolled the previous semester and will be enrolled after the break, shall be considered to be enrolled in college.

This service must be delivered in the family home or in a natural family environment, be available 24 hours a day, 7 days a week, including holidays and weekends. This service must include multiple in-person direct contacts and indirect contacts with the family each week. This service also includes discharge planning of specific community resources that connect families to concrete supports to build upon the parent resilience and fundamental parenting knowledge initiated by the IFP team.

Reunification, Foster Care, and Adoption Services (RFCA Out-Of-Home Services)

a. Case Management Service Delivery

Saint Francis's RFCA Service Delivery Model offers family-centered, family focused, community-based, evidence-based, and trauma-informed services for children and families. The RFCA Service Delivery Model on pg. 58 above provides a visual representation of our framework, model, and methodology. Aspects of service delivery, including ongoing case management, maintaining connections, community based services, and court/legal operations are focused on achieving timely child permanency.

Integral to Saint Francis's success in providing quality services is a deep understanding of the cultures and environments being served coupled with a thorough knowledge of the challenges these communities face. By balancing a foundation of RFCA core service delivery with agility and over 22 years of experience across 5 states (Kansas, Texas, Oklahoma, Nebraska, Arkansas), we have learned to refine our RFCA Service Delivery Model to meet the unique needs of diverse populations.

When Saint Francis receives a referral for Out-Of-Home Services (RFCA), Saint Francis will provide the following:

- Referral and provision of all necessary supports, services and interventions to address the conditions identified in the assessment provided by DHHS
- Monitor the community agencies providing services to children and families to ensure they are timely, consistent and helping mitigate safety concerns and helping achieving permanency
- Saint Francis will provide timely services and interventions that are individualized, accessible, culturally competent, linguistically appropriate and trauma informed.
- Saint Francis will document all contacts and information related to the family members, service providers and progress reports
- Saint Francis will complete assessments and evaluations through the life of the case and ensure they are updated and complete prior to closing a case on N-FOCUS
- Document using N-FOCUS within 3 days
- Provide transportation to for services
- Request reports for the court from service agencies including engagement of the child or parent in services
- Submit all required documents to DHHS for review and approval
- Saint Francis will collaborate as required with DHHS staff to engage the child and family in a relative/kin search, Family Team Meeting (FTM), and assessment process.

From intake to placement, in ongoing case management for RFCA services, and through case closure, Saint Francis will ensure that our service delivery model addresses and promotes the safety, permanency, and well-being of those in our care.

b. Intake/Placement for RFCA Services

Since 2000, Saint Francis has had admissions, placement, and on-call staff available to accept, disseminate, and process referrals 24 hours per day, 365 days per year. We are able to accept, assign, manage, and track incoming referrals from DHHS, to coordinate placement referrals, locate and arrange appropriate placements, respond to and coordinate after-hours emergency

calls—including dispatching staff if/when direct contact is necessary— and to engage in provider relations work with all placement providers. Provider relations work includes working with subcontractors on quality assurance/performance improvement (QA/PI) measures and maintaining placement management information. Having dedicated staff for this function facilitates timely and quality service for state partners and subcontractors.

The Placement Director will lead the Placement Supervisor, Placement Coordinators, and Clinical Utilization in securing the most appropriate, family-like, and least restrictive placement options that reduce the number of needed moves for children referred for out of home services. Local on-call staff will be qualified to administer placement screening tools for the child to assure a match with a family or facility that will best meet the child's needs.

Saint Francis Placement Coordinators will exhaust other options prior to placing a child outside the family home. As mentioned in RFA 5995 Z1 V.C.5, when placement outside the family home must occur, Saint Francis staff will:

- Document why Safety Planning in the home is not an option.
- Document why placement with the other parent is not appropriate.
- Report to DHHS using DHHS' preferred format summarizing the decision to place the child outside the home or current placement, demonstrating that options were exhausted prior to placing the child outside the home or current placement.
- Identify and consider all relatives and kin first, as possible placement options including placement with any known sibling;
- Ensure appropriately safe parental visitations occur on a regular and consistent basis if the child is not living with a parent;
- Ensure appropriately safe relative/kinship foster parents complete all activities required for licensing;
- Place siblings together when it is safe to do so and document safety concerns if siblings are not placed together;
- Ensure sibling visitations occur on a regular and consistent basis when siblings are not placed together;
- Ensure the continuity of family relationships and preserve connections for the child that includes but is not limited to connections with his or her parents, neighborhood, community, faith, extended family, Tribe, school, and friends;
- Ensure that the out-of-home placement is the least restrictive placement and most family-like setting;
- Ensure that placements are in DHHS provisionally licensed foster homes or licensed foster homes or licensed facilities;
- Ensure provisionally licensed homes receive full licensure within six (6) months of placement;
- Ensure that the child continues to be educated in their school of origin or the school that will support the goal of improving the child's achievement. The Subrecipient shall consult with DHHS if the child will not be attending his/her school of origin or a school that does not support the improvement of the child's achievement in school; and,
- Ensure that the child has the most normal and developmentally appropriate experiences that are generally afforded to children not involved with the child welfare system.

Saint Francis has developed a thorough and effective intake model for child welfare services. We value our DHHS partners' knowledge and expertise in gathering information about a child's supports, as well as in assessing their needs during initial assessments. We value the tremendous work being done at the Project Harmony advocacy and triage center. A strong partnership will be developed with the center. Case management teams will work closely with DHHS to ensure placement stability, continuity of care, and services for children.

Our case management and kinship teams initiate a rigorous search for relative and kinship connections, placement options, and suggested supports at the time of referral by discussing information with the child's assigned DHHS worker. Every minute counts when it comes to locating safe and appropriate out of home placement for children, and we endeavor to make the first placement the only placement for children. The role of the triage center at Project Harmony adds to the success of this endeavor by allowing the child to have a safe place for a few hours while assessing their needs and placement options.

Upon receipt of a referral, staff immediately enter pertinent information into the CIS/CMS system, and N-FOCUS, as needed, to ensure the best possible placement is located for the child if placement is not already been determined by DHHS. Simultaneously, kinship options are explored for each child coming into care. Placement staff immediately forward the referral to the appropriate case management teams. The supervisor then assigns a case management team to the child. Once placement has been determined, the Placement Coordinator relays information to the case management team.

When a child referred for out of home placement, the case management team will accept physical custody of the child from DHHS. Our staff will partner with the DHHS worker to ease the child's transition, to ensure the child's immediate needs are understood, that they are as comfortable as possible, and that all required information and documentation is received. The case management team also coordinates with kinship staff, including the X-Treme Recruiter (XTR), regarding any kinship placements being pursued. If the placement is a relative, a Kinship Worker will be assigned immediately to begin providing needed supports. The referred child will be immediately transported to the relative/kinship placement or foster home, ensuring it is most appropriate for the child's needs.

If the placement occurs after-hours, Saint Francis placement staff shares information that is available at the time with the foster family, including a copy of the Initial Referral. The family will be updated when additional information becomes available. At a minimum, the placement will include a placement agreement, access to medical treatment, medication, and the physical necessities required to properly care for the child.

i) No Reject/ No Eject

Saint Francis understands and accepts the No Reject/No Eject mandate for Full Service Case Management for Child Welfare Services. We will work with the State to ensure the smooth transfer of both new referrals and children being served in the current contract into the Saint Francis system of care.

Placement Coordinators will use the Saint Francis CIS/CMS and/or the N-FOCUS data management program and work with the child and family to prioritize placements close to the child's home. The placement search begins by exploring relatives from the child's community, then extending the search to include a relative placement regardless of location. Saint Francis

understands that maintaining the child's connection to relatives and kin throughout the life of the case promotes the child's continued connection with their home community. We explore relative and kinship placements options before moving to a foster parent in the same community and then expand our search outward. Our Placement Coordinators carefully rule out each option before moving to the next or less optimal placement, such as placement in congregate care outside of the region.

In the absence of appropriate relative or kinship options, Placement Coordinators review available openings with foster families in the child's home community and school (or preschool) catchment area. The process considers a multitude of factors, including gender, race, ethnicity, culture, language, school needs (e.g. special education), community/family support systems, behavioral issues, supervision needs, daycare, after-school programs, health and dental care, medication management, access to mental health resources, self-sufficiency needs, and potential for permanency. Saint Francis's goal is to make the child's first placement the only placement until permanency is achieved.

We know that each child is unique and the circumstances for their out of home care will often require additional collaboration between agencies to meet needs timely and efficiently. Saint Francis staff will seek to meet regularly with regional and local DHHS staff to get information as early as possible, understanding that no amount of planning can fully prepare for an emergency situation. Saint Francis has a reputation of being a good partner across five states to caregivers, contractors and subcontractors, and it will continue that practice in the Eastern Service Area.

ii) Placement in Home Communities

Saint Francis believes that all children should be provided safe placements that meet the child's individual needs. Saint Francis will work with DHHS upon referral to review all available information and assessments, and perform additional assessments as needed, to determine which placement options best address the child's needs. Placement Coordinators consider placement referral based on strengths, needs, and risk factors for each child, and coordinate with an array of community placement resources that can provide the appropriate services in the least restrictive environment.

Placement decisions are made in the best interest of the child. Decision factors include, but are not limited to age, gender, siblings, ethnicity, culture, language, school, distance from home community, and special needs. Therefore, Saint Francis will place children with the best available, most appropriate placement, regardless of who the CPA is for the foster family. Saint Francis Provider Relations is responsible for collaborating with case teams and DHHS to manage a child's placement. Provider Relations will meet monthly with subcontracted providers to solicit current and upcoming placement availability within their respective provider networks.

Relative placements are the first choice for children removed from their home, if safety can be provided in such placements. Kinship or family foster homes is the next level of care considered for placement. Saint Francis's RFCA Service Delivery Model promotes the placement of children within a family setting when safely possible using protocols and procedures adapted to cultural and geographic needs. **In the Kansas regions we have served since 2010, we have maintained an average 90% or higher rate of child placement in a family-like setting[8].**

[8] Ibid 1

Saint Francis's philosophy of community engagement and care leverages the strengths of community providers to best meet the needs of children and families. Based upon behavior management needs, a small percentage of the children and youth served may need a more structured environment to ensure safety. We evaluate current service availability and reach out to the community to expand capacity. If the community cannot provide the needed services, Saint Francis will expand the search area.

iii) Placement Stability

Saint Francis works for a child's first placement to be the best and only placement until the child achieves permanency. We offer kinship finding and support services, assessment tools to determine the least restrictive environment, training, and trauma-informed education for families and caregivers to promote placement stability. We will directly connect families and caregivers to community support systems through our own resources and those of the provider network and will conduct clinical reviews to address stability issues. Family Voice and Family Choice (FVFC) case planning incorporates the goals, tasks, and supports identified to build on existing strengths and increase parenting capacity and thus post-placement stability. From first contact with the family through case closure, Saint Francis supports connections between children, families, kin, and communities so that timely permanency is accomplished with support from Saint Francis and sustained by the family with naturally-occurring community supports.

For more information on how placement stability in local communities preserves connections for the child, please see CSM-3.

For more information on Utilization Management and placement stability, please see UTZ-1.

c. Case Planning

Case planning is a strength based, continuous and ongoing process that incorporates the principles of Family Voice and Choice (FVFC), conducted in partnership with the child, family, DHHS, community-based supports, and Saint Francis staff. Case planning meetings guide the family and the child to identify strengths and needs to develop a Case Plan that will build on those strengths and meet their needs. These meetings address the reasons the child was removed from the home, court duties, potential consequences, service and health needs, permanency plans, visitation plans, and other objectives necessary to achieving timely safety, permanency, and well-being for the child.

Through FVFC, families are empowered to choose their own tasks/activities and interventions, thus creating a sense of ownership in their Case Plan. Within the Case Plan objectives/goals and corresponding skills/instruction and activities needed to achieve them are written in a manner that captures the individual's and/or family's words and ideas, emphasizing existing strengths and skills to build the foundation for each family member's goal of maintaining an intact family. The Case Plan is a mutually developed written agreement between the child, birth family, and involved parties. The Case Plan establishes and formalizes the family's commitment to participate in activities progressing toward a specific permanency goal, addresses the reason for a child being placed in out of home care, and addresses the child's individual needs.

The FVFC model provides a variety of methods to engage children and youth to participate in the case planning process. This includes methods for both when the child can be physically at the family case planning meeting and when they cannot. The case management team will work with

the courts, DHHS, and the child or youth to develop the most appropriate way in which to allow the child/youth to contribute to the case planning meeting.

Kinship searches are initiated at the time of referral, during the Family Team Meeting (FTM), and throughout the life of the case to identify, locate, and engage relative, family, and kinship relationships that are safe, positive, and meaningful to the child. Those considered appropriate to the case planning process are invited to develop and carry out a plan that will lead to the safety, permanency, and well-being of the child. Saint Francis will make reasonable efforts to ensure children, youth, families, and family members who are the subject of the Case Plan and caregivers participate in case planning. See CSM-3 for how we engage family and kin to strengthen and preserve connections for the child.

Case management teams will notify required participants of the initial and subsequent service planning meetings for ongoing case management, including family meetings in which the youth is ready for discharge to permanency or when other changes occur in the Case Plan. DHHS will complete the initial FTM if still the primary case manager 15 days from legal status change.

Saint Francis will coordinate conferences and case planning staffing with DHHS, including but not limited to: Family Group Conferences, safety service meetings and meetings required by the court and DHHS.

Saint Francis values engaging families in family service design. We provide services in the most family-like setting possible, linking families to community-based diverse and comprehensive supports, and strengthening the capacities of families to function independently. Our family-centered practice model is characterized by mutual trust, respect, honesty, and open communication between those who are involved in the case. Full disclosure between parent/caregiver and worker is imperative to laying the foundation for mutual respect and building a positive relationship with the family. Saint Francis workers are trained in the principles of FVFC oriented case planning strategies, which values cultural humility in respect to each family's culture, history, perspectives, and challenges.

Case management teams use information gathered in the referral and assessments to guide the case planning process to address and ensure the health and safety of the children referred. Further assessments and screenings are made before the comprehensive service planning meeting and throughout the life of the case as needed. As the assessments drive the plan and the plan drives the services, staff will help families develop a Case Plan that addresses the unique strengths and needs of the family. Each family member is asked to identify tasks/activities to achieve their goal of maintaining the intact family. The child and family are assisted in accessing community-based supports and services to help achieve goals outlined in the Case Plan.

A comprehensive Case Plan is designed to guide service delivery that will meet the unique needs of the child and family. Case plans will at a minimum include a permanency plan, concurrent permanency plan, visitation plan, service plan, as well as transition/support services plan and a case closure conference when appropriate. Case plans are reviewed throughout the life of the case and updated to reflect the changing needs of the child and family. This includes adjusting the service type, frequency, and duration of services based on the individualized needs of the child and family members. The written Case Plan will be documented via CIS/CMS and/or N-FOCUS and in accordance with DHHS standards.

Case Plans will:

- Be relevant to the critical issues in the family situation
- Be realistic in terms of the emotional, physical, and intellectual capabilities of family members
- Be written in language that is clear and understandable to the family and youth
- Case Plan permanency objectives will be written in a manner that captures the individual's words and ideas, including the parents and the children ages seven (7) and older that are able to participate in the case planning process
- Utilize the family Strengths and Needs Assessment to allow the child/family to select the strategies and actions to achieve outcomes
- Address the issues identified in family and child assessments
- Specify the steps to be taken to address the identified issues
- Describe how success will be determined
- Specify the time lines and review dates
- Describe possible outcomes as the Case Plan is implemented
- Have the signatures of Case Plan participants
- Utilize and document the participation of the family
- Include any relevant orders from the court
- Include actions likely to be taken by DHHS and Saint Francis if conditions of the agreement are not fulfilled

The following outlines the steps within service planning:

- Family Voice and Choice is intentionally elicited and prioritized
- Youth Voice and Choice is respected
- Family members are encouraged to express their own views and self-advocate
- Case management team ensures options/choices reflect family preferences
- Respects and builds on family's culture and beliefs
- Family Voice and Choice guides care and planning
- Case plans are guided by family preferences and recognize the families' long-term, on-going relationship with child

i) Screening and Assessment

Assessment, both formal and informal, is an ongoing process that begins at referral and continues throughout the life of a case. At the point of referral, Saint Francis will utilize the assessment model approved by DHHS. *Structured Decision Making* (SDM) will be the primary assessment tool utilized for safety and risk for the initial planning for protection and mitigation of risk. Saint Francis staff will engage children and families utilizing the DHHS approved collaborative practice approach, *Safety Organized Practice (SOP),* including *Appreciative Inquiry*, *Motivational Interviewing* and *Cultural Humility*, to develop a respectful, trusting relationship while simultaneously observing and assessing the situation with every interaction.

The on-going assessment process provides information on a child and family's strengths, needs, resources, priorities, concerns, and unique characteristics and identifies services that will be most beneficial. Furthermore, assessments help staff evaluate the effectiveness of interventions.

Assessments are the key to effective planning for social, educational, behavioral, and related health services that will ensure safety and minimize risk. The information gathered from both the formal and informal assessments are included in the Child and Family Profile and is essential when developing Case Plan goals and reports to the court.

After the Family Team Meeting and prior to the first comprehensive Case Plan, the assigned case management team will work with the family to complete formal screens and assessments. Based on the results of the *SDM* assessment, the case management team will have a series of evidence-based assessments available to further explore individual areas to help support the case planning process.

A table of supplemental evidence-based assessments is available below (Table CSM.1.B):

CSM.1.B Table of Supplemental Assessments

Child Stress Disorder Checklist-Kansas (CSDC-KS): Completed by the parent/caregiver for every child birth to 18 and is used to screen for traumatic experiences/events and symptoms, both acute and chronic, associated with that experience.
Child Report of Post-Traumatic Symptoms (CROPS): Completed by every child age 6 to 18 to screen for traumatic experience/events and symptoms associated with that experience from their own perspective.
Ages and Stages Questionnaire-Social Emotional (ASQ-SE): Completed by the caregiver for every child birth to 2 to assess the social and emotional development including self-regulation, compliance, adaptive functioning, autonomy, affect, social communication and interaction with people.
Preschool and Early Childhood Functional Assessment Scale (PECFAS): Completed by the case management team for all children ages 3 to 5 to assess for emotional or behavioral symptoms or disorders.
Child and Adolescent Functioning Assessment Scale (CAFAS): Completed by the case management team for all children ages 6 to 18 to assess the degree of impairment in emotional, behavioral, psychiatric, psychological and/or substance abuse.
Parenting Stress Index – Short Form (PSI-SF): Completed by the primary caregiver, or parental reunification option, to assess the overarching domains of parenting stress including parental distress, parent-child dysfunctional interaction difficult child and overall stress.

The formal assessments (listed on pg. 60 in Family Preservation) utilized will be re-administered at different times throughout the life of the case, specifically prior to each Case Plan, at times of changes within the family, and prior to recommending reunification.

Once the assessments are completed and entered into the Saint Francis CIS/CMS system, the case management team receives "Practice Tips" that are put together for that individual client based on the individual scores of the assessments. The "Practice Tips" highlight services that could be helpful, conversations that may be beneficial to have, and things to do with the child and family to improve functioning. The case management team also receives sample Case Plan goals/tasks to discuss with the family that could address the needs identified through the assessment process.

The comprehensive Case Plan is informed by these assessments; the results of the individual assessments are added to the overall family centered assessment to create a Child and Family Profile that is utilized to create specific tasks and goals that address the assessed needs.

Currently, Saint Francis utilizes a Child and Family Profile as the comprehensive family-based assessment and provides a map for guiding the case management team and family in developing a comprehensive Case Plan. This comprehensive Case Plan in turn guides the work toward the reunification of the family unit. The Child and Family Profile assesses the children and family's strengths, needs, supports, characteristics and interactions in essential areas of functioning including family history, living conditions, financial conditions, interactions between adult caregivers, interactions between caregivers and children, supports available to the family, developmental stimulation available to the children, and each child's behaviors. The assessment includes questions related to relatives and kin, mental and physical health, alcohol and drug use/abuse, developmental disabilities, school, and community.

The Child and Family Profile brings together the initial DHHS safety and risk assessments *SDM*, the *North Carolina Family Assessment Scale (NCFAS-G+R)*, and any trauma and functional assessments utilized, including an *Ecomap* and *Genogram*.

The Ecomap diagrams the family's connections to the larger environment in which the family lives, and depicts relationships, communication patterns, and the flow of energy between family members, friends, and relatives outside the household, school, and other community supports and systems.

The Genogram is a diagram of the family across generations that identifies family members, their relationships, communication patterns, family patterns, and other important events. The Child and Family Profile is updated prior to each Case Plan as the formal assessments are re-administered. This allows for the family to see the progress being made and helps to outline the tasks and goals that are still needing to be accomplished.

ii) Family Team Meeting (FTM)

Saint Francis will collaborate with DHHS as needed to organize, plan, and attend the FTM within 72 hours of the referral. Saint Francis case management teams will actively participate in the FTM beginning with an informal assessment process by observing interactions, identifying safety concerns, and monitoring for trauma symptoms.

During initial contact, the staff introduce themselves, explain the reason for contact, and discuss the reason for the DHHS referral in detail, including the family's understanding for the referral. Court orders are discussed with the family, along with information regarding the legal process, responsibility of court parties, and upcoming scheduled hearings.

The case manager encourages the parent to involve others, including the noncustodial parent (if applicable) along with other community-based supports involved with the family. DHHS reviews roles and responsibilities during the FTM, and the case worker will provide the family with emergency contact information as well as co-parenting and other materials associated with the needs of the family.

Other meetings and assessments, including Parent Time within 3 days of a referral, may be scheduled during the FTM. If the permanency plan is reunification, this may include scheduling an Icebreaker meeting or phone call between foster and biological parents. Please see CSM-4 for more information on the purpose and function of Icebreaker meetings.

Saint Francis will share preliminary service recommendations for the child and family with DHHS during the FTM.

Saint Francis will collaborate as required with DHHS staff to engage the child and family in a relative/kinship search and assessment process. The Case Plan is developed using elements of the Family Voice and Family Choice (FVFC) model, engaging participants to contribute to the Case Plan by identifying individual goals, needs, and responsibilities that will contribute to the permanency plan.

By affirming and respecting the strengths of the child and family through FVFC, we invite a natural collaboration among the child, the family, their support system, community-based support systems, Saint Francis, DHHS, the court, and others in designing a plan and a course of action to make positive changes that will lead the child and family toward permanency. Saint Francis staff provide family-centered, evidence-based, trauma-informed, and community-based services for children and families referred. Participants may include, but are not limited to, DHHS, member(s) of the case management team, age appropriate children, caregivers, relatives, kinship, and foster families. Parents/caregivers are encouraged to invite other parties with a vested interest in the child's safety and well-being.

Children and families are informed of the assessment process, and formal assessments are scheduled prior to the comprehensive case plan meeting. If the case is court-involved, parents/ caregivers agree to follow court orders. A Safety Plan is created as appropriate and the family is provided a copy of this plan immediately. At this juncture, we collect releases of information and information on the children's/family's Medicaid or other insurance information. A signed copy of the Case Plan is provided to the family and to DHHS. The roles of DHHS and case management teams are clarified for the family and provided in writing. Children and families are apprised of the purpose of assessments, the fidelity of evidence-based screening tools, and how results are applied to this and subsequent Case Plan activities.

Parents/Caregivers and age appropriate children/youths participate in addressing activities to be completed immediately to address the safety concerns and the reasons for referral/removal. A plan for decreasing risk factors and increasing protective factors is initiated.

iii) Comprehensive Case Plan

The engagement and assessment process lead to a comprehensive Case Plan that guides service delivery to meet the unique needs of each family. This Case Plan is the mutually developed document formalizing the family's agreement to participate in achieving the permanency goal that is developed cooperatively with the child, family, kinship supports, DHHS, Saint Francis,

and other community-based resources. It builds on information provided by the child, family, their kinship supports, guardians, resource/foster families, school staff/records, court personnel, therapists, DHHS, Saint Francis, assessments, medical reports, and other sources of knowledge about the child and family. A Case Plan is required for each child in DHHS custody, and the needs of children not removed from the home but residing in the home/placement are addressed/assessed and become part of the Case Plan.

A permanency plan is decided along with the tasks and goals required to achieve timely placement. The case management team documents a reason if reunification is not the initial permanency goal. Case management teams then develop a visitation plan for parent, child, siblings, and other family members, recognizing that nurturing and attachments between participants is vital to strengthening protective factors and promoting reunification. Additional plans are developed for Worker/Child and Parent Time. Plans for contact will meet federal and DHHS regulations and will be documented on the Case Plan. If not already discussed, case management teams will discuss the purpose, expectations, and timeline of Icebreaker activities.

The Case Plan contains specific services to be provided to meet the needs of the family and identifies specific steps to be taken by the family, DHHS, Saint Francis case management teams, and any other service providers involved. The plan documents the steps to be taken to meet the child and family's permanency goals, time frames to meet these goals, and criteria for success. Each Case Plan requires, at a minimum, a permanency plan, concurrent permanency plan, service plan, visitation plan, as well as a transition or case closure plan when needed.

d. Life Books

Case management teams create a "Life Book" to keep children connected to things and people important to them. A Life Book, similar to a scrapbook, is created for children in our care, regardless of age, and contains documents that may be personal or meaningful to the child, such as photographs of family and friends, awards earned in school, notes and cards, artwork, and other items. A Life Book may keep the child connected to what they value as well as provide a way for case management teams to help the child articulate their own goals and needs for family case planning. Looking at pictures, papers, etc. with the child helps start conversations about what the child sees as important in his or her life and how we can keep them connected to the things that make them stronger.

e. Permanency Planning

Saint Francis achieves permanency for children in our care through reunification, adoption, guardianship, or Another Planned Permanency Living Arrangement (APPLA). We maintain permanency stability through ongoing assessments and supplying supportive "wraparound" services driven by the family through the transition period or length of time determined by the court.

We make placement, service, and permanency decisions based on the best interest of the individual child and using the family preferences and decision-making skills to guide the process. The experienced leadership and skilled staff who possess the ability to anticipate, collaborate, and adapt to the changing needs of the environment of the children and families served contributes to the ongoing success of the Saint Francis model and methodology. Saint Francis's permanency planning model can lead to shorter stays for children in out of home care

and increase the exits to positive permanency outcomes. This model allows us to document case progression and anticipate any changes that may occur to the permanency plan; conduct extensive relative, family, and kinship searches early on and throughout the life of the case; identify possible social and family supports for concurrent permanency plans; and to assess, identify, and provide wraparound services tailored to the family and child's needs to decrease time in out of home care and increase stability after placement.

The Case Plan, which can be reviewed or changed throughout the life of the case, will address steps that need to be taken to achieve the desired permanency outcome, and identifies services for a child or youth (and to the child or youth's family) with the following goals in mind: 1) a safe and permanent living situation for a child or youth; 2) a committed family for the child or youth; 3) an enduring and nurturing family relationship that can meet the child or youth's needs; 4) a sense of security for the child or youth; 5) a legal status for the child or youth that protects their rights; and 6) input from wraparound service providers and the family.

Saint Francis case management teams will promote reunification as a permanency plan unless it in not in the best interest of the child. Reasons why reunification was not chosen as a permanency plan will be documented in the Case Plan. An alternative permanency plan may include adoption, APPLA, or other permanency option defined by DHHS.

A child's permanency plan includes concurrent permanency goals consisting of a primary permanency goal and at least one alternate permanency goal. Concurrent permanency planning is the process by which Saint Francis and DHHS pursue two different permanency goals simultaneously. Working on both outcomes at the same time allows the child to achieve positive permanency as quickly as possible.

Concurrent case planning emphasizes frequent interaction with birth families to achieve the preferred permanency goal of reunification while simultaneously developing another goal as an alternative permanency plan for the child, if reunification cannot be achieved. Concurrent case planning minimizes the negative impact of separation and loss on the child and maintains the continuity in the child's family and sibling relationships.

i) Permanency through Reunification

Maintaining children in the home requires a focus on nurturing and attachment, increasing knowledge of parenting for child and youth development, recognizing and developing parental resilience, increasing social and emotional competence in children, and building connections to community-based supports that will sustain the family, assist in decision-making, and support permanency through reunification.

Saint Francis has currently achieved a permanency through reunification outcome of over 57%, compared to the national average of 49%, in Kansas[9].

When reunification is the agreed upon permanency plan, the case management team will collaborate with the child, family, and other professionals to provide intense reunification services to develop, monitor, and achieve permanency. This will include collaboration with a Family Support Worker to help ensure successful reunification. A Case Plan promoting reunification may contain more detailed visitation and service plans since reunification may require the case management team to spend more time with the family or provide the family with

[9] Ibid 2

different resources. The case management team will identify and connect the child/family to community-based supports that help the participants achieve goals toward reunification and provide a safe, stable environment for children. Assessments will determine the child and family's needs and strengths and will inform achievable goals and benchmarks for each individual to successfully meet before the child can be placed back in the home.

At the Worker/Parent visit, the case management team informs the parent/s of their progress or lack of progress toward reunification and reiterates the consequences for not meeting required and established goals in the Case Plan. If the family is having trouble or is incapable of meeting state and federal standards that demonstrate progression toward reunification, then the case management team, in concert with DHHS, courts, and any other appropriate entities, may indicate that changes in the Case Plan be made to reflect lack of progress. This could include changing service delivery or the Case Plan from reunification to a concurrent permanency plan, such as adoption, independent living, guardianship, or Another Planned Permanent Living Arrangement (APPLA).

a. Family Support Worker

Saint Francis is dedicated to providing reunification services to children and parents when the initial referral is received. At the FTM, a Family Support Worker will be assigned to the family to assist the case management team in coaching parents through perceived barriers and to identify services to rectify issues that caused a child's removal. The Family Support Worker will be responsible for ensuring that the child receives the dental and health services connected to the child and that visitation arrangements are confirmed. If the visit is to be supervised, they are the primary staff providing that support. They will also act as a liaison for community providers and gather information for the case management team to provide to court parties and other entities.

The Family Support Worker assigned to work with parents and/or guardians will have the following training: Documentation, Difficult Conversation, Case Management Procedures, Social Worker Safety, MANDT Day-1, Poverty, and Engagement.

b. Parent Support Worker

The Parent Support Worker will have contact with the parent and/or guardian at least one-time per week for the first 90 days after referral. This contact may be face to face or by phone depending upon the circumstance and the needs of the parents. Services will be provided to parents on a weekly basis for 90 days unless there are changes which make weekly contact unnecessary (please see Limited Engagement section below). Contact with parents will be weekly and each contact will be documented on the Worker/Parent Visit Activity Log. At least one Worker/Parent Contact per month will occur in the home. This contact will also assess the safety of other siblings who may be residing in the home. If there are safety concerns that would prevent in home visits, those will be staffed with a supervisor.

Engagement between the parent and Parent Support Worker may be limited due to the individual circumstances of each case. Instances in which Parent/Parent Support Worker interactions may be limited, as well as how Saint Francis staff plans on addressing these limitations may include, but are not limited to, the following:

- If a parent resides out of state, weekly phone contact will be made to help parents find resources in their area.

- If a parent is incarcerated, weekly interactions through phone call or letters may be used as deemed appropriate by department of correction guidelines.
- If a parent refuses intensive services, the Parent Support Worker will attempt to contact the parent weekly for 30 days. Contact will then be by phone one time per month to reassess their willingness to participate.
- If a parent completes all Case Plan tasks prior to 90 days, a staffing with the supervisor and case team will be held to assess continued engagement with the parent(s).

Instances in which a parent may be excluded from services may include the following:

- Parents who are incarcerated for 12 months or more. (*Parent Support Service will obtain information regarding location, inmate ID, and will send letter to the parent giving pertinent contact information to the case team.)*
- When a youth's initial permanency goal is not reunification, or there is a goal change within the initial 90 days.

c. Parent Support Services Procedures

Saint Francis Parent Support Services will begin the day of referral. Attempts will be made to make initial contact with parent(s) face-to-face or by phone. The procedure to initiate parent support services, and provide parent support services through on-going case management, is as follows:

- Obtain viable contact information for each parent or guardian
- Set up the Family Team Meeting/team meeting
- Answer questions and give guidance as needed to help parents initially engage in services.
- Attend the Family Team Meeting with Parent(s) to obtain necessary background information
- Set up next meeting with parent(s) within seven (7) days of Family Team Meeting.
- Within seven (7) days of referral, staff the referral with the Case Manager and obtain suggestions of Case Plan activities the parent(s) can work on prior to the actual Case Plan.
- Attend the initial Case Plan to learn about the needs of the parents and family and determine
- Within 30 days of referral, work with parent(s) to help them identify their support network by completing an Ecomap and providing a copy to the parent.
- Help parent(s) find resources needed to complete Case Plan activities in their community or other communities based on the resource needed.
- Provide necessary support to help the parent complete Case Plan activities which could include transporting the parent to appointments or help them obtain the service needed to complete Case Plan activities.
- Attend court hearings at the request of the parents or the case team.
- Participate in a Worker/Parent meeting with the case team one time a month to help the parent(s) prepare for transition of services.
- Complete progress reports as required by the supervisor; each report will be given to the case team and the supervisor. The progress report will outline reason for referral, services provided, barriers, strengths, status of parent(s), court orders, and summary of progress.
- Ask the parent(s) to complete a Survey in effort to track the quality of the service being provided and if the parent(s) feels the services is beneficial. The Survey's information will be entered by a designated person or will be completed online by the parent.

d. Parent Support Community Based Services

To assist families in achieving reunification, Saint Francis has worked diligently, and will continue to work diligently, to establish positive relationships with local service providers to ensure children and families have access to appropriate services in a timely manner. In developing a community-based network that provides families and children access to not only supportive social networks but financial, medical, and other community resources, Saint Francis engages the family in a "wraparound" approach to connect them to resources that will support the completion of reunification goals as well as reunification stability. This approach may include case management teams facilitating and scheduling an Icebreaker meeting between foster and biological parents. Please see CSM-4 for more information regarding the purpose and function of Icebreakers.

Creating a supportive social network for positive reinforcement and accountability is an important factor in developing a family's resilience to ineffective and unsafe parenting behaviors. The case management team will help families develop a social support network within their natural environment from extended family and close friends to schools, neighbors, fellow church members, and others. Saint Francis believes that, from the beginning, family-centered practice requires identifying extended family and kinship resources to broaden the natural support network of families involved in the child welfare system. Workers are trained in helping families identify both relative and kinship supports, such as those with personal ties to the family who are invested in their safety and well-being. Families are asked to identify individuals whose support will be beneficial to the reunification plan, and those individuals are asked to commit to be a support to the family.

In addition to social supports, Saint Francis will connect parents and children to concrete supports and community-based services to alleviate stressors that may lead to abuse, provide information and knowledge on how to parent affectively, promote life skills training, and any other needs addressed in the Case Plan. This "wraparound" approach includes, but is not limited to, connecting families and children to services that addresses financial, health, psychiatric, Substance Use Disorder, legal, work placement, and other needs.

The case management teams will tailor their Worker/Child and Parent Time plans to promote and encourage reunification as a permanency plan and to meet the needs addressed in the Case Plan. Since each Case Plan is strength-based and family/child specific, progression toward reunification will be determined by benchmarks set through the courts, the Case Plan, the Saint Francis case management team, and DHHS.

Reunification permanency planning approaches Worker/Parent visits with the *Do For, Do With, Do Without* approach; as the family enhances its protective capacities and functioning reaches a safe, healthy level, responsibility for Case Plan activities gradually transfers to family members. The gradual nature of increasing responsibility in tandem with acquiring skills and behaviors allows parents to care for their children in an increasingly competent manner.

At the initial level of intervention, a case worker may do many things *for* parents (e.g., scheduling of and transportation to appointments). As the family's level of functioning improves, the case worker will work *with* parents (i.e., demonstrating skills like arranging appointments, assisting with arranging transportation). By completion of case activities and upon assessment results indicating increased capacities for the safety, health, and well-being of children within the

home, the case manager will expect parents to perform necessary tasks *without* assistance, demonstrating their ability to utilize supports and services to maintain safety.

Once the case management team determines that the parent(s) have successfully completed tasks outlined in the Case Plan, Saint Francis may initiate reunification procedures. When Saint Francis, DHHS, and the courts confirm that the child can be safely reunified, and the child has been placed back in the home, the case management team will supply support services to the family to ensure stability in the placement, as well as the safety and well-being of the child.

e. Post Reunification Support Services

Saint Francis will initiate the reunification process when DHHS, courts, Saint Francis staff, and other entities verify that reunification of children with parents is safe. After the child has been returned to the home, Saint Francis case management teams will continue to supply support services as needed and as dictated by the court. These "wraparound" services are provided to increase the stability of the child and to assist family members in connecting with community providers to improve family functioning.

Saint Francis will provide and connect biological parents to community-based support services, beginning at the intake process and continuing through reunification, and supply transitional support services after reunification for a length of time directed by the court. For more information on the types of services available to Nebraska families, please see PPF-1 to PPF-5.

The primary goal of support services is to ensure that the permanent placement does not disrupt and result in the child having to reenter out of home care. Services will be provided to assist the child and family in obtaining and maintaining the resources needed to stabilize the child's permanency. Staff will assist families in developing their own support network of family, kin, and community providers to improve family functioning.

It is expected that families will experience some difficult times during the reunification period. Services and supports will be increased as needed to assure the stability of the placement during this time, including connecting the parents to day care services, as needed, to support the success of the reunification plan for the child and family. As in the reunification process, the goal will be to decrease the level, intensity, and frequency of services over time, allowing the child and family to exercise their ability to function on their own.

The case management team will conduct face-to-face contact with the child after reunification to ensure stability, safety, and well-being. This includes providing supervision after the child is returned to ensure safety and provide services as needed. The case management team will develop and conduct assessments regarding the safety in the home and monitor and assess the progress of the child and family toward managing without the organization's support.

Services will be revised as needed throughout this period, with a plan to gradually disengage the family so that they can maintain a stable environment with their own natural support system. The case management team will update the Case Plan and ensure that the Case Plan includes a deadline for terminating court involvement. The case management team will evaluate the plan every 90 days. Reports will be provided to DHHS, including documenting safety assessments, staffing where the decision of reunification is made, Case Plan and its updates, and contacts with collaterals and service providers.

ii.) Permanency Through Adoption Services

Saint Francis's philosophy is that all children need permanency in their lives. The Adoption and Safe Families Act (ASFA) guidelines suggest that when reasonable efforts to achieve reunification are not successful, and when permanency, safety, and well-being cannot be provided through reunification, other alternatives, such as adoption, must be explored in order to achieve timely permanency for children in out of home care.

Saint Francis actively supports maintaining family and kinship connections that promote permanency by conducting rigorous searches throughout the life of the case to identify and pursue relative and kinship resources. At referral, Saint Francis case management teams use kinship recruitment techniques to identify, contact, and connect families and children to relatives, extended family, and kinship supports to contribute to and support the Family Case Plan. Every effort is made to connect and place children with relatives early in the Family Case Plan and may be the preferable out of home care option.

When children become legally available for adoption, Saint Francis case management teams can draw from these resources as well as employ more intensive kinship recruitment techniques, such as Child Specific Recruitment, X-Treme Recruitment (see above), and the Adoption Exchange to contact potential adoptive families if the child does not have an identified resource for permanent placement. Families located through kinship searches are first considered for permanent placement if the child's goal changes to adoption or guardianship, thus reducing the number of losses for the child.

The decision to change the Case Plan from reunification to adoption is made by the child's case management team, DHHS, the State, and the court. Factors considered in establishing adoption as the permanency goal may include, but are not limited to, the following:

- The parent(s)' lack of progress in completing the goals and objective of the Case Plan
- Length of time spent in out-of-home care
- The wishes and concerns related to permanency options of youths age 14 and older
- The probability an adoptive family can be developed for the youth prior to age 18
- Existing placement with relatives or non-related kin on a permanent basis

In order to achieve timely permanency through adoption, Saint Francis equips our data management system with tracking measures that identify pivotal milestones in reunification efforts and notifies case management teams when such milestones are not being met. This method alerts the case management teams about the progression of permanency cases early on in the process and can prepare teams for potential Case Plan changes. The case management team tracks the viability of reunification efforts throughout the life of the case. If the courts and DHHS deem reunification to not be a viable option for the child, the case management team begins to provide its expertise in the adoption process to promote timely permanency for the child.

Termination of parental rights is considered if a child has been placed in out of home care for 12 continuous months, or 15 of the last 22 months. Throughout the case management process, there is full disclosure and involvement of families in decision-making. Therefore, when it is later decided that inadequate progress is being made toward reunification, and termination of parental rights is in the best interest of the child, parents are better able to understand the recommendations made by Saint Francis. Preparing birth parents for the possible permanency goal of adoption and the need for termination of parental rights is an ongoing process that begins with an open and honest presentation of the ASFA timelines throughout the life of the case.

When the permanency goal is changed to adoption and requires termination of parental rights, parents are again informed of their rights and how the process works in the court of jurisdiction. Saint Francis ensures that communications involve respectful, open, honest, and full disclosure with the parents. Parents are encouraged to consult with an attorney. Saint Francis case management teams then provide services to effectuate the child becoming legally available for adoption. This can occur through voluntary relinquishment of the child to the State by both parents/legal guardian/s, termination of parental rights of both parents with custody given to DHHS for the purpose of adoption, or a combination of relinquishment and termination of parental rights. Saint Francis updates the Case Plan and utilizes resources that will prepare both the birth family and child for the adoption process and finalization.

During the transition to adoption, the child's case worker will explain the new permanency goal to the child and will work to prepare the child for the adoption process. The case management team will work with the Foster Care Homes Director overseeing the recruitment database to identify families interested in being an adoptive resource for the child for children who do not have an identified adoptive family. Preparation of prospective families begins when they express interest in adoption. The families are asked to complete an Adoption Inquiry Form which initiates the adoption home assessment and preparation process for prospective adoptive resources. If the family already has an adoption home study on file, or one available from another private agency, this study is requested and updated as needed. The case management team, along with the current placement family, and other professionals involved with the child, help the child through the transition and grieving process. The case management team and the placement family prepare the child for a healthy attachment to their new permanent family.

Services are provided for both the child and the prospective adoptive family, respectively, until a match is made. Once a match is made and a family has decided to move forward with adoption, pre-placement, placement, and post-adoption services are coordinated with the best interests of parties involved, always keeping in mind the ultimate goals of permanency, well-being, and safety for the child. Saint Francis will provide post-adoptive (support) services to children and youth from the Eastern Service Area who have been legally adopted regardless of where the adoption was consummated.

Our staff train adoptive families on the availability and use of a wide variety of community-based services, such as Right Turn, to strengthen or create family and community-based networks that empowers children, youth, and families to achieve their goals and maintain permanency beyond their work with our organization. The case management team will continue to work with the child and adoptive family to maintain connections to "wraparound" services, connect them to local post-adoption resources, and help them to utilize community resources to support the family as needed, for as long as the court orders.

iii.) Permanency through APPLA

Saint Francis may consider Another Planned Permanent Living Arrangement (APPLA) when documentation indicates that other permanency options are unacceptable and do not promote the safety and well-being of the child. Through ongoing assessment, case planning, and service delivery, Saint Francis staff exhaust other permanency options prior to considering APPLA as a permanency goal. Saint Francis understands and supports the federal requirement that APPLA be the goal only when compelling reasons not to pursue reunification, adoption, or permanent guardianship exist. Prior to establishing APPLA as a permanency goal, the Saint Francis case

management team documents the compelling reason(s) to request a termination petition for a child who has been in out of home care for 15 of the last 22 months, as well as the reason(s) why reunification, adoption, or permanent guardianship is not selected as the permanency goal. This documentation is provided to the court.

Compelling reasons to have APPLA, including Independent Living, as a permanency goal may include an older teen requesting emancipation; a parent with an emotional or physical disability that precludes caring for a child even with supports, though a significant bond exists between parent and child; or a Tribe is identifying a planned permanency living arrangement for a Native American child. Such considerations and documentation are discussed with, and approved by, the case management team supervisor prior to holding the family case planning conference in which the change in the permanency goal is to be addressed. The participants in the family case planning conference are included in the decision-making process.

All children/youth need permanent life-long relationships with families who will love, nurture, guide, and protect them. Saint Francis staff keep this goal at the forefront of interactions/services related to youth with a permanency goal of APPLA. Staff continue to document rigorous efforts to maintain and/or build life-long connections and to find a permanent placement for youth with a goal of APPLA.

APPLA is meant to be a permanent placement for the child, not an out of home placement that can be indefinitely extended. Long-term out of home care placement is not an acceptable permanency option and will not be chosen as a planned permanency living arrangement or permanency goal. Legal permanency options for the child are continuously explored throughout the time the child is placed in out of home care, and at no time does APPLA rule out other more permanent options. APPLA is subject to ongoing review at later permanency hearings.

For more information on Independent Living Services, please YTH-1 to YTH- 4.

f. Community-Based Services and Case Plan Activities

Case Plan activities and community-based services/supports focus on the reasons for removal, addressing safety concerns, and procedures/timelines for rectifying unsafe behaviors. The case management team reviews the progress of the child and family, adjusting service needs and activities throughout the life of the case. Community-based services and Case Plan activities are tailored to the needs of the child and family and developed based on family centered practice principles.

Saint Francis staff are trained to empower and engage families in service design and to choose their own tasks and interventions, thus imbuing families with a sense of ownership of the Case Plan. During the service planning process, staff educate the family regarding community-based support networks and resources available to meet their assessed needs. Children and families are asked to choose tasks to achieve the permanency plan goal. The child and family are then assisted in accessing community supports and services to help achieve permanency goals. The consequences of action and non-action in completing Case Plan tasks, as well as not progressing in a timely fashion, are explained to the family.

Saint Francis staff utilize a variety of tools to teach needed skills to the family, including referrals and modeling. Parents may be referred to parenting courses, anger management, employment/vocational skills training, or other workshops for practical development of skills.

Staff may model appropriate parenting and domestic skills within the home, monitor interactions for trauma symptoms, and provide feedback on constructive/ deconstructive behaviors. A family's competency is measured throughout the life of the case by the *North Carolina Family Assessment* Scale (NCFAS) and *Structured Decision Making*. See pg. 60 above for a list of formal evidence-based tools utilized for ongoing case management.

While children are in care, case management teams are responsible for directly providing, or ensuring access to, a wide variety of health care and non-health care related services and supports for children and families. Case management teams refer families to a full array of services to help parents resume responsibility for the children in a safe and timely manner.

A sample array of community-based services and supports may include, but is not limited to the following: psychological/psychiatric evaluation/assessment; assessment, counseling and therapy (non-substance use); substance use testing & confirmation; substance use disorder (SUD) assessment, counseling and therapy; concrete services; parent/caregiver training; permanency planning meetings; visitation services; court-related services; court ordered supervised visitation; icebreaker meetings; day care services; and wraparound services.

Saint Francis case management teams will evaluate and report on the effectiveness of services being provided to children, youth, and families, as well as the family's level of compliance with services offered to DHHS and the court, so that adjustment to the Case Plan can be made if necessary.

g. Case Closure

Saint Francis case management teams will work jointly with DHHS, the family, and the court to determine when a child or youth and their family has achieved their permanency goal and are ready for discharge from services. SDM assessments will be completed and entered into N-FOCUS. When discharge is confirmed, case management teams will work with the child and/or family to develop a plan for case closure. This plan will help the child/family coordinate and maintain access to community-based services after leaving our care. The plan is a part of the Case Plan and will include services that will prepare a family for their child or youth's permanency. The case management team will coordinate and facilitate a family meeting when the child or youth is ready for discharge to permanency. See YTH-1 for more information on Independent Living and connecting youth aging out of care to PAL and other services.

h. Case Planning Documentation

Case management teams will document the Case Plans and changes to Case Plans, as well as meetings and visits with the family members in CIS/CMS and/or N-FOCUS. Saint Francis will create and maintain individual records that include, but are not limited to:

- DHHS case plans
- Individual treatment or service plan with updates documenting progress
- Reports required by contract
- Court reports and orders
- Documentation to support services such as who received services, when, duration provided
- Date and manner of submission of assessment, plans, or reports
- Case/activity notes
- Documentation of complaint investigations and court-related services

Documentation of support services received such as who received the services, who provided the services when and where they were provided, the duration and outcome may include: 1) date and manner of submission of assessments, plans, or reports required by contract and 2) case notes, including documentation of complaint investigations, court-related services.

CSM-2: Describe Saint Francis's approach to maintaining sibling connections and visitation, and parental visitation.	Comply: X

Response:

When placements outside the home must occur, Saint Francis will ensure that 1) sibling visitations occur on a regular and consistent basis when siblings are not placed together, and 2) appropriately safe parental visitations occur on a regular and consistent basis if the child is not living with a parent.

a. Sibling Placement

Saint Francis understands the importance of placing siblings together. We know that keeping siblings together can lessen the trauma of being removed from the home. When a referral is made for a placement, Saint Francis will seek an initial placement for siblings together, unless the clinical staff, the court, or DHHS recommends that the children are placed separately. Siblings may be placed separately if there is abuse among siblings or if one of the siblings needs a higher-level of care placement, such as in a residential treatment facility. When sibling groups are separated, Saint Francis will arrange at least one monthly contact between the siblings, or as determined by the Case Plan, if it is in the best interest of the child.

Placing siblings together when possible is a high priority. In instances when siblings are separated, Saint Francis conducts a quarterly case review to determine if separation continues to be in the best interest of the children. When the review indicates that the children can be safely placed together, a Placement Coordinator will immediately begin searching for a placement capable of supporting siblings. Often, Saint Francis will first ask the current placement for one of the children to accept his or her siblings as well. To minimize moves for the child/children, Saint Francis staff reviews the impact that the disruption may have on those in care before transferring placement to another family.

To promote the placement of siblings together in foster care, Saint Francis also will develop strategies to engage, recruit, and train foster care home providers to care for sibling groups. Please PLC-1 to PLC-3 section of this proposal for more information on foster care home and placement recruitment/training strategies.

b. Sibling and Parent/Family Visitation

Facilitating scheduled visitations and interactions between children and parents, siblings, and important family members is inherently one of the strongest pieces of the reunification process, and one of the greatest factors in maintaining a sense of normalcy for children in care[10]. Creating

[10] American Bar Association: *Promoting Placement Stability,*
https://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/chapter4.authcheckdam.pdf

a visitation plan and facilitating family and sibling visitation is vital to maintaining a child's connections and sense of self, as it is through this context that they connect most naturally with those important to them. Interactions provide crucial assessment opportunities by providing real-time insight to a parent's readiness to resume care for children, ability to model appropriate parenting skills, and to effectively manage social and emotional competence.

Visitation schedules between children and parents, siblings, and those important to the child are discussed and agreed upon during the Family Team Meeting (FTM). These schedules become part of the Case Plan and may be updated throughout the life of the case. Using elements of Family Voice and Choice (FVFC), the child and family can contribute to case planning tasks such as formulating a visitation plan and inviting important family members and others to become involved in the family case planning process. This connects and unites family and friends together to achieve permanency, safety, and well-being for the child.

Parent/Child visitation will be scheduled as ordered by the court and in the best interest of the child or children in the case. These visitations may also provide an important opportunity for case management teams to model, observe, and assess parenting behaviors and interactions between parent and child.

Each Saint Francis visit with the child is well planned and focuses on the child's safety, permanency, and well-being. The visits address issues such as the relationship/communication between caseworker and child; risk and safety assessments; physical and mental health assessments; educational needs; the visitation plan with family and kin; relationships with parents, siblings, and other relatives/kinship; relationships with foster care/out of home care providers; permanency planning/family case planning tasks and revisions; service delivery and impact/effectiveness of services; and goal attainment/progress of the child.

We support the need to maintain family connections in order to minimize traumatic loss and maximize continuity of relationships to foster a child's identity and development. Visitation/contact arrangements are determined in anticipation of permanency with thorough assessment, based on the child's desire to maintain contact, the safety and quality of that connection, and the adoptive family's interest and capacity to promote this.

CSM-3: Describe how Saint Francis will engage non-custodial parents and relatives in order to strengthen and preserve connections for the child. Include any Well-Supported, Supported, or promising practice evidence-based models that are used.	Comply: X

Response:

Saint Francis recognizes that by allowing children to maintain existing connections, stability and permanency outcomes are improved. Local placement and placement stability go hand in hand; when children are placed in their home communities and with relative or kinship caregivers, they are more likely to be placed with/stay connected with siblings, experience fewer placement moves due to the commitment of the family, exhibit fewer behavioral problems, avoid disruption, maintain academic standing, and report a more positive opinion of their placement and caregiver. Because of this, Saint Francis actively explores kinship and relative placements before moving to a foster parent in the same community and then moving outward.

Our Family Preservation and Reunification philosophy views family as "beyond the walls" of the physical structure in which a family lives. Referred families fit many different profiles: blended families, single parent families, other relatives raising the children, and those of which neither biological parent lives in the home. Research directs that, while safety is paramount, connection and contact with viable family members is important to the success of the Case Plan, and this is particularly true regarding the non-custodial parent. Assessment will include information on the non-custodial parent(s). After contact with the non-custodial parent is made, assessment will follow.

a. Non-custodial Involvement

The involvement of a non-custodial parent is achieved through a four-part process. An attempt is made beginning with the initial family contact to identify the non-custodial parent(s) to invite them to the Family Team Meeting. During the meeting and the assessment process, staff continue to pursue non-custodial parent identification and provide the residential parent with information on the importance of involving the non-custodial parent(s). Once identification has occurred, contact is attempted with the non-custodial parent(s) to engage them in the Case Plan development and implementation. Finally, efforts are documented in the case log. The goal of non-custodial parent involvement is to increase protective factors by bringing needed resources to the family.

A variety of resources are available to staff including brochures that are given to both residential care providers and non-custodial parents on the importance of involvement; materials are available for incarcerated parents; parents in the military and thus separated from the family; information for young fathers on parenting; and contact letters and script telephone guidelines. Materials are available in both English and Spanish languages. The *Fatherhood Involvement Guide* is a tool staff can use which provides best practice guidelines for locating, engaging, and empowering fathers. Although this guide focuses on fatherhood involvement, it may also be used to address absent mothers as well.

b. Relative and Kinship Involvement

Saint Francis strongly supports connections between children, family, friends, and community. Placing children in their home communities allows children to maintain existing connections, improves permanency outcomes and decreases the amount of trauma experienced by a child removed to out of home care. Community supports connect the child with their culture, schools, churches, and other social groups, which contributes to their perception of stability and sense of self.

The child and birth family are involved in the placement process as much as possible. Whenever feasible, older children and youth are encouraged to have a say in their placements. Once a foster family is selected, the child and birth family are provided information about the family (unless safety concerns identified by DHHS or the court preclude it).

Placements are first sought in the child's home community. Saint Francis will join providers within Eastern Service Area to increase capacity in placement and services that allow children to be placed within their home communities. This includes utilizing family finding and our relative/kinship recruitment resources and building foster home capacity that addresses the needs of children. When placement in the community is not available, Saint Francis believes that children should be placed in as close proximity to their home community as possible.

Saint Francis will utilize evidence-based and trauma-informed practices, such as Motivational Interviewing and Family Voice and Choice to engage non-custodial parents, relatives, and kin in the child welfare process (see pg. 60 above for formal assessments and pg. 73 for supplemental assessments and practices). Engaging those important to the child greatly increases protective factors that lead to the safety, permanency, and well-being of the child. Furthermore, these relationships have the potential to lessen the impact of trauma the child may experience due to removal of the home, keeping the child connected to normalcy activities, culture, social groups, and family supports.

CSM-4: Describe a plan on how Saint Francis will promote and enhance communication and support between foster parents and biological-parents, legal parent, adoptive parents, relative caregivers, guardians, etc. Include any Well-Supported, Supported, or promising practice evidence based models used.	Comply: X

Response:

Saint Francis's service delivery and ongoing case management philosophy promotes and enhances communication and support between foster parents and biological parents, legal parents, adoptive parents, relative caregivers, guardians, and others important in the child's life. Facilitating and supporting these connections creates a social and community environment focused on achieving the safety, permanency, and well-being of the child. Providing programs that train and encourage successful and meaningful interactions between participants is fundamental to our family preservation philosophy and connecting families to formal and informal resources can help parents and caregivers build the skills needed to maintain the child in the home.

Saint Francis's foster care homes philosophy and practices emphasize the expectation that foster parents will serve as mentors for biological parents. We reinforce this concept in every phase of interaction with the foster family, from initial engagement with potential foster parents through pre-service training, through trainings offered by means of the foster parent handbook, and through regularly scheduled foster parent meetings. Potential foster families are taught to see themselves as part of a team whose function is to work for the best interest of the child and family, as opposed to seeing themselves as a protector whose purpose is to keep the child safe from the biological family. Foster parents receive training to develop skills that support interactions between themselves and biological parents, from the initial Icebreaker contact to helpful ways of navigating a working relationship with a biological parent.

An Icebreaker phone call between biological and foster parents occurs within 24 hours of the child's placement. If deemed appropriate by Saint Francis and DHHS, a face to face Icebreaker meeting may be scheduled during the Family Team Meeting (FTM) for parents of children who are in foster care and whose permanency plan is reunification. The case management team facilitates, schedules, and is present at the meeting. The purpose of the Icebreaker is to create an opportunity for biological and foster parents to meet and engage in open communication

concerning the child's well-being. This face-to-face meeting can be a first step in building a relationship between the two, thus developing a natural support resource for the family.

Building the relationship between biological and foster parents is critical to reducing the trauma the child has experienced as a result of placement, in addition to creating an opportunity to alleviate a birth parent's worries about their child's placement. Facilitating a partnership between foster parents and families allows both to work jointly to reunify the child and achieve a safe home. This social support has several benefits, including keeping the child in contact with parents, allowing the foster parents to ask questions regarding the child's preferences, and allowing the parents to ask the foster parents for advice. Saint Francis wholeheartedly supports the philosophy behind Icebreakers and believes it has the potential to change the culture of foster care services in communities.

Furthermore, we believe that consistent and effective communication between Saint Francis, service providers, family and kinship connections, and potential foster and adoptive parents reinforces a culture of mutual support between participants. This includes communicating child welfare needs to the community as well as providing support systems and trainings that help foster and relative families navigate the child welfare services and keep adoptive and foster families engaged in the process of achieving permanency for children.

Saint Francis employs trained recruiters to proactively locate potential foster families. Our community-based intake process provides a streamlined, organization-wide procedure for recruitment. Staff in direct contact with potential foster families receive in-depth recruitment training to provide the best experience possible to those interested in fostering or adopting. We maintain on-going positive engagement with families throughout this process and encourage open communication and feedback to facilitate strong relationships.

Saint Francis believes in strengthening and building upon current methods of facilitating open collaboration and communication to improve child welfare services. Since 2014, our organization has participated in meetings with the National Center for Diligent Recruitment and has assisted in the development of the Diligent Recruitment Plan. As stated on their website, "diligent recruiting is a systematic process through which child welfare agencies recruit, retain and support foster and adoptive families that reflect the ethnic diversity of children awaiting placement." Saint Francis staff will continue to actively participate in future workgroups associated with the plan and apply any emerging practices to our work in Nebraska. Our approach to foster care home recruitment focuses on directly communicating the needs of children in out of home care to specific communities, potential adoptive families, local leaders, and stakeholders.

For a list of evidence-based and trauma-informed practices that facilitate these connections between caregivers, please see pgs. 60 and 75 above.

For more information on Saint Francis's plan to engage, train, and inspire foster, resource, and adoptive families, please see PLC-1 to PLC-3.

WRK Workforce

WRK- 1: Describe Saint Francis's plan to develop and sustain a stable case management workforce, to include: i. **Hiring process to determine knowledge, skills, and abilities for the workforce** ii. **Training, including ensuring staff are trained in trauma-informed care and to be culturally humble** iii. **Plan and process how to address the turnover rate and retention process.**	Comply: X

Response:

i. Hiring process to determine knowledge, skills, and abilities for the workforce

Saint Francis values the experience and knowledge base of government and nonprofit staff local to the Eastern Service Area who have served in the child welfare community, and we will prioritize recruitment of these staff. During the start-up phase, local child welfare professionals will be encouraged to speak with Saint Francis staff at hiring events to voice questions about the role of Saint Francis in the Eastern Service Area and our partnership with the State of Nebraska. We promote the utilization of experienced professionals who have existing relationships within the community, as these employees retain strong ties with the community, are knowledgeable of the local area and cultural demographic, and demonstrate a strong investment in the work that they do. Saint Francis will dedicate resources to recruit qualified individuals from within the community.

a. Cultural Competence – Staffing

Providing family-centered community-based services relies on a thorough understanding of the demographics, resources, and needs of the service area. Saint Francis involves extended family and kin as a part of the family's support system and provides services in the most family-like setting possible. We link families to community-based supports and strengthen the capacity of families to function independently. These are all essential to achieving and maintaining permanency for children. Saint Francis considers cultural competence a requisite component of our staff's set of knowledge, skills, and abilities, and seeks to bolster our employees' skill set in this area through trainings that teach and reinforce cultural humility.

Saint Francis's services are provided by our staff, caregivers, and subcontractors who live and work in the communities they serve. Our staff are connected to local resources and understand the demographics of the region as part of the community; their children attend local schools, they shop in the town's grocery store, and they go to church with their neighbors.

Saint Francis hires bilingual and multi-lingual workers who live or are willing to live in the area where they provide services. In trying to address the great diversity of our nation, Saint Francis continually trains staff, caregivers, and subcontractors to be culturally informed, sensitive, and respectful to each family's culture, history, perspective, and challenges. Families are the best

teachers of their personal family culture in the context of their community, and our staff, caregivers, and subcontractors respectfully learn from them.

Saint Francis's current service area covers over 70,000 square miles and includes urban as well as rural areas. Throughout our many years of service in family preservation, reunification, foster care, and adoption, Saint Francis has encountered clients of all races, ethnicities, spiritual affiliations, and sexual orientation, requiring that Saint Francis be sufficiently trained to meet their diverse needs and provide culturally responsive services.

Saint Francis addresses this need by providing thorough onboarding and training schedules that establish the laws and practices guiding each position's work, as well as establishing oversight protocols to assure compliance with these guidelines throughout employment. We have 37 offices in Texas, Kansas, Nebraska, Oklahoma, Arkansas, Mississippi, Illinois, and El Salvador, all staffed by people who live in the communities in which they serve and care deeply for them. Both urban and rural social work require knowledge of the unique cultures that make up a community, and Saint Francis has invested heavily in creating a diverse workforce to understand and meet their respective needs.

For more on the cultural landscape of the Eastern Service Area, please see CNT-5.

b. Conflicts of Interest – Staffing

Saint Francis has an ethical obligation not to enter into a partnership which poses a possible conflict of interest. We expect all staff who believe they may have a personal conflict of interest to notify their supervisor for reassignment. Corporate relationship conflicts are presented to our chief legal team for consultation. Our policies regarding conflicts of interest are clearly outlined in the Saint Francis Employee Handbook, which is discussed with and distributed to employees during agency orientation.

As part of onboarding, new employees complete a Conflict of Interest Acknowledgement and Disclosure of Substantial Interest Form, which requires disclosure of relationships with clients, personal or family interests in enterprises with which Saint Francis has business relationships, and outside employment or board service that could impair employees' performance of their duties to Saint Francis. The Saint Francis Employee Handbook requires employees to disclose outside interests that could influence their decision or actions as employees. The Handbook also requires employees to reverify their answers and inform Saint Francis within five days of any change that could lead to a new conflict. Saint Francis has introduced a policy requiring vice presidents and officers to annually re-verify their understanding of and compliance with Saint Francis policies, including the conflict of interest policy. The Handbook also requires employees to report other violations of conflict policies they are aware of, describing and listing the members of the management team that receives such reports, and providing a form for making an anonymous report.

c. Proposed Organizational Structure

Saint Francis's proposed organization structure chart for the Eastern Service Area is included on pgs. 35-36.

d. Staffing Plan

Saint Francis's staffing plan in Table WRK-1.A below includes each position's educational and experience requirements, as well as details of the position's primary responsibilities. Resumes of

current staff in key positions start located in Attachment R. Position (Job) Descriptions for roles to be hired start on Table WRK-1.A below.

Table WRK-1.A Position/Job Descriptions				
TITLE	FTE	CAPACITY	EXPERIENCE	ROLE
Asst. Vice President of Services	Full-Time 1 Staff	Master's degree in Social Work or related degree required.	5 years minimal of child welfare direct service experience.	Administer and manage the Regions service delivery and contract outcomes
Directors: Reintegration/Adoption/IL: Kinship: Support Services: Placement/ Transportation: Family Preservation	Full-Time 4 Staff 1 Staff 1 Staff 1 Staff 1 Staff	Master's degree in Social Work or related degree required.	4 years minimal of child welfare direct service experience	Administer and manage the service delivery and contract outcomes in specific departments
Child Placement Coordinator Supervisor	Full-Time 1 Staff	Bachelor's Degree, Master's degree preferred	3 years minimal child welfare direct service experience	Supervises placement coordinators and ensures that youth referred to the agency are placed in accordance with SFCS regulations and contract requirements.
Placement Coordinators	Full-Time 4 Staff	Bachelor's Degree, Master's degree preferred	1 year minimal child welfare direct service or related experience	Responsible for processing child placement referrals and placement.
Case Management Supervisors	Full-Time 12 Staff	Bachelor's Degree, Master's degree preferred	3 years minimal child welfare direct service experience	Supervises case management staff and ensures that appropriate services are being received.
Case Managers	Full-Time 62 Staff Target case load of 25	Bachelor's Degree, Master's degree preferred	1 year minimal child welfare direct service or related experience	Coordinating and delivery of appropriate services and level of care for youth.
Family Support Worker	Full-Time 31 Staff	HS diploma or GED	1 year minimum child welfare direct service or related experience	Provide direct home services to support case plan goals

Support Staff Supervisor	Full-time 3 Staff	Bachelor's degree preferred	1 year minimal child welfare support service related experience	Supervises support services; transportation, receptionist, file management, data entry, fleet and facilities
Data-Entry	Full-Time 12 Staff	HS diploma or GED required	Minimum of 6 months experience working in data entry or related experience	Responsible for data entry and report functions
Support staff	Full-Time 12 Staff	HS diploma or GED required	Minimum of 6 months experience working in teams and the public or related experience	Responsible for receptionist duties and support services such as case filing, copying and scanning documents
Drivers	Full Time or Part Time 45 Staff	HS diploma or GED required	Minimum of 6 months experience working in teams and the public or related experience	Responsible for safe transport of children and/or families for placement and appropriate services
Clinical Utilization Supervisor	Full-time 1 Staff	MSW or equivalent	1 year minimal child welfare support service related experience	Supervises clinical utilization and provider relations staff to assure quality of services.
Clinical Utilization Provider Relations/	Full-Time 5 Staff 1-In home 1 reint serv 1 placement 2 clinical UR	Bachelor's Degree, Master's degree preferred	3 years minimal child welfare direct service experience	Responsible for provider agreements for placement and services. Monitors quality of services and develops full array of services for children and families.
Kinship Supervisor	Full-Time 4 Staff	Bachelor's Degree, Master's degree preferred	3 years minimal child welfare direct service experience	Supervises kinship and ICPC staff and ensures that appropriate services are being received
Kinship Workers	Full-Time 30 Staff	Bachelor's Degree preferred	1 year minimal child welfare direct service or related experience	Coordinating and delivery of appropriate services in kinship and ICPC homes
Attorney	Full-Time 2 Staff	Juris Doctorate	1 year minimal child welfare legal experience. Licensed to practice in NE	Provides legal support to case management teams and liaison with court personnel

Clinical Utilization Specialist – Medicaid Liaison	Full-Time 2 Staff	Master's degree in Social Work or related degree required.	1 year minimal child welfare clinical or related services	Clinical utilization, discharge planning for high needs youth
Parent Support Workers	Full-Time 8 Staff	Support staff with HS diploma or GED	1 year minimal child welfare direct service or related experience	Direct support to reintegration families; skill building
Independent Living Coordinator	Full-Time 2 Staff	Bachelor's Degree	1 year minimal child welfare direct service or related experience	Direct support to youth aging out of foster care; skill building
Transportation Coordinator	Full-Time 3 Staff	HS diploma or GED required	Minimum of 6 months experience working in teams and the public or related experience	Schedule and coordinate transportation requests
PI/QA Director	Full-Time 1 Staff	Master's degree in Social Work, organization leadership or related degree required.	4 years minimal child welfare o other direct service or QA/PI experience	Administer and manage quality assurance, data and contract outcomes in specific departments. Manages continuous quality improvement
PI/QA Supervisor	Full-Time 1 Staff	Master's degree in Social Work, organization leadership or related degree required.	3 years minimal child welfare o other direct service or QA/PI experience	Supervises and quality assurance, data and contract outcomes in specific departments. Supervises continuous quality improvement plans
PI/QA Coordinators	Full-Time 1 Staff	Bachelor's Degree	1 year minimal child welfare direct service or related QA/PI, case read experience	Conducts case reads, supports direct service supervisors with data management
Customer Care	Full-Time 2 Staff	HS diploma or GED	Minimum of 6 months experience working in teams and the public or related experience	Provides customer concern supports
Trainers	Full-Time 3 Staff	Bachelor's Degree in social work Master's degree preferred	2 year minimal child welfare clinical or related services	Provides Program training and ongoing coaching

Education Coordinator	Full-Time 1 Staff	Preferred Bachelor's degree in social services or education	2 years minimal child welfare or education experience	Provides support to youth to meet education goals
Technology Coordinator	Full-Time 1 Staff	Bachelor's Degree in IT, Computer Science, or a related field	10 years' experience in technology sector. Supervisory experience preferred	Purchase, setup, configuration, design of IT-related hardware, software, and related, as needed for service and reporting per the contract
Security Administrator	Full-Time 1 Staff	Bachelor's Degree in IT or a related field	5 years working in IT field with information security	Oversees and evaluates network configuration and related software/hardware and conducts related background checks and reporting
X-Treme Recruiter	Full-Time 2 staff	Bachelor's Degree	1 year minimum child welfare direct service or related experience	Provides extensive kinship search and connections for children in out-of-home placement
Foster Care Homes (FCH) Director	Full-Time 1 staff	Master's degree in Social Work or related degree required.	4 years minimum child welfare direct service experience	Administer and manage the NE Region 1 service delivery and contract outcomes in specific departments
FCH Recruiter Supervisor	Full-Time 1 staff	Bachelor's degree in Social Work, Master's degree preferred	2 years' supervisory experience or 3 years' post-grad direct service experience	Supervision, coordination and training of recruiters; assign & track recruitment database
FCH Recruiters	Full-Time 3 staff	Bachelor's degree in Human Services field	Two years' experience child welfare direct service;	Engage communities & individuals, piquing interest in foster & adoptive families
FCH Supervisor	Full-Time 1 staff	Bachelor's degree in Social Work, Master's degree preferred	Two years' experience in child placement, child welfare direct services	Direct support and supervision of foster care homes staff
FCH Workers	Full-Time 8 staff	Bachelor's degree in Social Work or Human Services field	Two years' experience child welfare direct service;	Support resource families in providing safe, secure care for children in out-of-home placement

e. Staff Policies and Procedures

A policy and procedures manual created by Saint Francis for our current activities in Nebraska is in place, delineating the roles and responsibilities for subcontractors. The Client Services Leadership Team (CSLT) will develop other policy and procedures manuals based on those currently in use in our other states and modified to meet DHHS' guidelines for programs and services to be administered via this Contract. The Operations Manual for the Eastern Service Area will be updated and agreed upon by both parties to guide staff regarding responsibilities, roles, and expectations. As explained here, our procedures fold in relevant State requirements; at no time should our procedures manual conflict with the DHHS Operation Manual. In the case of any inadvertent conflict, the DHHS Operation Manual will prevail.

f. Personnel Files and Review

Saint Francis is committed to vetting Agents, Employees, Interns, Volunteers, Second Tier Subrecipients or Subcontractors via background checks and will follow the requirements contained in Section V of the RFP, pertaining to initial and any follow-up checks from the prescribed sources, and take the appropriate actions according to our Eastern Service Area Contract.

To assure that the quality employees that Saint Francis either has already hired or brings on board to serve the children and families in Nebraska's Eastern Service Area continue to be worthy of the trust necessary to provide direct services to children/youth and families, Saint Francis will conduct a biennial review of staff files chosen by random sample, to assure that requirements such as those pertaining to licensing, background checks, and certifications continue to be met. Saint Francis acknowledges that while DHHS will provide the sample methodology, we will "select a point in time prior to identify a random sampling of personnel files," per the Operation Manual that was provided with this RFP. We look forward to working with DHHS through the methodology, timing, and review process.

Saint Francis understands that it is our responsibility to conduct in-house reviews as well as reviews of our subcontractors, unless those subcontractors are "subject to regulation, licensing, or certification requirements that include background checks on themselves or their staff," as stated in the Operation Manual that is included with the RFP document package.

ii. Training: including ensuring staff are trained in trauma-informed care and to be culturally humble

The Saint Francis Training Department provides staff with the knowledge and competencies needed to achieve professional excellence, maximize productivity and above all, to meet the individualized needs of our clients. The Training Department supports the strategic goal of being a learning organization. The team provides internal training and coordinates trainings by external experts on best practices to assure that a comprehensive knowledge of the material offered is available to staff. The Training Department offers in-person and online training. Required trainings differ between positions and the level of contact staff have with clients, but a minimum of 24 hours of training is required every year for most positions. All completed training is documented and maintained in a database to assure that requirements are monitored, the results of which are provided at the request of DHHS.

Saint Francis looks forward to partnering with DHHS on training opportunities. Prior to contract implementation, Saint Francis shall submit a Training Plan to be approved by DHHS. All DHHS staff will be invited to attend Saint Francis trainings via a monthly training announcement email.

Saint Francis will also provide DHHS with a quarterly reports of trainings conducted. Such reports shall contain descriptions, participants, and hours of each training.

The Training Department is overseen by the current Director of Training, who has 25 years of child welfare experience as a master's level social worker. Additional trainers are used for particular areas of expertise, such as computers, databases, legal issues, CPR/First Aid, and crisis de-escalation.

Core training is based on job-specific staff development requirements that are designed to help staff successfully fulfill their roles. Training is competency-based and addresses attitudes and beliefs, knowledge, and skill application. Supervisory and peer support are instrumental in building competency through the use of shadowing, coaching, mentoring, and direct supervision. Continuing education is designed to enhance staff performance, development, and retention. The goal is to capitalize on each staff member's assets and skills to improve the quality and efficiency of services. Trainings are built upon a foundation of family engagement and family-centered case planning. Motivational Interviewing techniques are utilized through both a trauma-informed and culturally humble lens.

a. Initial and Ongoing Training

Saint Francis provides orientation training on a multitude of levels to ensure that staff have the tools necessary to perform their job responsibilities successfully. First, new staff meet with Human Resources staff to cover the Employee Handbook and Standard Operating Procedures to become familiar with Saint Francis's mission, core values, history, organizational structure, goals, expectations, and personnel policies and procedures.

Next, new staff complete the Saint Francis Online Orientation Program that consists of the individual training modules shown in Table WRK-1.B.

WRK- 1.B. Online Orientation Program Trainings				
Saint Francis Heritage	Bloodborne Pathogens	Boundaries	Car Seat Installation	Child Abuse and Neglect
Client Rights	Customer Service	Diversity and Culture	HIPAA Compliance	NCS Defensive Driving
Risk Management	Safety in the Workplace	Sexual Harassment	Suicide Prevention	

Supervisors or their designees are responsible for providing new staff with orientation regarding their specific programs and offices, and ensuring all questions are answered. Staff then complete the same initial pre-service training used for Child and Family Services Specialists employed by DHHS. Staff also complete security awareness and acceptable use training initially and on an annual basis. Supervisors or their designees then complete the DHHS formal assessment process for staff to demonstrate their competency prior to assuming case management responsibilities.

This assessment process consists of oral and written evaluations of the staff's case management knowledge and skills. The results are kept on record and provided at the request of DHHS.

Next, staff complete the in-person trainings listed in Table WRK-1.C that are required to complete their day-to-day job responsibilities:

WRK-1.C. Initial In-Person Trainings			
Case Management Procedures	Documentation	Court Reports	Due Diligence
Assessments (CAFAS, NCFAS, PSI, ASQ, CROPS, CSDC)	Ethical Boundaries	Ethics of Cultural Competence	CPR/First Aid
Trauma Informed Care with Children and Families	Motivational Interviewing	Suicide Risk Assessment and Precaution Intervention	Structured Decision Making/Safety Organized Practice

Ongoing training assists employees in meeting the requirements of certain specialties, certifications, or licensures, and consists of the topics at a minimum in Table WRK-1.D below.

WRK-1.D. Ongoing Formalized Trainings			
Trauma Impact: Brain and Body	Safe Sleep	Ethics (Dual Relationships)	Human Trafficking 101
Social Worker Safety	Self-Care	Self-Regulation and De-Escalation	Diagnosis and Treatment
Bridges out of Poverty Overview	Advice from Child Sexual Predators	Adverse Childhood Experiences	Working to Keep Families Together

In addition, online training on the topics in the following Table WRK-1.E are available.

WRK-1.E. Online Trainings			
Reasonable and Prudent Parent Standard	Multi-Ethnic Placement Act	Six Protective Factors	Oral Fluid Drug Testing
The Period of Purple Crying	Permanency Roundtables	Documentation	Immigration
ICPC	Kinship	Legal Issues	Visiting Children in Out-of-Home Placement
Casey Life Skills	Transition Plan for Successful Adulthood	Emergency Procedures	Active Shooter 101
Trauma in Infants, Young Children, and their Families	Suicide Prevention	Bed Bugs in Home Visits	Keeping Kids Safe Online
Child Development	Ethical Professional	Trauma Focused Cognitive Behavioral Tx	Car Seat Installation
CAFAS	Childhood Domestic Violence	Trauma: Working with Parents Involved in the Child Welfare System	Trafficking 101
Federal Discrimination Law	Strengthening Families		

The preceding describes Saint Francis's typical operation when it comes to initial and ongoing training for new Saint Francis case management staff. We acknowledge DHHS' requirement detailed in Section 11 of the Operation Manual provided with the RFP and are ready to work with DHHS to assure that staff are provided both initial and ongoing training pursuant to LB853 and, per the Operation Manual, "use the same program for initial training used for all Child and

Family Services Specialists employed by DHHS." We understand that, per the RFP, the training must also be in compliance with Neb. Rev. Stat. § 68-1214, maximize IV-E training funds for the State, and be approved by DHHS utilizing best practice guidelines.

The variety of training offerings and the vast experience of our training leadership is a testimony to Saint Francis's ability to deliver a range of trainings, both in-house and in conjunction with DHHS, to strengthen the staff that will in turn endeavor to strengthen families in the Eastern Service Area.

a. Leadership Training

Saint Francis places great emphasis on the continuous improvement of our leadership staff. To that end, a leadership training program is provided to enhance leadership skills and to develop the future leaders of the organization. Topics, listed in the below Table WRK-1.F include:

WRK-1.F. Leadership Training			
Leadership and Influence	Essential Skills of Leadership	Essential Skills of Communicating	Communicating Up
Workplace Harassment	Performance Appraisals	Generation Gaps	Personality Types
Providing Performance Feedback	Effective Discipline	Improving Work Habits	Motivating Team Members
Coaching Job Skills	Developing and Coaching Others	Managing Complaints	Resolving Conflicts
Hiring Winning Talent	Employee Onboarding	Retaining Winning Talent	

b. Trauma-Informed Care Training

Saint Francis staff receive formal training in trauma-informed care. Trauma-informed training encompasses initial and ongoing training provided by the Saint Francis Training Department, as well as internal and external subject matter experts.

Trauma Systems Therapy (TST) by Glenn N. Saxe is designed for children and families for whom trauma is not only part of the past, but an ongoing part of their present and everyday life. It is designed for children and families facing ongoing stress in poverty, family and community violence, parental mental illness, and substance use. Frequently, these children receive care in service systems that are frayed and fragmented.

TST addresses two things: first, the traumatized child who is not able to regulate emotional states; and second, a social environment and/or a system of care that is not sufficiently able to help the child regulate these emotional states.

It is a systematic approach and requires the collaboration between parents, guardians, relatives, friends, teachers, social service workers, therapists, psychiatrists, and advocates home-based and community-based clinicians. TST offers all of these participants a highly focused and integrative treatment approach. Saint Francis utilizes this model to provide a basic framework for trauma-informed care for all staff, whether they are providing direct or support services.

A brief overview of other trauma-informed trainings follows in Table WRK-1.G :

WRK-1.G. Other Trauma-Informed Trainings: *brief overview*	
Adverse Childhood Experiences (ACEs)	• Developed by Kaiser-Permanente and the CDC • Explains ACEs study, findings, and inter-connectedness of ACEs between individuals, families, communities, and society as a whole • Key factors affecting behavior across a lifetime are addressed, including the role of traumatic stress experienced during childhood and its effects on health, development, biology, and behavior.
Trauma Impact: Brain and Body	Examines how traumatic stress occurs at different stages of life, how it impacts both brain and body, and how resilience can heal the impact of trauma
Trauma-Informed Care with Children and Families	• Derived from the National Child Traumatic Stress Network's (NCTSN) Comprehensive Child Welfare Trauma Training Toolkit • Explores causes, types, and effects of trauma, and strategies for using trauma-informed care to enhance the goals of safety, permanency and well-being

The Training Department coordinates ongoing trauma-informed training sessions provided by experts with specialized certifications in traumatization who are available to meet with staff for case consultations.

c. Safety, Permanency, and Well-being Trainings

Saint Francis understands the importance of federal guidelines established by the Children's Bureau in regard to safety, permanency, and well-being, and we abide by these standards. This training is critical to the foundation of direct service staff and is completed during the initial training period. For staff to be successful in their roles they must understand the 36 items comprising the Child and Family Services Reviews' seven (7) outcomes and the seven (7) systemic factors upon which their day-to-day practice is measured.

d. Disproportionality and Cultural Competence Training

Saint Francis's programs are trauma-informed, family-focused and community-based. Understanding the unique demographic characteristics of the populations being served is integral to our practice and, thus, to the training necessary to prepare staff to serve the children and families in the Eastern Service Area. Saint Francis views cultural competence as our staff having an understanding of their own world views and the world views of their clients and the community, and then applying their ability to understanding various culturally-informed perspectives to the services that are delivered to their clients and the community.

Staff are required to take *Diversity and Culture* as a part of the Saint Francis Online Orientation Program within the first two weeks of joining the organization. Gaining cultural competence, like any important child welfare skill, is an ongoing process. Saint Francis provides a framework to help our staff integrate cultural factors into their interactions with children and families. We also seek to motivate our professionals and organization to examine and broaden our cultural awareness, embrace diversity, and develop a heightened respect for people of all cultural groups. Organizational support allows counselors, case managers, and administrators to integrate culturally congruent and responsive services more consistently across the continuum of care.

Saint Francis staff are encouraged to take *Ethics of Cultural Competence* training, guiding to discover self and others in an effort to embrace the importance of "meeting their clients where

they are." Excerpts from the video *Knowing Who You Are* give staff a first-hand look at the importance of culture and identity to youth in care. This half-day training is geared towards direct service employees and covers the following objectives: components of culture; explain how cultural "lenses" are formed; differentiate between what cultural competence is and is not; review what the Codes of Ethics of five social service disciplines have to say about culture; discuss common themes among the Codes; list characteristics and tips for working with cultures commonly experienced in social services; outline the steps to responding with cultural competence; review placement considerations related to culture; and explore ways to maintain children's connections to their cultures.

Please see CNT-5 for Saint Francis's assessment of the cultural landscape of the Eastern Service Area, which will be emphasized during trainings, assessments, and case plans throughout our service model.

iii. Plan and process how to address the turnover rate and retention practices.

Employee retention maximizes an organization's ability to provide service, not only from the organization's perspective, but also from the perspective of those served. In addition to the employee recruitment strategies outlined above, which includes sourcing staff members from the community since they're more likely to understand the unique characteristics of the Eastern Service Area and speak the prevailing languages in the area, and the initial/ongoing training also described above, the below describes Saint Francis's offerings, from a prospective employee interview through the length of that employee's tenure, that are aimed at reducing the turnover rate.

One key to employee retention is selecting the right candidate for the position, from the perspective of everyone involved. Saint Francis's hiring process includes the utilization of program staff as well as Human Resources representatives to interview candidates for open positions. This allows the candidate to receive a good description of what the job entails and also helps enable Saint Francis to determine whether the candidate is a good fit for the position, the team and the organization. Additionally, this helps achieve buy-in from the specific program with which the candidate may possibly be working, and it facilitates the start of the relationship between the potential employee and program staff, which will then be built upon as the employment relationship unfolds and throughout their tenure with Saint Francis.

In addition to interview teams consisting of HR and program staff, another tool to help with recruitment and retention of staff is the referral bonus. Current staff may receive a bonus if they refer a person to Saint Francis if that referred person is then hired and stays with the Saint Francis team for a prescribed amount of time. Saint Francis also has an organization wide onboarding program that new hires to the organization complete. This process starts when the offer is made, walks a supervisor through how to onboard a new employee, offers training on mentoring new employees, and allows the new employee time to shadow and learn before they are given a caseload.

Other tools and programs Saint Francis use to retain its valuable team members include:

- Tuition Reimbursement Plan
    - Allows employees to have college course tuition and fees reimbursed if it is determined it can benefit the organization and allows Saint Francis to grow their own workers
- Employee Recognition Program

    - Highlights the good that so many of our employees do day-in and day-out
- "Stay" Interviews
    - Invites employees to share vital information, and allows Saint Francis to gather pertinent data, on what is working and what is not working, from the employee's point-of-view, to help prevent the need for "exit" interviews.
- Employee and Leadership Development
    - Numerous training opportunities (initial and ongoing), as detailed above.
        - Leadership Development includes leadership training by our internal training department, "one-on-ones" with our Organizational Development Manager, and outside training opportunities that enhance the ability to coach employees and develop leadership skills and language that is used across the organization.
- Progressive Work Policies, such as:
    - Just Culture, designed to empower all team members to work together to build and maintain a safer and higher quality work environment – both for us as well as the children and families we serve
    - Infants at Work, allowing parents or guardians to bring their infant to work, subject to their responsibilities and to ensuring the physical safety of the infant
    - Pets at Work, wherein participating offices periodically allow the employees to bring their pets to work for the day
    - Opportunities for leadership development
- Benefits package including insurance, retirement, paid time off, and flex time
- A work environment which prioritizes positive interactions and encouragement among team members, regardless of organizational level or department
- Regular research into prevailing wages for relevant occupational classification codes, utilizing sources such as the U.S. Bureau of Labor Statistics information for the areas we serve to assure that valuable staff are competitively compensated for their position and according to their qualifications, in the region/area where they work.

For more information on the current Case Worker retention, as well as caseload, in the Eastern Service Area, please see CNT-5.

CNT Continuum of Services

CNT- 1. Describe a plan of how Saint Francis will develop, implement, manage, and deliver a continuum of evidence-based models used in the context of the service continuum that will be available for children and families, in both court and non-court cases, in order to achieve the permanency goals identified while delivering ongoing case management.	Comply: X

Response:

Saint Francis employs consultation review meetings to evaluate the organization's most vulnerable children to ensure that each child and their family are receiving the best services and

supports offered. Supports are tailored to meet the individual needs of each child and family. A three-tiered consultation approach is used, focusing time and energy in evaluating needs. At each consultation meeting, individuals familiar with the child's case come together as a team actively plan for the next 90 to 180 days. Along with the consultation review process, a child's level of service is reviewed every 90 to 180 days.

The case management supervisor will determine what tier of review the child needs to achieve permanency in a safe, stable environment. The following levels of review are available:

1. Placement Stability
2. Care Management Coordination (CMC)/Level of Service Review
3. High Acuity Clinical Care Consultations

Our Clinical Utilization team is involved in complex case staffing involving high-needs children and higher-acuity youth. Consultations are face to face meetings with the Clinical Utilization Specialist designed to be an in-depth discussion of the elements of a case and evaluation of services. The participants of the consultation are open to all parties involved in the case which could include the Case Manager, Supervisor, Director, Foster Care Worker, Foster Care Parent etc. The Clinical Utilization Specialist will facilitate the meeting.

Details for the review process can be found in the Utilization Review section UTZ-1.

CNT- 2. The bidder should describe a plan to ensure at least 30% of prevention services will meet the criteria for Well-Supported, Supported, or promising practice evidence-based services, as outlined in FFPSA, in its service continuum for the first year; at least 40% of prevention services will meet the criteria for Well-Supported, Supported or promising practice evidence-based services, as outlined in FFPSA, in the second year, and 50% or more of prevention services will meet the criteria for Well-Supported, Supported or promising practice evidence-based services as outlined in the FFPSA, in years following.	Comply: X

Response:

The Saint Francis Clinical Department is invested in researching services that meet the FFPSA criteria and how they would fit into the service continuum in Nebraska. Additionally, our organization has a National Director of Partnerships and Policy who works with FFPSA across the country. At a national level, we are advocating for expansion of the evidence-based practice list. Our membership with the Family Focused Treatment Association provides access to information and training on FFPSA through webinars and other methods.

At this time, Saint Francis will focus on building capacity to provide FCT to 50% of prevention families referred to Saint Francis Family Preservation. We will utilize the guidelines listed above to ensure that 30% of prevention services will meet the criteria for Well-Supported, Supported, or promising practice evidence-based services, as outlined in FFPSA, in its service continuum for the first year; at least 40% of prevention services will meet the criteria for Well-Supported, Supported or promising practice evidence-based services, as outlined in FFPSA in the second year; and 50% or more of prevention services will meet the criteria for Well-Supported,

Supported or promising practice evidence-based services as outlined in the FFPSA in years following.

CNT- 3. The bidder should describe a plan of how it will prevent children from being removed from the family home by developing, implementing, managing, and delivering a continuum of evidence-based services, including all Well-Supported services, as outlined in the FFPSA, as well as supports, that will be available for children and families, 24 hours a day, 7 days a week, 365 days a year, during the time that DHHS is conducting the Initial Assessment of safety and risk.	Comply: X

Response:

Saint Francis will prevent children from being removed from the family home by developing, implementing, managing, and delivering a continuum of evidence-based services. These services will meet the criteria above. The continuum of evidence-based services includes, but is not limited to, Structured Decision Making (SDM), Motivational Interviewing (MI) and either Family Center Treatment (FCT) or Intensive Family Preservation (IFP). SDM will provide the opportunity to assess families for both risk and safety factors allowing the referral to appropriate services. MI combined with principles of Family Voice and Choice will keep families engaged in the process while moving into an intensive treatment program of either FCT or IFP. Both FCT and IFP are required to support families 24 hours a day/7 days a week during the referral period. Staff will work with families to then build informal and formal supports that will support them during the year. Details for these evidence-based services are outlined in CSM-1 to CSM-4.

Please see Attachment S for a catalogue of in home services available in each zip code of the Eastern Service Area.

CNT- 4. The bidder should demonstrate how it will ensure delivery of Well-Supported, Supported, or promising practice evidence-based services to the following populations:	Comply: X

Response:

Saint Francis has experience serving the populations listed in CNT-4, Attachment Six of RFP 5995 Z1. We will work with subcontractors in the community to provide well-supported, supported, or promising practice evidence-based services to a) children ages birth to five (5); b) Infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from pre-natal drug exposure, or a Fetal Alcohol Spectrum disorder; c) children who have an intellectual disability, Autism Spectrum Disorder, or who demonstrate behaviors consistent with children who have an intellectual disability; d) children who have been exposed to domestic violence; e) children who have extensive histories of trauma; f) children who have limited connections with supportive adults; g) youth that intersect both the child welfare and juvenile justice systems; h) youth identified as survivors of sex trafficking; and i) youth who are near the age of majority and preparing to transition to adulthood.

Saint Francis will utilize Trauma Systems Therapy (TST) to provide service for those children and youth who have extensive histories of trauma. TST is designed for children and families for whom trauma is not only part of the past, but an ongoing part of their present and everyday life. It is designed for children and families facing ongoing stress in poverty, family and community violence, parental mental illness, and substance use. Frequently, these children receive care in service systems that are frayed and fragmented.

To provide services for youth identified as survivors of sex trafficking, Saint Francis has formed an alliance with the International Social Services-USA Branch to provide cross-border social services to children and families separated by voluntary or forced migration, adoption, abduction or human trafficking. As of 2018, International Social Services and Saint Francis conduct joint information sessions for social workers, judges, lawyers and other child protection professionals, focusing on the international processes required to reunify children with their families abroad.

Case management teams use an approved screening tool to determine whether a child may be a victim of Human Trafficking. If it is suspected the child *may* be a victim, the case management team will notify local Law Enforcement and refer the child to one of Saint Francis's trained, licensed staff members to complete a full Human Trafficking assessment.

The need for 24/7 service provision has changed dramatically in recent years. The needs of high acuity children disrupting from placements and needing acute hospital screens, coupled with limited placement availability, have driven us to enhance service provision by establishing an after-hours unit of staff. The goal of the unit is to ensure children, families, and group homes receive the support necessary to keep children safely in placement. After-hours Care Coordinators are the central point of contact for all caregivers experiencing challenges with children in care, including birth, foster, relative, and NRKIN families, or residential providers.

As experts in de-escalation, after-hours Care Coordinators assess situations and provide immediate support and direction to caregivers. Coordinators also serve as the central point of contact for the community, DHHS, and Law Enforcement, including human trafficking assessment requests.

Human Trafficking awareness is a part of foster parent training/ Reasonable and Prudent Parent Standard training.

Saint Francis staff will collaborate with the community to identify and develop local resources that promote independent living skills for youth who are near the age of majority and preparing to transition to adulthood. Utilized strategies, services, and programs include, but are not limited to, the following:

- *Trauma Systems Therapy (TST)-* designed for children and families for whom trauma is not only part of the past, but an ongoing part of their present and everyday life. It is designed for children and families facing ongoing stress in poverty, family and community violence, parental mental illness, and substance use. Frequently, these children receive care in service systems that are frayed and fragmented.
- *Youth Thrive-* Youth Thrive offers financial literacy curriculum for youth as well as opportunities to save money through a matching program. Youth Thrive teaches youth to open a savings/checking account, establish emergency funds, maintain credit score, and budget for items and activities. Also helps recruit support families and support systems

- *Your Money Your Goals-* Developed by the Consumer Financial Protection Bureau. Prepares staff to answer youth's questions about financial responsibility.
- *The Opportunity Passport Program-* Provides education and incentives for youth to save money and develop healthy spending habits. Programs include teaching youth how use bank services, set financial goals, maintain positive credit history, rent housing, and smart purchasing and provides a 2:1 savings match rate for youth so that they may save money to purchase a car, make repairs, pay for education, or other items.
- *Youth Advisory Council:* Monthly meeting facilitated by IL Coordinator. Youth who have already transitioned out of foster care can meet with those who are in the transitioning process. Meetings provide insight into service gaps or programs that could be developed to help youth succeed.
- *Healthy Empowerment Adolescent Relationship Training (HEART)-* An evidence-based skill-building program for youth ages 10-18 that educates youth about healthy relationships. This curriculum enhances the youth's five core competencies of social and emotional learning: Self-Awareness, Self-Management, Social Awareness, Relationship Skills, Responsible Decision Making.
- *Senior Services/Fatherhood Initiative Program-* Programs for pregnant or parenting teams to teach positive parenting skills and provide mentoring services.
- *Bridges to Independence (B2i)-* Coordinated by DHHS for young people between 19 to 21 years of age who are aging out of foster care. Provides a dedicated Independence Coordinator for qualifying youth, Health Care insurance if eligible through the Affordable Care Act or through Medicaid, and a monthly maintenance payment. Helps youth access resources available through DHHS.
- *Project Everlast-* Project Everlast is a grassroots effort that promotes using community resources to improve a youth's opportunities and networks for housing, transportation, health care.

These resources are detailed in the Youth Services YTH-1 to YTH-3. Saint Francis case management teams, IL Coordinators, and Education Coordinators will also utilize programs and practices that provide evidence-based, trauma informed strategies to engage youth in healthy development of these skills.

CNT- 5. The bidder should describe a plan on how it will assess gaps in service array for the populations served and said plan shall include how it proposes to fill these gaps in services. Gaps in service means that needed services for families are not available due to capacity issues or there are no Second Tier Subrecipients or subcontractors in the area that provide needed services	Comply: X

Response:

Saint Francis assesses gaps in service array by reviewing Nebraska's DHHS Annual Report and other state data. While an early review of services shows gaps in the areas of behavioral health, Saint Francis will continue to conduct data driven analyses to identify and target more specific service needs. This allows Saint Francis to be proactive rather than reactive in our response to the Eastern Service Area's specific needs.

When a gap in services for families has been identified, due to capacity issues or lack of Second Tier Subrecipients or subcontractors in the area that provide needed services, Saint Francis will work to provide wraparound support services to the family until the needed service becomes available. For example, Saint Francis may provide a Family Support Worker to perform services until therapy can be started. Because Saint Francis will be staffing to provide some services internally, the ability to "fill in" for subcontractors during times of shortage is available.

a. Licensed Child Placement Agencies and PRTF's

As an organization dedicated to serving the Eastern Service Area, we will build relationships with various service providers to help us meet the needs of the children and families referred to our care. We will partner with Licensed Child Placing Agencies (LCPAs) to help with the recruiting, training, and placement of the children that are referred to us. According to the *Roster of Child Placing Agencies Licensed in Nebraska*[11], there are a variety of LCPAs that we are able to partner with in Douglas County (see Table CNT-5.A).

Working closely with these agencies will be important due to the daily need for placing children. We will also work with Psychiatric Residential Treatment Facilities (PRTF's) in order to provide additional support for those youth and children who have different or higher level needs. According to the *Psychiatric Residential Treatment Center Roster* for the state of Nebraska, there are three psychiatric residential treatment centers that are in Douglas County and none in Sarpy County[12] (see Table CNT-5.B on pg. 109 below for a roster of known LCPAs).

[11] Division of Public Health, Roster of Child Placing Agencies Licensed in Nebraska, http://dhhs.ne.gov/publichealth/documents/Child_Placing_Roster.pdf

[12] State of Nebraska Roster Psychiatric Residential Treatment Centers, http://dhhs.ne.gov/publichealth/Licensure/Documents/PRTF%20Roster.pdf#search=prtf

Table CNT-5.A. Douglas County Licensed Child Placing Agencies

Name	Address	Phone Number	Type of Service
Father Flanagan's Boys' Home	378 Bucher Drive, Boys Town, NE 68010	(402) 964-7230	Foster Care & Adoption
Lutheran Family Services of Nebraska	124 S 24 St Suite 200, Omaha, NE 68102	(402) 342-7038	Foster Care & Adoption
Priority Foster Care	1707 J Street, Omaha, NE 68107	(402) 850-4577	Foster Care
Release Ministries	3223 N. 45th Street, Omaha, NE 68104	(402) 455-0808	Foster Care & Adoption
Child Saving Institute, Inc.	4545 Dodge St, Omaha, NE, 68132	(402) 553-6000	Foster Care & Adoption
OMNI Behavioral Health	5115 F Street, Omaha, NE 68117	(402) 397-9866	Foster Care & Adoption
KVC Behavioral Healthcare, Inc.	11550 I Street, Suite 100, NE 68137	(402) 742-8800	Foster Care & Adoption
Bethany Christian Services	11319 P Street, Suite 5, Omaha, NE, 68137	(712) 737-4831	Adoption
Holt International Children's Services	12100 W. Center Rd, Suite 523A, Omaha, NE 68144	(402) 934-5031	Adoption
Nebraska Children's Home Society	4939 S 118 ST, Omaha, NE 68137	(402) 451-0787	Foster Care & Adoption
Jewish Federation of Omaha, Inc.	333 S 132 ST, Omaha, NE 68154	(402) 334-8200	Adoption
NOVA Treatment Community, Inc.	8502 Mormon Bridge Road, Omaha, NE 68152	(402) 455-8303	Foster Care & Adoption
Nebraska Families Collaborative	2110 Papillion Parkway STE 110, Omaha, NE 68164	(402) 498-1240	Foster Care & Adoption

One of the centers is CHI Health Immanuel in Omaha. This facility notes that it is "… a 20 bed facility designed to treat children and adolescents, ages 6 to 18, which have been diagnosed with psychiatric disorders. The PRTF provides specialized medical psychiatric, psychosocial and behavioral treatment services to assist youth and their families in gaining the skills necessary to demonstrate mental health and positive community adjustment"[13].

Additionally, the search returned a facility named Boys Town Residential Treatment Center-West, also in Omaha. This center's program offers services such as separate environments for children ages 5-11 and adolescents 12-18, 24-hour trained professional supervision and consultation, medication evaluation and reduction program, integrated mental and physical health care, licensed school with recovery program, family centered parent training and an aftercare program[14]. According to the aforementioned psychiatric residential treatment center roster, there are 80 beds within this PRTF[15].

[13] CHI Health, https://www.chihealth.com/residential-treatment-center
[14] Boystown National Research Hospital, https://www.boystownhospital.org/residentialtreatment/Pages/default.aspx
[15] Ibid 12

Nova Treatment Community is also on this roster. According to the roster, it has 30 beds[16], although it is not clear how many of those are for adults versus the adolescent population they also serve. According to their website, "NOVA's Psychiatric Residential Treatment Facility (PRTF) is a highly structured, therapeutic environment for dually diagnosed adolescents, ages 13-18 in need of intensive services to treat substance use and mental health disorders, along with severe emotional and behavioral problems"[17].

A separate search shows other residential type facilities in Omaha, such as the Omaha Home for Boys-Inspiration Hill Residential Care, which, according to their website, "provides a safe, stable environment where at-risk young men live, learn and grow to become productive, independent adults"[18]. They also note, "The program serves high school age boys who live on our main campus and attend the Omaha Home for Boys High School while also having access to therapy, employment opportunities, recreation and other support services"[19]. Another residential type facility is Youth Care and Beyond. Youth Care and Beyond have Family Style Homes that offer "a family with a live in, awake overnight and other trained adults to provide security, safety and teaching"[20]. They also offer a Life Skill Reporting Center, which "provide[s] teaching, supervision, tutoring and community service for youth"[21].

b. CASA

CASA, or Court Appointed Special Advocates, are an important resource due to the fact that they "recruit, train and support citizen-volunteers to advocate for the best interests of abused and neglected children in courtrooms and communities"[22]. According to the Nebraska CASA Association website, there are two CASA organizations in the Eastern Service Area. There is one in Douglas County, located in Omaha. Additionally, there is a CASA in Sarpy County, located in Papillion.

c. Caseworker Information

According to the *Children and Family Caseload Status Report,* there are 195 total staff in the Eastern Service Area. Of the total staff 184 were in compliance, giving them a 94.4% in compliance rate according to the February 2019 averaged data[23].

The "child welfare profession has struggled, nationwide, to maintain a trained and skilled workforce dedicated to providing services and support to assist families"[24], and the State of Nebraska Children and Family Service Specialists (CFSS) has also experienced this issue. In 2017 there was a 32% rate of turnover, with employees leaving the agency or changing positions

---

[16] Ibid 12
[17] NOVA Treatment Community, https://www.novatc.org/treatment-programs-services/adolescent/
[18] Omaha Home for Boys, Inspiration Hill, https://omahahomeforboys.org/programs-services/inspiration-hill-residential-care/
[19] Ibid 18
[20] Youth Care and Beyond, https://www.youthcareandbeyond.org/care-for-youth
[21] Ibid 20
[22] Nebraska CASA Association, https://www.nebraskacasa.org/who_we_are/what_we_do/
[23] Children and Family Caseload Status, http://dhhs.ne.gov/Reports/Children%20and%20Family%20Services%20Running%20Caseload%20Report%20-%202019.pdf
[24] Nebraska Department of Health & Human Services: *2018–2019 DHHS Business Plan,* http://dhhs.ne.gov/Pages/srd_srdindex.aspx

within the agency[25]. Research has found a relationship between caseworker turnover and "a significant increase in length of stay and a significant decrease in the likelihood of achieving reunification"[26]. Of the children in the Eastern Service Area 43.3% had 1–2 caseworkers, 29.2% had 3–4, and 27.5% had 5 or more caseworkers[27].

Additionally, within the Eastern Service Area there is a higher rate of change compared to the other service areas, with 27% of the children in care having "5 or more caseworkers during their current episode in care" [28]. One way in which Saint Francis could help mitigate this turnover would be to collaborate with Social Work programs at local universities. Following is a listing of schools whose social work students may have an interest working with Saint Francis[29],[30].

		Degree(s) offered				# Social Work Students/Degree		
School	Graduate Rate	Bachelors	Graduate	Distance (miles) to Douglas County	Distance (miles) to Sarpy County	Associates (2016-2017)	Bachelors (2016-2017)	Masters (2016-2017)
Univeristy of Nebraska at Omaha	45%	Yes	Yes	14	22		31	80
Creighton University (Omaha)	78%	Yes		15	25		10	N/A
Union College	49%	Yes		53	40	--	2	N/A
Nebraska Wesleyan University	69%	Yes		48	35		18	N/A
University of Nebraska at Kearney	56%	Yes	Yes	181	167		28	N/A

d. Poverty

The U.S. Census Bureau noted that 10.8 % of Nebraska's individuals are at poverty level[31]. Individuals 18 years and younger had a below poverty rate of 14 %[32], with 6 % of children living in extreme poverty (i.e., an annual income of $12,429 or less for a family of two adults and two children)[33]. Within Douglas County 39.9% of children fall below the 200% federal poverty rate, the highest rate, and 23.8% in Sarpy County[34]. Nebraska has a food insecurity of 18.3 %[35], with a monthly average of 78,482 households receiving SNAP benefits[36]. Additionally, Nebraska is

[25] Ibid 24
[26] Ryan, J. P., Garnier, P., Zyphur, M., & Zhai, F. (2006). Investigating the effects of caseworker characteristics in child welfare. *Children and Youth Services Review, 28,* 993–1006. doi: doi:10.1016/j.childyouth.2005.10.013
[27] State of Nebraska Foster Care Review Office, Annual Report 2017–2018, http://www.fcro.nebraska.gov/pdf/FCRO-Reports/2018-annual-report.pdf
[28] Ibid 27
[29] National Center for Education Statistics: *College Navigator*, https://nces.ed.gov/collegenavigator/
[30] Nebraska Social Work Programs and Degrees Guide, https://www.socialworkguide.org/schools/nebraska/
[31] United States Census Bureau: Quick Facts Nebraska, https://www.census.gov/quickfacts/fact/table/ne/PST045217
[32] Kids Count https://datacenter.kidscount.org/data/tables/43-children-in-poverty-100-percent-poverty?loc=29&loct=2#detailed/2/29/false/871,870,573,869,36,868,867,133,38,35/any/321,322
[33] Kids Count https://datacenter.kidscount.org/data/tables/45-children-in-extreme-poverty-50-percent-poverty?loc=29&loct=2#detailed/2/29/false/871,870,573,869,36,868,867,133,38,35/any/325,326
[34] 2018 Community Health Needs Assessment Report, https://www.douglascountyhealth.com/images/stories/2018-Adult-Assessment-report-2.pdf
[35] Kids Count https://datacenter.kidscount.org/data/tables/8384-food-insecurity?loc=29&loct=2#detailed/2/any/false/870,573,36,868/any/16983,16989
[36] Supplemental Nutrition Assistance Program: State Activity Report Fiscal Year 2016, https://fns-prod.azureedge.net/sites/default/files/snap/FY16-State-Activity-Report.pdf

ranked 4th in the nation when it comes to affordable housing[37]. Furthermore, 14 % of children live in high poverty[38] while 8 % live in high poverty areas[39]. Researchers have shown that children living in high poverty areas are more likely to experience negative social determinants of health, including increased child maltreatment, food insecurity, and household substance abuse[40]. According to the *State of Nebraska Foster Care Review Office Annual Report 2017–2018*, 63.5% of removals were due to parental neglect, with parental substance use "an adjudicated reason for removal for 44.2% of children reviewed", domestic violence for 15.5% of the children, and physical abuse for 10.3% of the children.

e. Substance Use

The U.S. Department of Health and Human Services found that since 2010 there has been a 10% increase in the number of children in foster care across the country due to an opioid crisis[41]. "Foster care entries and overdose deaths are related nationally"[42]. In 2016, Nebraska experienced an increase in the overdose death rate of 6.9 overdose deaths for every 100,000 people[43]. Nebraska has also seen an increase in the number of opioid overdoses from 2.4 to 3.0 per 100,000 people[44],[45]. During the 2017–2018 fiscal year 49.5% of children removed from their mother were removed due to documented substance use, 27.4% of the children removed from their father due to substance use[46]. This is one of the largest barriers to permanency: the continued use of substance(s) by the parent(s), which impact parenting abilities.

f. Adverse Childhood Experiences

An Adverse Childhood Experience (ACE) describes a traumatic experience in a person's life occurring before the age of 18. Experiences include such things as physical, emotional or sexual abuse. The CDC-Kaiser Permanente Adverse Childhood Experiences Study[47] shows that ACEs can have serious, long-term impact on a child's health and well-being by contributing to high levels of toxic stress that derail healthy physical, social, emotional, and cognitive

---

[37] U.S. News & World Report: Affordability Rankings:Determining the most affordable states, https://fns-prod.azureedge.net/sites/default/files/snap/FY16-State-Activity-Report.pdf

[38] Kids Count https://datacenter.kidscount.org/data/tables/43-children-in-poverty-100-percent-poverty?loc=29&loct=2#detailed/2/29/false/871,870,573,869,36,868,867,133,38,35/any/321,322

[39] Kids Count https://datacenter.kidscount.org/data/tables/6795-children-living-in-high-poverty-areas?loc=29&loct=2#detailed/2/29/false/1691,1607,1572,1485,1376,1201,1074,880,11/any/13891,13892

[40] Chung, E. K., Siegel, B. S., Garg, A., Conroy, K., Gross, R. S., Long, D. A., ... Fierman, A. H. (2016). Screening for social determinants of health among children and families living in poverty: A guide for clinicians. Current Problems in Pediatric and Adolescent Health Care, 46(5), 135–153. doi:10.1016/j.cppeds.2016.02.004

[41] U.S. Department of Health and Human Services ASPE Research Brief: Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from A Mixed Methods Study, https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf

[42] Ibid 41

[43] Ibid 24

[44] NIH National Instute on Drug Abuse: Nebraska Opioid Summary, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/nebraska-opioid-summary

[45] Ibid 24

[46] Ibid 27

[47] CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study, , www.cdc.gov/violenceprevention/acestudy/about.html

development. ACEs increase the long-term adult risk for smoking, alcoholism, depression, heart and liver diseases, and dozens of other illnesses and unhealthy behaviors[48].

The HRSA's 2016 National Survey of Children's Health[49] found that of Nebraska's youth, 42.1 % of 0-17 years and 34 % of 0-5 years old had 1+ ACES. Of these children 25.9 % had chronic health conditions and 12.6 % had chronic emotional, developmental, and/or behavioral conditions. The United Health Foundation's 2018 report[50] found that 19.9 % of Nebraska's children had two or more Adverse Childhood Experiences (ACEs) — ranking them fourteenth in the nation. In Douglas County the prevalence of 4+ACEs was 14% and even higher in Sarpy County at 18.5%[51].

The Child Welfare League reported that the number of child victims in Nebraska has decreased by 19.1 % since 2011, with the ratio of victims of child abuse or neglect for 2015 at 7.4 per 1,000 children. They also reported a 24 % decrease in the number of children living in out of home care since 2011[52].

g. Cultural Competency

Top 5 Non-English Languages Spoken (Table CNT-5.C)

State	Language[53]	State	Language[54]
Nebraska		**Kansas**	
1	Spanish	1	Spanish
2	Somali	2	Vietnamese
3	Karen	3	German
4	Dinka	4	Chinese
5	Vietnamese	5	Tai-Kadai

Saint Francis recognizes the importance of being culturally humble, and we will seek to provide cultural advisors and translators to families in our care to help them better navigate and understand their roles and responsibilities as well those of the child welfare system. Within Douglas County 4.6% of the population age 5 and older live in linguistic isolation (i.e., no persons age 14 or older in the home are proficient in English) and 1.1% of the population in

[48] Ame Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., ... Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14, 245—258. https://www.ajpmonline.org/article/s0749-3797(98)00017-8/pdf

[49] Bethell, CD, Davis, MB, Gombojav, N, Stumbo, S, Powers, K. Issue Brief: A national and across state profile on adverse childhood experiences among children and possibilities to heal and thrive. Johns Hopkins Bloomberg School of Public Health, October 2017. http://www.cahmi.org/projects/adverse-childhood-experiences-aces/

[50] America's Health Rankings, United Health Foundation: *Nebraska in 2018*, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/NE

[51] Ibid 34

[52] CWLA: Nebraska's Children 2017, https://www.cwla.org/wp-content/uploads/2017/04/NEBRASKA-revised-1-2.pdf

[53] Addendum Two Questions and Answers and Revised Schedule of Events, http://das.nebraska.gov/materiel/purchasing/5995/5995%20Z1%20Addendum%20Two%20Questions%20and%20Answers%20-DAS%202%2011%2019.pdf

[54] Statistical Atlas: *Languages in Kansas*, https://statisticalatlas.com/state/Kansas/Languages

Sarpy[55](See Table CNT-5.D). Saint Francis recognizes the necessity of providing interpretation services to clients who are not proficient in English and the benefits that come with the parent understanding what is going on in court and/or with their Case Plan.

Table CNT-5.D. Ethnicity of Children in NDHHS Care[56] 2018	
	Percent
African American	15.6
Anglo	63.2
Asian	1
American Indian/Alaska Native	5.9
Hispanic	19.7
Native Hawaiian/Other Pacific Islander	1
Unknown/Other	2.2

h. Visitation

Reunification is the major goal for the majority of children who are currently in the child welfare system and this is facilitated through family and child visitation. However, according to the *State of Nebraska Foster Care Review Office Annual Report 2017–2018*, "about 1/3rd of children's parents court-ordered to have visitation were NOT consistently visiting their children"[57]. Among parents who did not regularly visit no particular reason was given by mothers 84.3% of the time and 78.6% of the time by fathers[58].

There many benefits of consistent and frequent visitations between children and their biological parents, including strengthened child and parent relationship(s) due to the creation of stronger attachments, as well as improvements in the child(ren)'s well-being while they are in care (e.g., improved mental health, fewer behavioral problems)[59],[60],[61]. Consistent and frequent visits are also significantly associated the child(ren) being reunified with their parent(s); research has shown that children who visit with their mothers often are 10 times more likely to achieve

[55] Ibid 34
[56] Ibid 27
[57] Ibid 27
[58] Ibid 27
[59] McWey, L. M., & Mullis, A. K. (2004). Improving the lives of children in foster care: The impact of supervised visitation. *Family Relations, 53,* 290–300. http://www.jstor.org/stable/3700347
[60] Sanchirico, A., & Jablonka, K. (2000). Keeping foster children connected to their biological parents: The impact of foster parent training and support. *Child and Adolescent Social Work Journal, 17,* 185–203. https://doi.org/10.1023/A:1007583813448
[61] McWey, L. M., Acock, A., & Porter, B. (2010). The impact of continued contact with biological parents upon the mental health of children in foster care. *Children and Youth Services Review, 32,* 1338–1345. doi: 10.1016/j.childyouth.2010.05.003

reunification than those who do not[62], and that this also decreases the length of time spent in care[63],[64].

Please see CSM-1 to CSM-4 for more details on how Saint Francis plans to address parental engagement. This plan will cultivate creative solutions to develop and reinforce a foster care and community culture that engages biological/non-custodial parents and relatives in the child welfare process. Facilitating relationships between foster and biological parents will help achieve safety, permanency, and well-being of the child. For more information on the materials and strategies we use to train foster parents on the engagement process, please see PLC-2.

i. Transportation

Transportation can often be taken for granted, especially by those who can readily access a vehicle and drive for themselves. However, children in the foster care system are entirely dependent on the services provided by their placement and the service provider. Additionally, family engagement, which is essential for reunification, can be hindered through a lack of transportation services being provided to the parent(s).

Currently, Nebraska's Child and Family Services is experiencing issues with transportation services and was noted as an area needing improvement in the *Nebraska Child and Family Services Review Round 3 Program Improvement Plan.* Additionally, there has been a "lack of efforts to adequately engage and connect families to appropriate services such as… transportation," which has impacted placement stability and timely reunification[65].

During the development of this proposal, we were able to meet with Omaha Bridges out of Poverty, the Douglas County CASA, Christian Heritage and Project Harmony. Both the Douglas County CASA and Christian Heritage shared concerns in regard to the transportation of children, with Douglas County CASA noting that this has caused important meetings for children to be missed or cancelled (please see ENG-1). Additionally, in meetings with Licensed Child Placing Agencies in Nebraska, the majority of the providers also noted an issue with transportation in the Eastern Service Area.

Please see CSM-1 for more information on Saint Francis's transportation system.

---

[62] Davis, I. P., Landsverk, J., Newton, R., & Ganger, W. (1996). Parental visiting and foster care reunification. *Children and Youth Services Review, 18*, 363-382. http://dx.doi.org/10.1016/0190-7409(96)00010-2

[63] Farmer, E. (1996). Family reunification with high risk children: Lessons learned from research. *Children and Youth Services Review, 28,* 403–424. https://doi.org/10.1016/0190-7409(96)00012-6

[64] Hess, P. (2003). *Visiting between children in care and their families: A look at current policy.* http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.507.288&rep=rep1&type=pdf

[65] *Nebraska Child and Family Services Review Round 3 Program Improvement Plan,* http://dhhs.ne.gov/children_family_services/Documents/NE%20PIP%20Re-Submission%205-14-18.pdf

PLC Placement Capacity

PLC-1: Outline a detailed plan that describes how Saint Francis will ensure that a sufficient capacity of trained resource families are available to foster and adopt children in the Eastern Service Area, including developing and implementing specific strategies to recruit resource families for historically difficult to place children.	Comply: X

Response:

a. Assessment of Need

Seeking partnerships with agencies currently providing foster care services in catchment areas to which we are new has been a hallmark of Saint Francis service provision for 22 years. Saint Francis is committed to accessing the best possible foster and adoptive families for children in the Eastern Service Area. To create the strongest network for children and families in need, Saint Francis believes that collaboration with local child placement agencies is integral to understanding the availability of resource families and making those families available to children in the state's custodianship.

Saint Francis's key transition staff and other executive team members met with child welfare stakeholders throughout the service area and learned of strengths and weaknesses within the system along with what they perceived as the hinderances to providing quality care. Stakeholders discussed the issues of capacity with regards to a shortage of foster care homes in the service area, the need for foster care families that are willing to serve children that require greater than basic level care, and to strengthen continuity of care and coordination. The stakeholders also shared concerns about consistency concerning the expectations of CPAs and foster parents.

Saint Francis is currently in the process of securing commitments from possible child placing agency partners throughout the Eastern Service Area (please see ENG-1). Additionally, Saint Francis will monitor and consistently hold providers accountable to the expectations of both the CPAs and foster parents to ensure that all children in foster care are receiving the same quality of service. This will be essential as, according to Saint Francis's CIS/CMS database, 75% of children are currently placed with subcontractors.

For those youth needing a higher level of care, accessing residential services may be necessary. Saint Francis will seek partnerships with the four residential treatment centers (current as of March 2019) in the Eastern Service Area, as well as partnerships with agencies able to meet the needs of traumatized children and those exhibiting serious mental health concerns. It is essential that we access an array of services in a concerted effort to meet the needs of every child to create an effective and comprehensive continuum of care, which is paramount to a child's success. Saint Francis will structure a provision of services in the Eastern Service Area which accounts for the vast needs of children in care.

One of the greatest needs throughout the nation that may impact the Eastern Service Area is the recruitment and retention of foster families, essential components in providing safe, stable,

family-like settings for the children placed in out-of-home care[66]. Foster parents are pivotal in helping children heal while also helping them in the reunification process. Additionally, the foster family can act as a support and role model to biological parents. This ability beneficially impacts the lives of those in care by creating an additional element of security and stability throughout the reunification process and creating greater synergy between the placement and biological families. Protecting, preserving, and building upon the strengths of foster parents is essential to retaining them as foster families, and to accomplish this, we have designed a retention program that emphasizes appreciation, training, and learning opportunities to open channels of communication.

b. Capacity

In addition to recruiting Saint Francis families to license as foster care homes, Saint Francis will work with local CPAs to increase capacity to meet the established 2:1 ratio of two licensed foster home beds for every child in out of home care in the Eastern Service Area. According to Attachment 3 "Service Area Monthly Summary," as of June 2018 the Eastern Service Area has approximately 1,559 children in out of home care. To maintain a ratio of 2:1 as described above, 3,118 licensed foster home beds would have to be available. Maintaining the 2:1 ratio of foster care beds for every child in out of home care in the Eastern Service Area will take time and comprehensive strategic planning; thus, Saint Francis will implement a multifaceted capacity building plan.

First, utilizing our comprehensive recruitment plan, we will partner with other CPAs around a campaign to increase awareness of the need for foster families across the Eastern Service Area. We will also work with all local CPAs to assess and engage current relative and kinship families to become licensed foster families. This will assist in drawing federal funding as well as give providers an opportunity to encourage qualified families to consider expanding their capacity to accept children with whom they do not already have an established relationship into their homes.

Secondly, we will work with the Nebraska Foster and Adoptive Parents Association (NFAPA), one of our key partners, in the effort to increase foster home capacity. Saint Francis has a solid working relationship established with NFAPA in Central and Western Nebraska. NFAPA refers families to our agency and we utilize them as a training resource for both pre-service and on-going training.

Our third approach will be carried out through our provider relations and utilization management staff. We will work with CPAs to assess current foster homes and the utilization of their licensed capacity. By reviewing the Nebraska Caregiver Responsibilities (NCR) tool with families, CPAs can initiate conversations with families to determine their ability to expand their capacity for caring for children. This assessment can be used to discover areas families feel comfortable expanding into or to determine areas in which foster families may be struggling to provide the care needed by various children.

A training and support plan will be developed to assist families in growing their abilities based on the results of the NCR and the family's wishes. The training and support plans prepare families to expand their skillset, allowing them to accept more challenging behaviors, large sibling sets, and to encourage openness to utilizing to the full capacity of licensed beds in their

---

[66] Nolan, K. (2018, July 20). Foster Care. *CQ researcher*, *28*, 609-632. Retrieved from http://library.cqpress.com/

home. This concept of growing and developing existing homes will also increase capacity by building from existing resource families.

Recruiting resource families for children who have historically been more difficult to place is discussed below in PLC-2.

Going forward, Saint Francis will utilize X-Treme Recruitment to locate relative and kinship families to source placement opportunities for children in care and increase the overall number of licensed foster home beds. We will work with kinship families to become licensed, providing necessary supports to assist them in meeting licensing standards.

c. Resource Families

Saint Francis will begin a pilot project in Nebraska's Eastern Service Area to develop Resource Foster Families to provide placements and permanency for children. Our Resource Family Program will deliver high quality foster care and wraparound services through the delivery of foster care services, respite care, biological family support, education, mentoring, and supervised visitation services. Resource parents will provide 24/7 care for children removed from their caregiver.

The Resource Family Program provides resources for engagement and foster parent support that will enable foster parents to establish a mentorship role, help facilitate visitation between the biological parents and child, provide transportation for the child to appointments, school and school activities, and a thus maintain a level of normalcy for the child by preventing disruption of service delivery. This pilot project will embrace the concepts of co-parenting where the resource parent and the biological parent share in as much of the parenting of the child as possible while ensuring safety and well-being of the child.

Typical interactions between foster parents and biological parents range from fairly straightforward arrangements, scheduling, or encouraging children to call their parents regularly to share news and experiences, to situations where both the biological and foster parents agree to attend school meetings, medical appointments, and other activities. Resource Families will support the reunification process by arranging and facilitating consistent and frequent interactions and visits between children and their biological parents as outlined in the Case Plan. Visits and interactions may include biological parents visiting the foster parents' home. These visits allow the foster families to model positive interactions, including disciplinary techniques. As role models and mentors, foster families contribute to successful reunification.

PLC-2: Describe a plan of how Saint Francis will recruit and retain licensed foster parents in the Eastern Service Area who will meet the unique and special needs of children and children's caretakers under this subaward.	Comply: X

Response:

a. Supports and Training

Saint Francis approaches recruitment, retention, and supports for foster families in the same manner that we approach our service delivery practices: from a family-centered, community-

based perspective. Saint Francis's vision and mission, to provide healing and hope to children and families and to transform lives and systems in ways others believe impossible, provides the basis for our interactions with foster families and caregivers, including foster, adoptive, and kinship families. We ensure mission-based interactions through policy and procedure, training, program implementation, quality assurance, and feedback. The core principles of respecting the family, seeking strengths in families and communities as solutions, involving families as partners in service delivery, and connecting families to community supports and services apply throughout all of our recruitment and retention processes.

Saint Francis's retention program philosophy:

- To train and enable experienced and skilled foster parents to improve the quality of care for children.
- To strengthen the family's ability to meet the needs of children exhibiting very difficult behaviors.
- To decrease placement disruptions by recruiting and training foster parents that meet specified needs.
- To increase the positive visibility in communities and promote a stronger, healthier foster care culture.

Ongoing support and training are essential components of Saint Francis's foster parent retention process. According to data collected from our Quality Assurance and Performance Improvement (QA/PI) Departments, with over 813 foster homes throughout Kansas, Nebraska, and Oklahoma, our success in retaining families is evidenced by having a satisfaction rate of 97.4%. Relatives and kin are also encouraged to become licensed, and we will assist them in the process, providing a similar level of support as licensed foster homes.

Support for foster families begins at the time of their initial contact with the agency. It continues throughout all aspects of preparation, training, placement, moves, crisis intervention, support, and day-to-day interactions with families. Preparation, training, and support groups are available at times and locations that take into consideration the needs of participating families. Foster families are part of the team working together to assure safety, permanency, and well-being for children in out-of-home care. A key element in providing support to foster families is assigning a foster care worker to work directly with each family. Providing support, especially during the initial placement period, during crisis and disruptions, and even during successful reunification, is essential to retaining experienced and committed foster families.

Direct and indirect supports are the foundation for successfully retaining quality foster families. Direct contact (face-to-face and phone) is provided in accordance to the expectations based on the level of service determined by the NCR tool. These supports include 24/7 accessibility of dedicated staff, 24/7 crisis support, foster parent support groups, the Families Helping Families mentoring program, respite care, recognition for a job well done, assistance accessing community resources, and the Saint Francis Families website[67]. Saint Francis also connects foster families with additional support by providing information on United Way and 211 and other community based resources. A placement support plan is developed with each foster family for each new placement within seven days of the placement.

[67] Saint Francis Ministries, https://saintfrancisministries.org

In addition to constant and consistent support from Saint Francis staff, the foster families, relatives, kinship caregivers, and providers are encouraged to attend monthly trainings on a variety of topics regarding the care of children who have been abused or neglected, thereby helping foster parents to create connections to other parents while receiving trauma-informed training. These opportunities help equip foster parents to understand the way in which complex trauma may present through a child's behaviors as well as provide them with tools to face these challenges and develop their parenting skills.

Our training opportunities are integral to strengthening the abilities of foster parents and staff alike. Monthly training announcements will be posted on the Saint Francis Families website and will also be sent to DHHS, direct care providers, subcontractors, and community providers to assure that the valuable information offered in these sessions is disseminated as widely as possible for the benefit of the children served. Additionally, course schedules will be posted on the Saint Francis Families website. A list of foster parent training topics offered in 2018 is included below (PLC-2.A).

PLC-2.A. Saint Francis's Foster Parent & Provider Trainings		
A Walk in Their Shoes	Moment to Moment: Teens Growing Up with FASD	Cognitive Behavioral Refresher
Styles of Caregiving	Anger- How to Respond to Angry Outbursts	Documentation, Review of Forms, Policies & Procedures
Family Crisis Center/Support Group	Safety Overview of Infants/Babies	Human Trafficking: Internet Safety
Foster Care 101	Court Training	Typical Development and Our Triggers
Bullying	Working with Birth Parents	Trauma as a Sensory Experience
Supporting Children- Sexual Abuse	Coping Skills	Summer Resources
First Aid and CPR	Practicing Self-Care So You Are 100%	Sneaky Children
Caring for Children with Special Needs	Adolescent Behavioral Health and Development	Developmental Milestones
Foster Children & Pets	Human Trafficking	Connecting with Others
Addiction, Attachment and ACEs	Partnering with Birth Parents	Allegation Prevention
Trauma and Our Children	Self-Care with Massage and Essential Oils	Discipline Strategies & Supports
Depression in Children	Bereavement and Foster Children	Creating Healthy Freezer Meals
Sexting, Aggression, and Bullying in Young Children	Holiday Safety Tips	Lying and Stealing
Bugs & Such	Understanding the Adoption Process	Safe Sleep for Infants
Behind Closed Doors (Court Testimony)	Shared Parenting- Be a Part of The Village	Unconditional Parenting: Moving from Rewards and Punishment to Love and Reason

PLC-2.A. Saint Francis's Foster Parent & Provider Trainings		
Attachment Repair Tips & Techniques	Sexually Inappropriate Behavior	Partnering for Success- Connecting with Birth Parents
Stop, Reflect, Connect	Partnering with Birth Parents: Don't Count Us Out- Our Story is Not Over	Exploited & Missing Child Unit Questions & Answers
Lifebook Training	Shared Parenting/Icebreakers	Substance Abuse in Adolescents and Child Management
Making Children Comfortable in the Home	The Cost of Caring	Fetal Alcohol Syndrome Diagnosis
Trust-based Relational Intervention Training (TBRI)		

Saint Francis's foster care homes philosophy and practices emphasize the expectation that foster parents will serve as mentors for biological parents. We reinforce this concept in every phase of interaction with the foster family, from initial engagement with potential foster parents through pre-service training, through trainings offered by means of the foster parent handbook, and through regularly scheduled foster parent meetings. Potential foster families are taught to see themselves as part of a team whose function is to work for the best interest of the child and family, as opposed to seeing themselves as a protector whose purpose is to keep the child safe from the biological family.

Foster parents receive training to develop skills that support interactions between themselves and biological parents, from the initial Icebreaker contact to helpful ways of navigating a working relationship with a biological parent. The Icebreaker contact is an opportunity to create initial rapport between families and the expectation is that this contact will occur within 24 hours of placement. Foster parents are trained in the importance of this initial contact and are supported through the process by Saint Francis staff. We encourage the use of a script for the Icebreaker conversation as a way of facilitating the communication of critical information.

Potential foster and adoptive families complete TIPS-MAPP (pre-licensure training) prior to accepting children into their homes. An exception to this would be instances of kinship placements where a prior relationship has been established. Pre-license training for kinship is completed as part of the requirement to become fully licensed and can be completed after placement of the child has occurred. Relative families may take the pre-service training but are not required to do so. However, they are encouraged to attend any of the trainings provided by Saint Francis and will be notified of our monthly trainings.

If relatives choose to become licensed, they are not required to complete the pre-service training; however, if kinship families choose to become licensed, they are required to complete pre-service training. Both relative and kinship homes will be encouraged to become licensed. Trainings will be scheduled at times that are convenient to families with children, with evening and weekend hours available. It is vital that our trainings be offered at times and in manners which are designed for the intended audience. Sessions will be scheduled within or near the communities to limit obstructions to attendance.

Additionally, all relative, kinship, and foster parents must complete the Reasonable and Prudent Parent Standard and Human/Sex Trafficking training prior to placement.

As a provider of foster home services, Saint Francis will work cooperatively with the network to offer multiple training sessions throughout the Eastern Service Area. Saint Francis foster care families trained as co-leaders in TIPS-MAPP will lead pre-service classes and serve as mentors for potential foster families through the training and licensing process. TIPS-MAPP trainers will reinforce the existing structure of any pre-service training in local communities by increasing the number of trainers available to work with different CPAs to train families pursuing licensure. By contributing to the pre-training infrastructure, we will be able to effectively manage and train recruited foster care families.

Saint Francis's Information Technology team is currently developing a secure, state-of-the-art electronic data management system for our services that will launch mid-2019. We currently utilize a cloud-based, secure electronic data management system for our Child Management and Child Information Systems (CIS/CMS), which is a three-pronged system including a component for child placement to monitor utilization of services and placements. Reports are used to assess trends that may indicate a change in the demand for services or a shift in population, which is then communicated to recruitment teams for strategizing recruitment and retention plans. For example: our system allows us to track how many miles from their home a child is placed. Therefore, if children were being placed outside their home community, it would trigger a review of the number of children in out-of-home placement compared to the number of local placements available as a first measure of assessment of causes for this trend. It allows us to look at other trend reports also, such as rate of siblings being placed together and other outcomes.

The placement system uses algorithms to measure a child's needs against a provider's ability to meet them to deduce the best possible outcomes for that child. A child's minimum match criteria can be set by case workers so that a child is not placed with a family unable to care for their particular behavioral or physical needs. This system is utilized to gather information regarding potential families as well, such as documenting the inquiry source (which is then utilized to analyze the effectiveness of recruitment strategies) and tracking potential families through the foster care process (allowing for the identification of barriers or points that families drop out of the process and the time required for the family to complete the process). This data is then analyzed to problem-solve barriers and enhance efficiencies for assisting and supporting potential families through the licensing process.

Using placement management system algorithms accounts for a child's specifically identified safety and behavioral needs, a foster family's capacity to meet those needs, and the best possible match between the child and the bank of families available. This will help to: 1) reduce the number of moves a child experiences while in out-of-home care by placing them with a family most capable of meeting their needs from the outset, and thereby lessening disruptions from placement; and 2) assure that a child with specialized needs, which are entered into the child's profile in the system, is not placed with a family who is unable to meet their minimum match criteria. This has the potential to improve the child's experience, as well as the foster, relative, or kinship family's experience as a part of the child welfare network in Nebraska.

b. Recruitment

Saint Francis will develop a comprehensive recruitment plan utilizing child data (i.e. demographic information, sibling sets, reason for removal, and other parameters) as well as nationally recognized best practices to create a two-tiered approach to increase the number of potential foster and adoptive families. Saint Francis will collaborate with other CPAs to employ a region-wide campaign to increase awareness of Nebraska children in out-of-home care to augment the capacity of foster and adoptive families. We will specifically target recruitment of families willing and able to care for sibling groups, older youth, children and youth with high mental/emotional/behavioral challenges, and families able to maintain a child's cultural and ethnic connections. This campaign will function in tandem with a community-based outreach that personalizes the needs of children at the local level within the Eastern Service Area to promote on-going engagement with potential foster families, adoptive families, community leaders, and stakeholders. Our recruitment plan is designed to inspire potential foster and adoptive families to make the initial call to inquire about foster care and adoption.

The Saint Francis Recruitment department will work with our Marketing and Communications department to efficiently utilize diverse forms of media and person-to-person interaction with the public to widely disseminate the needs of the Eastern Service Area children and inspire the decision to become foster families. Our Marketing and Communications staff will work with transition team members and recruitment staff to identify and implement targeted marketing strategies, including the use of paid media outlets.

The use of media for recruitment is based on the geographic needs of foster families and the demographics of children and families. Media recruitment is timed to coincide with public meetings, classes, or local expos and events. Saint Francis has experienced positive responses from potential foster families through paid sponsorships on Christian and public radio stations and through print advertisements. Additionally, we use social media to provide interested parties with rapid access to information regarding fostering and adoption. We actively post successes and opportunities on our Twitter and Facebook accounts to maintain a media presence and generate community awareness online.

Our Marketing Department will create a regional public relations presence to further promote recruitment, with frequent news releases to media outlets highlighting recruitment needs. News releases focusing on children's issues, foster parent recognition, training opportunities, and informational meetings are regularly distributed. Special human-interest stories focused on foster families and in-depth stories in publications and social media provide additional avenues for informing the public. Saint Francis's public relations work is carried out at the local, regional, and state levels by staff interviews with media, through educational presentations to service clubs, churches, and school groups, as well as through establishing a presence on the editorial pages of local newspapers. We also explore state, county, and city proclamations highlighting foster care and adoption.

Saint Francis focuses on directly communicating the needs of children within the specific communities we serve to potential foster/adoptive families, community leaders, and stakeholders. By keeping in constant contact with interested parties within the region, including through established community-based avenues such as Kiwanis and Rotary Clubs, the Chamber of Commerce, schools, churches and other secular and faith-based organizations, Saint Francis promotes an on-going dialogue regarding the needs of children in care. We utilize data to target the specific needs of each community by comparing the number of children in out of home care

from the community/county to the number of children placed in their home community or county. In addition, many of our staff are heavily involved in the communities in which they serve, are actively involved in civic groups and churches, and willingly represent the needs of children in conservatorship.

Saint Francis employs trained recruiters to proactively locate potential foster families. Our community-based intake process provides a streamlined, organization-wide procedure for recruitment. Staff in direct contact with potential foster families receive in-depth recruitment training to provide the best experience possible to those interested in fostering or adopting. We maintain on-going positive engagement with families throughout this process and encourage open communication and feedback to facilitate strong relationships.

Initial contact regarding a family's interest in foster care is made through various avenues, including through the Saint Francis recruitment toll-free number, the Saint Francis website, and other venues. General demographic and contact information are obtained from the potential resource family, and a recruiter is assigned to serve as the family's main point of contact and provide timely follow-up to the inquiry. The assigned recruiter engages the interested family in conversation about their interests and motivation and explains existing capacity needs in their community. Based on the family's level of interest after the initial contact, each family is placed on a recruitment track. When a family decides to pursue licensure, they are assigned a "Champion of the Family" who will help them through the succession of licensing steps and keep the family engaged throughout the training process, learning the details of becoming licensed, and finally to welcoming a child into their home. Details on the status and accountability of recruitment activities are documented and used by supervisors to ensure and encourage effective recruitment.

Through our Fostering in Faith program, Saint Francis reaches out to the faith-based community to communicate the needs of our older youth without identified resources. This information is distributed (with the youth's permission) to a wide network of churches throughout the area being served. Congregations put our children's stories in their bulletins and flyers, and members actively pray for their permanency and well-being. This outreach can lead to lifelong connections for youth and their families and inspire a church members to become a foster or adoptive parent through ongoing information about the need for caregivers. We can share information on our successes with this venue with other CPAs. We also encourage our recruiters to utilize their own connections and relationships with churches to enhance this outreach effort, and to promote this among other staff and our current foster families. Saint Francis believes that strong recruitment lies in relationships, evidenced in our Power of You initiative, that encourages current foster families to refer potential foster families. Research supports the idea that our current foster parents are our best recruiters. In the same way, Saint Francis helps to facilitate and encourage mentoring relationships between current foster care families and potential foster families.

Saint Francis places emphasis on the importance of retaining recruited foster care families. As with any other system, keeping good partners is the most valuable resource to sustaining development and growth. Retention activities include, but are not limited to, creating and helping to connect foster care families to support systems and mentors, foster/kinship family appreciation events, and soliciting their feedback as a valued partner of Saint Francis. These strategies have been very successful in the urban and rural counties of Kansas's Wichita region where we have served just under 9,500 children since July 1, 2013.

Saint Francis is committed to recruiting new foster and adoptive families in the Eastern Service Area through our activities; we do not recruit existing homes licensed by other child placing agencies. In an effort to promote a continuum of services throughout the Eastern Service Area, Saint Francis will promote congenial affiliate relationships with other providers and work cooperatively with the network to meet the goals of proximity, special needs, and sibling placement by sharing resources in the best interests of the children.

Strength-based localized recruitment will be enhanced by Saint Francis staff living and serving in the Eastern Service Area. By making use of staff with strong community-based ties in recruitment and the belief that recruitment is a community effort, Saint Francis will develop and solidify relationships in these communities to successfully recruit more foster care homes.

PLC-3: Describe a plan of how Saint Francis will support relative and kinship homes in the Eastern Service Area.	Comply: X

Response:

Saint Francis's philosophy and approach to permanency for children is that their family of origin is the best primary source for permanency. Families are vital to the health and wholeness of children and can act as a child's greatest source of support and advocacy. Relatives and kin can help the child maintain connections with their culture, schools, churches, friends, and community, which contributes to the child's perception of stability and sense of self.

The definition of kinship includes relatives or others who have a significant relationship with the child or the child's family, such as a godparent, teacher, coach, or family friend, and provide residential care for a child. A relative includes a person who can trace a blood tie to a child. Persons related by blood may include a parent, grandparent, sibling, great-grandparent, uncle or aunt, nephew or niece, great-great-grandparent, great uncle or aunt, first cousin, great-great-great grandparent, great-great uncle or aunt, or a first cousin once removed (the child of a first cousin). Termination of parental rights does not alter or eliminate the blood relationship to other relatives. A relative may also be a person who is or was related to the child through marriage or previous marriage (terminated by death or divorce) and includes, but is not limited to, step-parents, step-grandparents, and step-aunts or step-uncles to the first degree, even though the marriage may have ended in divorce.

Saint Francis recognizes that allowing children to maintain existing connections improves permanency outcomes and decreases the amount of trauma experienced by the child in being removed to out of home care. When children are placed with relative or kin caregivers, they are more likely to be placed with/stay connected with siblings, experience fewer placement moves due to the commitment of the family, exhibit fewer behavioral problems, and report a more positive opinion of their placement and caregiver. Because of this, our placement, kinship and case management staff actively explore placements with relatives and kin before moving to a foster parent in the same community and then moving outward.

Kinship searches promote timely permanency regardless of the family's permanency goal, as the identification and inclusion of relatives in family case planning provides a social support network for the family during the reunification process or can provide potential stable placement options for the child when reunification is not a viable option.

Nebraska has excellent outcomes for placement with relatives and kin which speaks highly of the commitment of DHHS staff to search for relative and kin prior to referral of children to out-of-home care. Saint Francis will support initial and planned relative and kinship placements by collaborating with DHHS to initiate extensive relative and kin searches at the time of referral, and to make ongoing inquiries throughout the life of the case. This includes engaging family members, including the child, at the protective custody hearing, the time of referral, Family Team Meeting (FTM), case plan meetings, and other meetings with the family, as well as completing genograms, maternal/paternal kinship forms, and other assessments.

Our Kinship Team employs X-Treme Recruiters (XTRs), whose sole responsibility is to locate and engage family connections. XTRs begin a search for extended family when a child is not placed with relatives or kin at the time of referral. The search will be completed by the XTR or referred to Family Finding Services when appropriate. Once potential families are located, XTRs contact families and inquire about their willingness to be a placement or support to the child. XTRs assure that background checks, walkthroughs, and other safety assessment are completed before placement can occur. The XTR remains the point of contact for the potential placement family until a kinship worker is assigned.

When a relative option is identified for placement, staff immediately begin the kinship assessment process. If DHHS is the primary case manager and walkthroughs, background checks and relative placement packets are completed, our kinship team will begin the kinship home study. When Saint Francis staff identify potential kinship families, our kinship team will initiate requests for background checks, complete walkthroughs of the home, and begin the Kinship home study process. On the same day/night of referral, a staff member conducts a health and safety walk-through check of the home and completes a preliminary assessment of the family's ability to provide for the needs of the child. Relative placements must meet the safety and background requirements to provide placement for children in out of home care. A thorough kinship home study will be completed within 30 days of placement, according to DHHS standards and format.

Relative caregivers are not required to complete preservice training or become licensed as foster parents but will be encouraged to do so. Nonrelated kin are required to complete TIPPS-MAPP and become licensed foster parents. Additional classes/trainings are available to all relative and kin caregivers. Educational topics may include, but are not limited to, stress management, self-esteem, substance abuse, discipline, identifying and accessing community resources, and information about the child welfare system. For a list of classes please see PLC-2.A above.

Kinship workers are assigned to relative families just as foster care workers are assigned to kinship families during and after the licensing process. Kinship workers assigned at the time of the placement conduct Worker/Caregiver visits, assessing the family in their home at least once a month (or more often, as needed). These face-to-face visits are in addition to the regular Worker/Child visits completed by a member of the case management team. Other contacts between the kinship team and the relative family include phone and email communications.

The kinship team works to assure the safety of the child, educate and assist the relative family in understanding the child welfare system, educate them on the importance of legal permanency for children, and provide the supports necessary to meet the needs of the child in placement. This includes providing supports for children, relative caregivers and families, connecting caregivers to local resources to meet the child's and family's needs, explaining and verifying eligibility of

financial resources or permanency care assistance that may be available to the caregiver while the child is in the home, and ensuring daycare services for eligible kinship families. Furthermore, the kinship team will assist kinship caregivers seeking licensure as a foster parent.

Relative and kinship caregivers are asked if they will consider being the permanent placement family for the child during the reunification process or other permanency plan. Case management teams continue to engage the relative placement family in conversation concerning the child's permanency plan throughout the life of the case.

ENG Community Engagement

ENG- 1: Draft Community Engagement Plan describing how Saint Francis will engage community partners who connect children and families to available programs and resources, including food pantries and other non-governmental resources.	Comply: X

Response:

Saint Francis is committed to effective Community Engagement in the communities we serve. In our 74 years of work in various mid-western states and regions, we have developed and refined our community engagement process to connect services, people, and institutions to implement successful child welfare strategies.

We believe the following key principles are integral to establishing a community-based model that connects children and families to local resources and supports. We will adhere to these principles as we partner with DHHS to develop a continuum of services for children in families in Douglas and Sarpy Counties (Eastern Service Area).

- *Collective Impact* – Saint Francis believes that the development of effective interventions for children and families requires a strong network of connected providers across multiple disciplines working together from multiple perspectives. Saint Francis values the unique input of consumers, practitioners, providers, and subject matter experts as we work in partnership to strengthen services for children and families.
- *Design Thinking* – Saint Francis believes that the manner in which services are designed and implemented matters to children, families, and fellow providers. Saint Francis values local input about how well our systems are working for our consumers and partners, and strives to be responsive to increase effectiveness, efficiency, and stakeholder satisfaction.
- *Hospitality* – As a mission centered, Episcopal-affiliated organization, Saint Francis strives to treat partners and community members warmly and with regard for the value of each individual person. We seek to create and convey hospitality to all community members who participate in our engagement activities.
- *Innovation* – Saint Francis strives to constantly improve our service processes, approaches, and outcomes. Saint Francis knows that effective innovation is much more likely when we take the time to listen carefully and routinely to consumers and partners.

- *Inclusiveness and accessibility* – The voices of the most vulnerable consumers and marginalized communities are critical for meaningful community engagement and for effecting the lasting change that stops the cycle of abuse. We strive to ensure that engagement efforts are accessible. (i.e., Using accessible locations, coordinating transportation, providing child care for designated focus groups or forums, and providing printed materials in multiple languages.)
- *Respect* – Saint Francis strives to treat every person with whom we interact in a respectful manner. Respect can be demonstrated through effective listening, appropriate responsiveness to concerns or ideas, and by recognizing that every person's time and perspective are valuable. We demonstrate respect by offering opportunities for input and involvement while not oversaturating consumers and partners with questions, surveys, or meetings.
- *Transparency* – Saint Francis seeks to build trust with local communities and partners by sharing information in a timely and open manner in order to gather needed feedback and input from community partners and consumers.

Saint Francis has developed relationships with many local stakeholders in Nebraska through our work in Intensive Family Preservation, Intensive Family Reunification, Family Support and Visitation, and Agency Supported Foster Care. We will continue to build upon existing relationships as well as establish new community partnerships with local stakeholders that will provide services for children and families in the Eastern Servicc Arca. Saint Francis will use three main strategies (inform, consult, involve) to develop a preliminary engagement plan for this area.

1) *Inform*: Upon the announcement of the award and along each step of the transition process, Saint Francis will conduct outreach in the Eastern Service Area's distinct communities to provide information about our organization and to educate partners and communities about our role as the Full Service Case Management for Child Welfare Services provider, our timeline for commencing services, and the activities to take place during this process
2) *Consult*: Upon the announcement of the award, Saint Francis will host consultative groups to share information, request input regarding the role and processes of our position, and we will gather recommendations for effective community engagement strategies and activities.
3) *Involve*: Throughout the preliminary period, Saint Francis will involve community stakeholders formally and informally as we build processes and protocols that connect Nebraskan children and families to services and resources. The goal of the Preliminary Community Engagement Plan will be to identify effective, long-term strategies for ongoing involvement of consumers and stakeholders to be employed throughout the contract period.

During the preliminary period (after the award and before the start date for contractual services) Saint Francis will conduct primary engagement activities geared toward our core strategies of informing the community of who we are and what to expect, consulting with the community on the implementation of our roles and responsibilities, and involving the community in developing a final Community Engagement Plan. The purpose of a preliminary community engagement is to

begin establishing a process in which to engage the community as well as to identify the most appropriate services for the catchment area.

The purpose of a Preliminary Community Engagement Plan is to:

- Establish a process for creating a long-term final community engagement plan
- Ensure the process is measurable and actionable for implementation
- Ensure needed resources are allocated for initial and long-term community engagement process
- Ensure the final community engagement plan is developed in an informed and transparent manner within each major population hub.

The community engagement plan will center on the three strategies mentioned above (inform, consult, and involve). In previous and ongoing community engagement efforts, Saint Francis has used the following activities and we anticipate that these activities will be included in our Eastern Service Area engagement plan (see table ENG-1.A):

Table ENG-1.A Informing Activities:	Consulting activities
Traditional and social media	Community conversations
In-house publications and communications	Surveys / questionnaires
Website	Focus groups
Community presentations	Online comment
Involving Activities:	
Eastern Service Area Adoptive and Foster Advisory Committee	Program liaison activities
Working groups	Community partnership projects

Saint Francis staff will contact and communicate with stakeholders with whom we have already formed a relationship. Additionally, we contacted many of those who were involved with the previous Full Service Case Management provider's work during development of our proposal response. We will seek and involve new agencies with a vested interest in the development of our community engagement plan. While initial contact will be made by individual and group visits, phone calls, and emails, Saint Francis will set up in-person stakeholder meetings in each defined population hub within the first 60 days of being awarded the contract. We have allocated resources, such as employing skilled staff and marketing and media tools, to organize engagement plans activities (see table ENG-1.B).

Table ENG-1.B Resources for Preliminary Community Engagement Plan	
Interim Community Engagement Facilitator(s) in Eastern Service Region (subcontract)	
Long-term Community Engagement Specialist in Eastern Service Region (employee)	
Marketing and communication materials	
Print media purchases	
Physical space for stakeholder meeting	
Stakeholders	
Children and youth in foster care, foster care alumni	Families of children in foster care, including non-custodial parents
Relative or kinship caregivers	Court-appointed special advocates
Alumni families who have received DHHS services in the past	CPS local staff
Members of the judiciary	Law Enforcement

Table ENG-1.B Resources for Preliminary Community Engagement Plan	
Representative(s) of the Regional Disproportionality Advisory Committee	Attorneys representing parents, children, and DHHS
Juvenile Justice Agencies	Child Welfare Boards
Local School Districts and Universities	Foster Parents
Residential Child Care Providers	Purchased Service Providers
Local Community Service Providers	Transitional Living Centers where available
Nebraska Workforce Agencies	Faith-based organizations
Health Providers	Tribal Representatives and Community
DHHS	Managed Care Organizations
Non-traditional local community resources and leaders, and other county and/or community stakeholders	Nebraska Foster and Adoptive Parent Association (NFAPA)

Saint Francis currently has two (2) Nebraska offices located in Grand Island and North Platte, and we have established relationships with many stakeholders throughout the state. We are also utilizing our engagement teams to engage other community members and resources in anticipation of the requirements to be met in this proposal.

Saint Francis values the information received from stakeholders, and we believe that this feedback strengthens service delivery and understanding between parties. Contributions from stakeholder meetings will be used to inform program improvements in addition to case management policies and procedures. Reports may be distributed highlighting the results from stakeholder meetings and outlining specific objectives and goals that may improve service delivery and overall customer satisfaction.

After stakeholder meetings have been held, a follow-up newsletter will be mailed to participating agencies, families, organizational partners, and other interested parties informing them of the results of the meeting and policy and procedure changes occurring as a result of the feedback received from families. We share information gathered from stakeholder meetings directly with supervisors and team members in our organization during training modules on identified policy and procedure changes, and will share them with DHHS, as well.

a. Families and children

Information is collected from families through client satisfaction surveys. The information from the survey is reviewed by the appropriate program director and shared with staff members as an ongoing barometer of their service delivery and the impact their programs are having on clients. The information is used in the performance improvement process to implement systems that improve projects.

Saint Francis also uses Focus Groups and Community Round Tables to solicit feedback from Families and Children involved in the foster care system. From time to time, Saint Francis may ask families and young people receiving services to participate in a round table discussion or focus group. Participation is strictly volunteer-based, and responses and the sources of the responses are confidential. The feedback is used to make services customer friendly, easily accessible, and remove barriers that may be preventing a family from accessing much needed resources.

In the development of this proposal, we have reached out to following stakeholders:

- Omaha Bridges Out of Poverty

- Douglas County CASA
- Christian Heritage
- Project Harmony (Child Advocacy Center)
- Children's Square
- Apex Foster Care
- Boys Town
- Paradigm
- Nebraska Children's Home Society

As part of our draft preliminary community engagement plan for children and families, our future outreach efforts will include, but will not be limited to, the following:

- Project Everlast
- Shelters
- Food Banks
- Heartland Family Services
- Community Alliance
- Capstone Behavioral Health
- Nebraska Family Support Network
- Douglas County CMHC

During the development of this proposal, we were able to meet with Omaha Bridges out of Poverty, Douglas County CASA, Christian Heritage, Project Harmony, Children's Square, Apex Foster Care, Boys Town, Paradigm, and Nebraska Children's Home Society. We were impressed with these organizations and all showed a willingness to work with Saint Francis if awarded the contract. Douglas County CASA was critical of the current provider and concerns shared were in regard to the transportation of children and the missing or cancellation of important meetings for children. They also felt that the current provider does not provide services but uses subcontractors, so there is a lack of accountability and control over some of the subcontracting providers. CASA also noted a problem with court performance of the current case workers. Omaha Bridges Out of Poverty was positive about their role in the current system. They were complementary of the providers around the Omaha area and felt they are an important part of the continuum of services to help families work through poverty and get back on their feet.

Christian Heritage is a faith based organization who shares some similarities with our organization. They are comfortable with the current system but would also work well with Saint Francis. Their recruitment and training of foster parents is first class and they have chosen to focus on programs, such as Fatherhood Initiatives, that keep families united. Christian Heritage noted that it is important to build trust with the local providers. They noted many problems with transportation as well, and they felt there is a gap in services particularly in finding a good Therapist for children. They also felt that staff training and staff turnover was a problem. Lastly, we were able to meet with Project Harmony, the Child Advocacy Center for the Eastern Service Area. They are a key stakeholder for the area and offer many services, including a triage center for children being placed in out of home care, a school-based program called Connections, a missing youth initiative where missing children are brought in for medical exams, provided food and clean clothing, and complete forensic interviews when identified as victims of abuse.

b. Attorneys, guardian ad litem, and other legal stakeholders

The Saint Francis Legal Department trains staff to have a thorough knowledge of local court systems, to submit reports as required, to attend court hearings, and to be prepared to testify in court. Working with the courts on behalf of children and families is essential to the accomplishment of Saint Francis's mission. On a daily basis, Saint Francis works in 19 of the 31 judicial districts in Kansas and works with approximately 95 different judges and county/district attorneys serving the Kansas court system. In addition, Saint Francis works with other judges who may hear termination cases and appeals. The judicial system is a key community resource in providing for the safety, permanency, and well-being of children in out-of-home placement.

In Nebraska, two (2) attorneys will be hired to work in the Eastern Service Area. They will meet frequently with judges, county/district attorneys, guardian ad litem, other attorneys, CASA, Citizen Review Boards, and DHHS. Saint Francis Staff Attorneys gather outcome data and work with local Saint Francis supervisors and directors to present information about Adoption and Safe Families Act (ASFA) timelines and the importance of timely permanency. Saint Francis will initiate contact with judges and county/district attorneys located in the Eastern Service Area upon notification of the Contract award to begin the process of learning their expectations and prepare appropriate training for Saint Francis staff.

Judges play a definitive role in determining if abuse or neglect of a child has actually occurred. They approve permanency plans and monitor both recommendations and court orders to ensure that "reasonable efforts" have been made in compliance with federal and state laws, such as ASFA. Ultimately, the judicial system determines whether a child who has been removed from their birth family can return, or whether it is in the best interest of the child that parental rights be terminated. Given the magnitude and potential impact of these decisions, it is incumbent on organizations such as Saint Francis to work in concert with the courts to ensure the most positive outcomes possible for children.

The Saint Francis Legal Department has worked over the past two (2) years to develop Legal 101 (beginner), Legal 102 (intermediate), and Legal 103 (advanced) trainings for staff. **In addition, Saint Francis cooperated extensively with University of Kansas School of Social Welfare to develop video-based training for court improvement. This collaboration resulted in the training being employed across Kansas to educate contractors, DCF, court staff, other providers involved in the child welfare system, and the public about Child In Need of Care (CINC) proceedings in general, as well as an in-depth comprehensive training series for contractor staff that is used for orientation of new staff and as a refresher for experienced staff.**

As part of our ongoing effort to provide quality services and customer satisfaction, Saint Francis conducts an annual survey of judges. The survey provides valuable feedback regarding performance, which shapes policy, training, and service delivery, specifically improving court performance. The surveys, presented to every judge who hears CINC cases, are brief and focused and, for convenience, are sent with a pre-stamped return envelope.

Historically, Saint Francis has received over a 50% response rate. Judges have typically given Saint Francis a rating of good to excellent in the areas targeted. Many of the judges commented on the high quality and competence of Saint Francis social workers, underscoring the importance of focusing training and coaching on developing well-trained and qualified social workers, who become the lynchpin for successful work with the courts.

The survey has allowed Saint Francis to target specific districts for performance improvement. The survey sets the stage for future collaboration with, and feedback from, the court system with the goal of improving outcomes for children and their families. Saint Francis will conduct similar surveys of Eastern Service Area judges if the Contract is awarded to Saint Francis. Other key partnerships involve working with CASA through cross-training employees and volunteer staff so that all are better informed about roles and responsibilities.

In the development of this proposal, our community engagement teams reached out to Douglas County CASA. After the contract is awarded, legal teams will begin to connect with the following stakeholders:

- Douglas and Sarpy County Attorneys' Offices
- Douglas and Sarpy County Judges
- DHHS Attorneys
- Juvenile Justice Staff (such as Crossover Youth)
- Sarpy County CASA

Saint Francis will meet with additional legal stakeholders as needed to provide quality services to children and families in the Eastern Service Area. In doing so, we will build an expert knowledge regarding local court systems and legal resources.

c. Law Enforcement (including juvenile justice agencies)

Saint Francis understands the importance of an effective working relationship with Law Enforcement. We keep an open dialogue and meet regularly with the local police force in the communities we serve. Our Kansas model employs work with law enforcement to identify and assess probable victims of human trafficking. Our developed expertise in identifying human trafficking has led to Saint Francis staff training many of the police forces around the state to recognize signs of sex trafficking.

Saint Francis also works closely with law enforcement when young people in foster care run away. We understand the danger young people face when they run away, and we work closely with law enforcement to find them and get them to safety. The Care Center emergency on-call number is available to all law enforcement agencies for use in locating police protective custody placements after hours and on weekends.

As part of our draft Preliminary Community Engagement Plan, Saint Francis staff will reach out to, among others, the following:

- The Omaha Police Department
- Douglas County Sheriff
- Sarpy County Sheriff's Office
- Bellevue Police Department

At Contract Award, Saint Francis will begin reaching out to local law enforcement to discuss and enact plans and strategies for children in our care and in the local community who may be vulnerable to human trafficking, homelessness, and other risks. In doing so, we will help enhance and create a law enforcement community that understands these social issues in the effort to develop real solutions and strategies to counteract the risks faced by vulnerable children in the Eastern Service Area.

d. Local School districts

Schools perform a very important role in the success of a child in foster care. Children placed in out of home care often experience a lack in academic progress as evidenced in the number of missing hours or credits needed for age-appropriate grade placement or graduation. Saint Francis works to keep children from slipping through the cracks academically by assuring that children with learning disabilities receive an Education Coordinator to advocate for them in their school. Our Education Coordinators work with reunification case management teams to advocate for children and ensure they get the services they need to be successful. This may include, but is not limited to, helping a child get an Individualized Education Program (IEP) that will allow them to have the services and support they need to be successful within the classroom. The Education Coordinator works closely with the child's school to build a collaborative relationship. This relationship pays dividends when we are trying to get children back in school if they have a new placement.

Saint Francis's communication strategy with schools requires a multi-lateral engagement process; both Saint Francis and the school communicate in a way that generates feedback to ensure children in our care receive the educational supports they need. We ask them to report any issues a child has in school or in meetings (such as IEP or disciplinary meetings) to our case management team. We let them know immediately if a child has been placed in their district and we would like to enroll the child as soon as possible. The child's case manager immediately informs the school if a child is moved and will no longer be in their school because of placement changes, and the case management will also inform the school that the child is being transferred to in order to make sure school officials are receiving the child's credit and school records. This helps alleviate the frustration schools feel when trying to locate absent students, as well as enhances the school's ability to anticipate the needs of the student.

School personnel are included in the community panel and have an important voice in working to improve the foster care system. At contract award, Saint Francis staff, such as Education Coordinators, will begin working with school and academic stakeholders in the area. These future outreach efforts include, but are not limited to, the following:

- Eastern Service Area Public Schools
    - Elementary
    - Secondary
    - Post-Secondary
    - Nebraska Children – Back on Track
    - Central Plains – Education and Training Voucher.

More information on our plan to provide education resources to youth receiving Independent Living Services is provided below.

e. Faith Based Organizations

Saint Francis has established relationships with many faith-based organizations and stakeholders in Nebraska through our current work in providing Family Preservation, Intensive Family Reunification, and Family Centered Treatment services in the region. We will continue to seek and engage these resources as we develop our service model in the Eastern Service Area. In future community engagement efforts, we will reach out to other faith based organization such as:

- Catholic Charities
- The Interdenominational Ministerial Alliance
- Habitat for Humanity
- Episcopal Church and Charities
- Churches and religious institutions of all denominations.

Additionally, we employ Community Relationship Specialists who engage organizations and communicate the needs of our children and families, be it commodities and goods such as housing, furniture, groceries, transportation, or other needs. Our Associate Director of Development oversees Saint Francis's CarePortal, an initiative of the Global Orphan Project, to connect churches to local agencies whose families are in need. In Nebraska we have met with Christian Heritage who manages the CarePortal. Christian Heritage is active with many churches in Omaha area and they invited Saint Francis to be involved in training on how we can use the CarePortal in Nebraska if awarded the Eastern Service Area.

Fostering in Faith is another program utilized to educate local stakeholders of the community's child welfare needs as well as promote community involvement in implementing services to meet these needs. Saint Francis's Fostering in Faith Program engages local faith-based community stakeholders to actively participate in developing and providing community-based resources for Nebraskan children and families, with an emphasis on meeting the needs of older youth who are seeking permanency and other independent living resources.

Churches and other religious communities in the network offer support through hosting and supporting community events that educate the public of the need to build strong permanency options for local youth. Participants may also promote outreach activities to increase placement capacity or awareness in their communities. They may distribute the profiles of older youth needing a permanent resource (with the youth's permission) to a wide network of churches throughout the nation. Congregations may feature children's stories in bulletins and flyers, actively praying for the permanency, safety, and well-being of foster children, as well as host pre-service trainings, appreciation activities, and the provision of respite days, meals, hard goods, occasional childcare, and even compassionate ears.

Furthermore, these faith-based community outreach activities lead to lifelong connections for children and families and may inspire church members to become a foster or an adoptive parent. Fostering in Faith resources are often utilized to connect youth transitioning out of foster care to social supports that provide and develop mentorships and other positive adult and peer relationships. Saint Francis readily shares information on our successes with this venue with other CPAs to create a community that actively promotes positive placement options for Nebraska's youth.

f. Foster Parents

Saint Francis believes that highly trained foster parents are one of the key components of a quality child welfare system. To help achieve goals of maintaining highly trained foster parents, Saint Francis holds regular Foster Parent training sessions and invites all foster parents to attend, regardless of their sponsoring agency.

Saint Francis also involves foster parents in Community Panels and round table discussions to get feedback on ways to improve and on our performance. One such example is the most recent Saint Francis Joint Commission survey where a foster parent feedback group was conducted by

one of the surveyors. Foster parents provided feedback that their greatest joy was their work to collaborate with their foster children's originating family, to facilitate their reunification, and be a support in place after the children returned home. One family stated their first comment to the child's parents is "We are not here to take your children from you, we are here to get them back home to you." This statement resonated with staff and both biological and foster parents. It has since been utilized for training foster parents.

In the development of this proposal, Saint Francis staff have contacted many organizations that help facilitate the growth of trained quality foster care families. These organization include, but are not limited to, the following:

- Nebraska Foster Parent Association
- Family Focused Treatment Association
- Apex
- Boys Town
- Cedars
- Children's Square
- Child Saving Institute
- Christian Heritage
- KVC, Behavioral Healthcare, Inc.
- Nebraska Children's Home

We were fortunate to meet with most of the Child Placing Agencies in the Eastern Service Area, and we were impressed with the service level of many of the providers and felt that they have a high standard in terms of quality of foster homes. Most of the foster care providers expressed a sense of openness and collaboration and that the ability to be innovative is valued. They noted that there is a good grievance process in place and differences in opinions are usually settled in a positive manner.

One of the providers noted a definite feeling of "us versus them" with providers in the Eastern Service Area and the rest of the state. Some of the providers noted that there is a lack of properly trained staff and inconsistent expectations for the workers, different standards for some staff, and higher standards for some service providers. Almost all of the providers noted a problem with transportation. Saint Francis plans on developing a strong transportation system to address these issues in addition to developing a foster care parent teaching curriculum with foster care support workers in place to alleviate inconsistencies in service design and implementation.

Some advice we received from providers to be successful in the Eastern Service Area was to have good utilization review and do a better job of vetting sub-contractors as some are providing services that are low-level. One contractor said "openness and honesty are highly valued and if we say we will do something, we need to follow through." One provider shared a concern about switching to a new primary contractor because the last transition caused issues. Saint Francis reinforces the importance of maintaining a strong service culture based upon continuous quality improvement; our Quality Assurance and Performance Improvement Departments have policy mechanisms in place to evaluate service performance (see CQI-1). Saint Francis has also developed a Utilization Plan (see UTZ-1) and a Case Management Philosophy that combines evidence-based practice with service delivery to ensure the appropriate services are being provided in the best way possible (see CSM-1 to CSM-4).

We will continue to engage community stakeholders with similar goals of enhancing the foster care community in the Eastern Service Area. We plan to meet with other stakeholders, including the Omni Treatment Community, to continue to grow our connections with local resource providers and to develop a program that retains foster parents that can address a variety of placement needs. For more information on Saint Francis's plan on developing placement capacity, please see PLC-1 to PLC-3 in the placement capacity section of this proposal.

g. Residential Providers

Saint Francis believes that children should be placed in a family setting. In Kansas, Saint Francis has a YTD average rate 90.5% of placing children in a family-like setting for the Wichita Region as well as the West Region (both urban and rural areas of the state) for FY18[68]. Furthermore, according to the State of Nebraska Foster Care Review Office Annual Report (2017-2018), children in the Eastern Service Area continue to be placed in family-like settings at high rates (96.5%)[69]. However, some children are not able to be safely cared for in a family-like setting, and to provide the best services possible for these children, Saint Francis will develop connection with quality residential placements that can meet their individual and specific needs. Our Utilization Review team works closely with residential programs to ensure children are not lingering in that system and that programs have the necessary information to immediately begin work with the young people referred for care.

Saint Francis schedules quarterly provider meetings that residential providers are expected to attend. During the meeting, outcome data is shared with the providers and any changes in expectations are discussed in detail. Providers also get an opportunity to share their thoughts on Saint Francis's performance and provide input in order to mutually improve the systems and strategies utilized to serve this demographic of children in our care.

We have held open discussions with service providers such as Boy Town, and we will made further outreach efforts in forming relationships with other service providers such as the Omaha Home for Boys, Youth Care and Beyond, CHI Health, and Nova. We are excited for the opportunity to work with service providers to develop and connect children to resources that improve outcomes and contribute to permanency, safety, and well-being.

h. Purchased Service Providers

While visiting service providers in the Eastern Service Area we found a network of providers who had worked together to develop creative and effective services. They all talked about being an important part of the continuum of services necessary for children to move to permanency. Saint Francis staff had encouraging conversations with the providers and we are comfortable working with these quality agencies.

As part of ongoing community engagement plans, Saint Francis will facilitate quarterly provider meetings where we listen to providers for feedback, discuss performance on outcomes, review expectations, and present training opportunities to other organizations and child welfare providers. These meetings promote quality service design through sharing valuable information

---

[68] Kansas Department for Children and Families: Placement in Family Like Settings SFY2018, http://www.dcf.ks.gov/services/PPS/Documents/FY2018DataReports/FCAD_ContractOutcomes/ChildrenInAFamilyLikeSettingSFY2018.pdf
[69] Ibid 27

and service feedback in order to improve our work and streamline the system/network to enhance provider services. Saint Francis approaches our relationship with purchased service providers as one built about mutual concern for the safety, permanency, and well-being of those in our care, as well as cultivating respectful collaborations to improve services. Saint Francis believes that bringing providers together to listen to concerns and discuss creative and impactful solutions to problems builds trust between service providers and establishes a culture of quality improvement and partnership.

We have currently contacted and held discussions with service providers such as:

- Paradigm
- Apex
- Boys Town
- Children's Square
- Child Saving Institute
- Christian Heritage
- KVC, Behavioral Healthcare, Inc.
- Nebraska Children's Home Society

Our future community engagement efforts with service providers includes, but is not limited to, meetings with

- Lutheran Social Services
- Omaha Home for Boys
- Cedars
- Omni Care

We were able to meet with Paradigm to introduce ourselves and discuss the many in-home services they provide for children in foster care and their families. They felt the current contractor was good to work with and since their agency does good work, they are one of the first to receive referrals. They were willing to work with Saint Francis but also happy with the current arrangement.

i. Local Community Service Providers

We were impressed by the number of services and opportunities that are available for children and their families within the Omaha area. Many of these are donor or grant supported and are offered at no charge to the family for services. We found programs to assist incarcerated mothers and fathers in maintaining visitation with their children, programs that offer many levels of support to those families struggling with intergenerational poverty, and a myriad of services available to children and young people through Central Navigation, including active services for substance use disorder treatment and mental health needs.

Providers included Omaha Bridges Out of Poverty, Christian Heritage, Paradigm, Apex Children's Square, Nebraska Children's Home Society, and Boys Town. Saint Francis is also looking forward to the opportunity to work with Project Everlast, the Omaha Home for Boys, Omni Care, Good Will, and Heartland in connecting children and families to available services. Saint Francis will continue to work to expand this network and work with community agencies to develop grants or seek donations to support these services.

j. Managed Care Organizations

Saint Francis has a long history of working with Manage Care Organizations responsible for Medicaid. As Medicaid provider in Nebraska, we have worked with each of these organizations to make sure our qualified providers have been credentialed to provide care. We also have much administrative experience working with children with Medicaid insurance to assure coverage is up to date and can be accessed when needed. Managed Care Organizations include, but are not limited to, Nebraska Total Care, Well Care of Nebraska, and United Health Care. For more information the services available through ACCESSNebraska and other means, please see sections PPF-1to PPF-5.

k. Non-traditional community resources and leaders

Saint Francis will connect with those community resources and leaders that offer wrap around and other services that fit the unique needs of children and families. For More information on service gaps and community resources, please see CNT-1 to CNT-5 of this proposal.

l. Other county and/or community stakeholders.

It is important to include organizations such as the Scouts and 4H when discussing community organizations that can have a positive influence of young people in Foster Care. These organizations provide great leadership, skill building experiences, and mentorship for children in foster care. We also recognize the importance of a child's time in foster care being as normal as possible and will work to offer children opportunities to participate in standard age-appropriate events, such as clubs and camps, that are available to their peers.

We will reach out to organizations that provide mentorship services and much needed but often overlooked services such as day care centers and community based groups that may offer services or initiate services based on need. This includes, but is not limited to:

- YMCA
- Girl Scouts
- Boy Scouts
- Eagle Scouts
- 4-H Clubs
- Big Brothers and Big Sisters of the Midland
- Day Care Centers
- Mentorship services
- Vocational services.

We will invite these stakeholders, such as day care center staff, to community panels and work to build collaborative relationships and build understanding for trauma-informed care and community-based resources. For instance, day care plays an important role in child welfare as they care for children who been exposed to trauma from abuse and neglect. Saint Francis provides training when requested for day care staff to assist them in their work with children who may be experiencing issues associated with the mental and/or physical abuse they may have experienced. Furthermore, social and mentor groups such as Big Brothers Big Sisters connect youth to communal supports and provide mentorship to those who are building independent living skills and are transitioning out of care.

ENG-2 Plan of how Saint Francis will engage in meaningful consultation, collaboration, and coordination with federally recognized tribes to support children and families with tribal affiliations.	Comply: X

Response:

Saint Francis has experience working with Native Americans as a foster care provider for Native American children and also as the case manager for child welfare cases in Kansas. Our attorneys have created a training for the case management teams that explains the Indian Child Welfare Act (ICWA) and what that means to the workers as they work with children of Native American heritage. We also have experience working with Native American Foster Homes and the placement of children in our foster homes by the Tribe. Much of this work has occurred in Oklahoma, which has a large Native American population.

Saint Francis has supported Native American Kinship homes in the Chadron, Scottsbluff, and York areas in Nebraska. We have completed kinship home studies and worked with tribes on services for children, as well as contact with their parents. Saint Francis supported an adoption of an enrolled tribal child in one of our ICWA approved licensed foster homes by completing the adoption study for this ICWA home. The Director of Nebraska has also made contact with Misty Frazier, the Director of the Nebraska Indian Child Welfare Coalition. The purpose of this contact is to work together to advocate for resources for tribal youth, no matter which tribe they are affiliated with in Nebraska.

T&T Transition Planning

T&T -1: Describe a plan of how Saint Francis will collaborate with DHHS to ensure that families experience a smooth and non-disruptive transition from initial assessment to ongoing case management.	Comply X

Response:

Saint Francis currently has a robust and fully-functioning case management system in place, with policies and procedures in existence for Admission and Intake, Client Services, Assessments, Customer Care, Program Improvement, Family Preservation, Adoption, Reintegration Case Management, Independent Living, Placement, Permanency, Court-Legal, ICPC, Post-Permanency Support Services, Kinship, Foster Care Homes, Provider Relations, and other on-going case management services.

The foundation for the Saint Francis RFCA (reunification, foster care, and adoption) and Family Preservation (in home service) Service Delivery Models is in place and has been successfully implemented for over 22 years. As we have done across the five (5) states in which we provide child welfare services, we will continually engage with community and partnering organizations such as DHHS to ensure a smooth transition into the Saint Francis on-going case management service network.

Currently, Saint Francis works with DHHS to deliver quality care to Nebraskan children and families through our Family Preservation, Intensive Family Reunification, Family Support and Visitation, and Agency Supported Foster Care services in the Western and Central Service Areas. We will endeavor to continue to deliver this quality of care in the Eastern Service Area.

Saint Francis will work with DHHS to adapt and implement our in home (Family Preservation) and out-of-home (RFCA) case management service delivery model to best address the needs of children and families in the Eastern Service Area to facilitate a smooth transition and non-disruptive transition from initial assessment to ongoing case management.

To ensure a smooth transition from DHHS to Saint Francis services, placement coordinators, case management teams, and other staff will be trained in the Eastern Service Area RFCA and Family Preservation Service Delivery and RFCA Service Delivery Models (shown again on pgs. 150 and 151 below) are designed to offer family-centered, community-based, trauma-informed services to the children, families, and providers we serve. From the beginning of the life of each case, case management teams will provide services to children and families in the most family-like setting possible to provide for the safety, permanency, and well-being for children in our care.

Saint Francis will collaborate with DHHS to define and follow DHHS regulations and policies as required by state and federal law. We will work with DHHS to establish an amended and agreed upon Eastern Service Area Operations Manual that outlines the processes and expectations for standardization in the operation and delivery of case management and related services. The Operations Manual will be reviewed and amended as agreed to by both Saint Francis as subrecipient and DHHS in the manner specified in the Operations Manual.

a. No Reject/ No Eject

Saint Francis will adhere to DHHS's guidelines by accepting all referrals made by DHHS (No Reject) and continue to meet the individual needs of children and youth referred (No Eject). We will accept all children/youth referred by DHHS who are referred for ongoing case management and provide services to the child and their family, regardless of race, religion, color, gender, sexual orientation, disability, ethnicity, ancestry, national origin, or familial status. It is our policy to comply with the Americans with Disabilities Act and other federal and state laws and regulations concerning both employment of individuals and services to clients with disabilities, and to assure that a consistent and fair process is in place to help individuals with disabilities when a reasonable accommodation is requested. We will work with the State to ensure the smooth transfer of both new referrals and children being served in the current contract into the Saint Francis system of care.

Saint Francis will provide case management to families with children between the ages of 0 and 19 who are either court involved or referred from DHHS for voluntary in-home (family preservation) services. Once a child is referred to the Saint Francis, that child will be served until permanency is achieved. Regardless of needs, level of service, placement circumstances, media attention or other extenuating circumstances, Saint Francis understands the terms "No Eject" and "No Reject," and we will diligently work to provide services necessary for each child to reach permanency. Saint Francis will work with DHHS in accessing the exceptional care rate, should more specialized care be required to meet a child's needs, and will engage providers within the

network of care to wrap community services around higher-needs children to ensure their success.

Saint Francis will maintain the capacity to accept referrals for paid foster care and on-going case management. Saint Francis is available 24 hours a day, 365 days per year (including holidays) to accept referrals from DHHS for case management. DHHS will have contact information for Saint Francis staff during business and after-hours. Saint Francis recognizes that emergency situations cannot be confined to business hours and will ensure on-call staff are available to provide immediate response to new referrals at all hours.

b. Intake Process

Our organization has developed a thorough and effective intake model (see CSM-1) for child welfare services. We value our DHHS partners' knowledge and expertise in gathering information about a child's supports, as well as in assessing their needs during initial assessments.

Our intake process is structured to immediately support the children in care and to alleviate the fear for the child being taken in if placed in out of home care. Children removed from their home and their parents/caregivers entering the child welfare system both experience a pivotal trauma. Our intake process is structured to immediately support a child, alleviate fear, and to find the best possible, least restrictive environment to begin the healing process.

At the time of referral for Coordinated Response Services Access, DHHS will determine and communicate to Saint Francis via phone the response time required for Saint Francis's response and whether the response must be in person or for a specified need such as placement. When there is a need for immediate planning services or placement is needed, the Saint Francis will respond within two (2) hours unless otherwise directed by DHHS. Otherwise, we will respond to referrals for services access within 24 hours. A response is defined as direct phone or face-to-face contact with the family who is the subject of the referral. In a two (2) hour response, Saint Francis staff may be required to meet the DHHS Child and Family Services Specialist at the family home to arrange safety services, to facilitate and ensure a safety provider will respond to the home or to secure placement for a child(ren) being removed from the family home. In the event that out-of-home placement is required, Saint Francis will be responsible for providing supervision to the child(ren) if agency based placement is not located within three (3) hours of the requires for Agency Based Foster Care. When requested, Saint Francis will participate in the initial family team meeting, which will be held within 72 hours of referral as arranged and facilitated by DHHS.

As mentioned in CSM-1, families referred for Family Preservation (in home services) are assigned to a Case Manager who will collaborate with DHHS staff to communicate important information as well as make initial contact with the family within 24 hours of our receipt of the referral. During initial contact staff introduce themselves, explain the reason for the contact, review referral information, explain the home visit and encourage the parent to involve others including the non-custodial parent if applicable, and other community supports involved with the family. The Case Manager and family determine a date and time to hold the Family Team Meeting (FTM) with the family's schedule taking precedence. Please see CSM-1 for more details.

For those families referred for out of home services, a trained member of the case management team or Placement Coordinator will collaborate with DHHS to compile information from parties directly involved in the child's care and have knowledge of the child's needs. Saint Francis will accept referrals, find safe placement, and/or provide necessary services to children and families in a timely manner. Saint Francis will maintain a professional and qualified staff that recognizes and meets the needs of those referred to our care.

c. Placement

As we know that each child is unique and the circumstances for their out-of-home care will often require additional collaboration between agencies to timely and efficiently meet needs, we will seek to meet regularly with regional and local DHHS staff to get information as early as possible, understanding that no amount of planning can fully prepare for an emergency situation. Saint Francis has a reputation of being a good partner across five (5) states to caregivers, contractors and subcontractors, and it will continue that practice in the Eastern Service Area.

We are able to accept, assign, manage, and track incoming referrals from DHHS, to coordinate placement referrals, locate and arrange appropriate placements, respond to and coordinate after-hours emergency calls including dispatching staff if/when direct contact is necessary, and to engage in provider relations work with all placement providers. Provider relations work includes working with subcontractors on quality assurance and performance improvement(QA/PI) measures and maintaining placement management information. Having dedicated staff for this function facilitates timely and quality service for children and families as well as state partners and subcontractors.

The Placement Director will lead the Placement Supervisor, Placement Coordinators, and Clinical Utilization in securing the most appropriate, family-like, and least restrictive placement options that reduce the number of needed moves, for every child referred for out of home services. Local on-call staff will be qualified to administer placement screening tools for the child to assure a match with a family or facility that will best meet the child's needs.

We value the tremendous work being done at the Project Harmony advocacy and triage center and a strong partnership will be developed with the center. Case management teams will work closely with DHHS to ensure placement stability, continuity of care and services for children. The role of the triage center at Project Harmony adds to the success of this endeavor by allowing the child to have a safe place for a few hours while assessing their needs and placement options.

Once a child is referred for out of home placement, case management team staff will accept physical custody of the child from DHHS. Our staff will partner with the DHHS worker to ease the child's transition, to ensure the child's immediate needs are understood, that they are as comfortable as possible, and that all required information and documentation is received. The case management team also coordinates with kinship staff, including the X-Treme Recruiter (XTR), regarding any kinship placements being pursued. If the placement is a relative, a Kinship Worker will be assigned immediately to begin providing needed supports. The referred child will be immediately transported to the relative/kinship placement or foster home, ensuring it is most appropriate for the child's needs.

Placement Coordinators work with DHHS to locate placement options based upon the child's age, gender, sibling relationships, ethnicity, culture, school, distance from home, and special needs. If the child has been identified as needing additional services or a placement that is

treatment based, the clinical utilization specialist becomes involved to assure placement and treatment options are navigated in the child's best interest.

If the placement is after-hours, Saint Francis placement staff shares with the foster family all information that is available at the time, including a copy of the Initial Referral. The family will be updated when additional information becomes available. At a minimum, the placement will include a placement agreement, access to medical treatment, medication, and the physical necessities required to properly care for the child.

d. Transportation

Our Transportation Coordinators are trained to accommodate the transportation needs of referred children regardless of distance from the local Saint Francis office. The Transportation Coordinator will dispatch Saint Francis staff to retrieve the child from their location and will be responsible for scheduling, assigning, and managing transportation requests for children in our care (see CSM-1). Saint Francis will collaborate with DHHS, the child's case manager, Placement Coordinator, and drivers to maintain consistent communication regarding transportation events for placement.

e. Family Engagement

To further facilitate the smooth transition from DHHS initial assessment to referral of Saint Francis's on-going case management, including in-home and out-of-home services, Saint Francis uses a family-centered service model to engage in respectful, honest, and open communication between those involved in the case. Keeping families aware of procedures and individual expectations associated with a referral to Saint Francis's services helps to ensure that families remain engaged in the child welfare process, as well as are able to contribute to and remain active members in the child's case plan. Parties involved in the child's care are given the name and contact information of the child's case worker and any other pertinent information. This assures that families and parties are able to contact case workers and other staff when needed as well as remain engaged in the child welfare process and the child's case plan.

Kinship and relative placements are an important resource for out of home care. Placing the child with a family member can reduce the traumatic impact of being removed from the home, contribute to positive permanency outcomes, provide much needed support resources to the birth family after reunification, and keep the child connected to their culture, tradition, values, and identity. Saint Francis will work with DHHS to locate and assess appropriate kinship and relative placement options, as specified by the roles and responsibilities of each organization. For more information concerning intake and placement protocols and procedures, please see CSM-1.

Saint Francis will also provide and connect biological parents to community-based support services beginning at the intake process and continuing through the life of the case, to help support a seamless transition into Saint Francis care.

T&T Turnover Planning

T&T- 2: Describe a plan of transition of case management services that includes but is not limited to : i. An outline and implementation plan that prepares for a successor agency. ii. An outline of service model components that will clearly explain service structure and evidence-based practices implemented at or during subaward execution. iii. An outline and implementation plan that addresses: a. Staffing b. Use and transition of equipment c. Transition of case management to successor agency d. Migration of any data owned by DHHS e. Dispute resolution between DHHS and Saint Francis in regard to cases, caseloads, and reimbursement for services.	Comply: X

Response:

i. An outline and implementation that prepares for successor agency.

At the end of the RFP 5995 Z1 subaward term or other subaward termination, Saint Francis will aid in the transition to any new arrangement or provider of services. The respective accrued interests or obligations incurred to date of termination will also be equitably settled. Upon termination or expiration of this subaward, DHHS will work with Saint Francis to transfer all services as efficiently as possible with the goal to have all necessary services transferred by the effective date of the expiration or termination of the subaward. However, in the event that a transfer of all necessary services is not possible, Saint Francis will continue to provide necessary services in accordance with all terms and conditions of this subaward until necessary client services are completely transferred.

Within 30 days, except as otherwise agreed upon, Saint Francis shall assist and cooperate in the orderly transition and transfer of subaward NE 5005 Z1 activities and operations with the objective of preventing disruption of services. This includes but is not limited to:

- Transfer of completed or partially completed deliverables to the State
- Transfer ownership and title to completed or partially completed deliverables to the State
- Return to the State information and data, unless Saint Francis is permitted to keep the information or data by contract or rule of law. Saint Francis may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Saint Francis's routine back up procedures.
- Cooperate with a successor subrecipient/agency, person or entity, in the assumption of the obligations of RFP 5995 Z1 subaward.
- Cooperate with successor subrecipient/agency, person or entity, with the transfer of information or data related to RFP 5995 Z1 subaward.

- Return or vacate state owned real or personal property related to RFP 5995 Z1 subaward
- Return data related to RFP 5995 Z1 subaward in a mutually acceptable format and manner.

Saint Francis will coordinate with DHHS, and the successor agency, as needed, to develop an agreed upon transition governance team, exit procedure/transition plan, and agreed upon scope for exit/transition management, plan of activities and timelines to carry out the exit procedure/transition plan, measurement of completion for exit plan/transition planning, and finalization of service closure.

a. Exit Procedure/Transition Plan with DHHS[70],[71]:

1) Exit/Transition Governance Team

Establishing a transition governance/team will include parties agreeing to meeting attendees; agendas and frequencies of DHHS, Saint Francis, and successor agency involvement. The transition governance and/or team may include, but may not be limited to:

- Assistant Vice President of Services for Eastern Service Area: Coordinate activities between branches of Saint Francis Eastern Service Area services, DHHS, and successor agency to develop a timeline for activities for transition implementation of case management services and oversees execution of timeline for activities for transition implementation and conclusion of case management services .
- Transition Project Managers: Saint Francis, DHHS, and Successor agency, Coordinate activities between contractors throughout transition; provide workspace for all transition staff; facilitate transition meetings.
- IT Transition Leads; Saint Francis, DHHS, and Successor agency. Ensure IT activities are completed during transition, document IT processes, tasks, and activities for transition.
- Contracting Officers: Saint Francis, DHHS, and Successor agency. Responsible for overseeing contract actions and deliverables, responsible for ensuring accountability on funding and budget items pertaining to the contract.
- Configuration Managers: Saint Francis, DHHS, and Successor agency. Ensure training documentation is complete; ensure completion of user and technical manuals; ensure all documentation is in accordance with DHHS standards; ensure proprietary materials are not part of transition.

2) Exit/ Transition Agreement

Establish an agreed upon transition plan and/or exit agreement between Saint Francis, DHHS, and successor agency that will outline responsibilities and timeframe throughout the agreed upon

---

[70] ProjectManagementDocs: Transition Out-Plan Template, https://www.projectmanagementdocs.com/template/project-closure/transition-out-plan/#axzz5jngKsYPQ
[71]National Outsourcing Association: Exit Management and Transition Checklist, https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwjVo6ua0JThAhWnna0KHfcSAGMQFjAAegQIAxAC&url=https%3A%2F%2Fplatformoutsourcing.nl%2Ff%2Ffiles%2Fdownload%3Ff%3Dartikelen%2Fexit-hercontracteren%2Fexit-checklist-noa.pdf&usg=AOvVaw01wmbx3nTDRkqh0k5GKviA

period of transition of case work, files, staffing, equipment, data migration owned by DHHS, and dispute resolution between parties. The exit agreement will contain, but will not be limited to, the following:

- Legal Documentation/Agreement
- Understanding of contractual obligation for providing notice and timeline of activities to be followed to ensure obligations are met and Saint Francis is treated fairly.
- Constructing an exit agreement framework that will have the capacity to define the exit/transition obligations to be fulfilled by Saint Francis, and the mechanism to be used to measure completion.
- Saint Francis, DHHS, and successor agency agreement to scope of termination, objectives, timescale, and contractual obligations of transition plan/exit agreement.

3) Prepare Requirements for Exit Agreement/Transition Plan. This may include, but is not limited to the following:

- Commence transition planning with successor agency and DHHS
- Identify case management roles and activities to be performed and delivered by the successor agency.
- Provide any relevant documentation pertaining to transferable contracts/licenses as required by the successor agency.
- Agree to permitted levels of access to successor agency of office space, data, files, etc.
- Discuss successor agency's anticipation of resource requirements from Saint Francis.
- Agree to knowledge transfer and education mechanisms between successor agency and Saint Francis.
- Define and agree process to transition transferable contracts/licenses to successor agency.
- Define and agree to resource requirements from Saint Francis (assuming successor agency resource requirements are already agreed as part of contract negotiation with DHHS). These must, at a minimum, meet Saint Francis's contractual obligations for termination.
- Define and agree to data/information exchange process between all parties.
- Define and agree to terms for the transfer of in-house developed software, scripts, tools or command procedures required by Saint Francis to perform the services being terminated.
- Agree to date and time for Saint Francis to cease providing in-scope services.
- Agree to payment schedule between DHHS and Saint Francis for all exit costs and outstanding service invoices.
- Review access for Saint Francis staff and arrange for these to be removed during appropriate exit phase
- Once scope for exit management has been agreed, plan out the activities for agreeing to timelines, deliverables, and measurement of success and completion for transition planning.

4) Exit Agreement/ Transition Planning Complete
    - Joint agreement that exit planning/ transition planning is complete.
5) Service Closure
    - Execute transition plan as agreed with all parties during exit/transition planning
    - Saint Francis will return secure access encryption devices at the appropriate exit phase without impacting the continuing delivery of services while terminating services.
    - Saint Francis staff will return access permits/passes issued by DHHS for access to DHHS locations for Full Service Case Management RFP 5995 Z1.
    - Full and final settlement of outstanding disputes between DHHS and Saint Francis for Full Service Case Management RFP 5995 Z1
    - Saint Francis ceases to provide Full Service Case Management Services to DHHS as defined by RFP 5995 Z1 and agreed upon between Saint Francis and DHHS.

b. Transfer Procedure with Successor Agency:

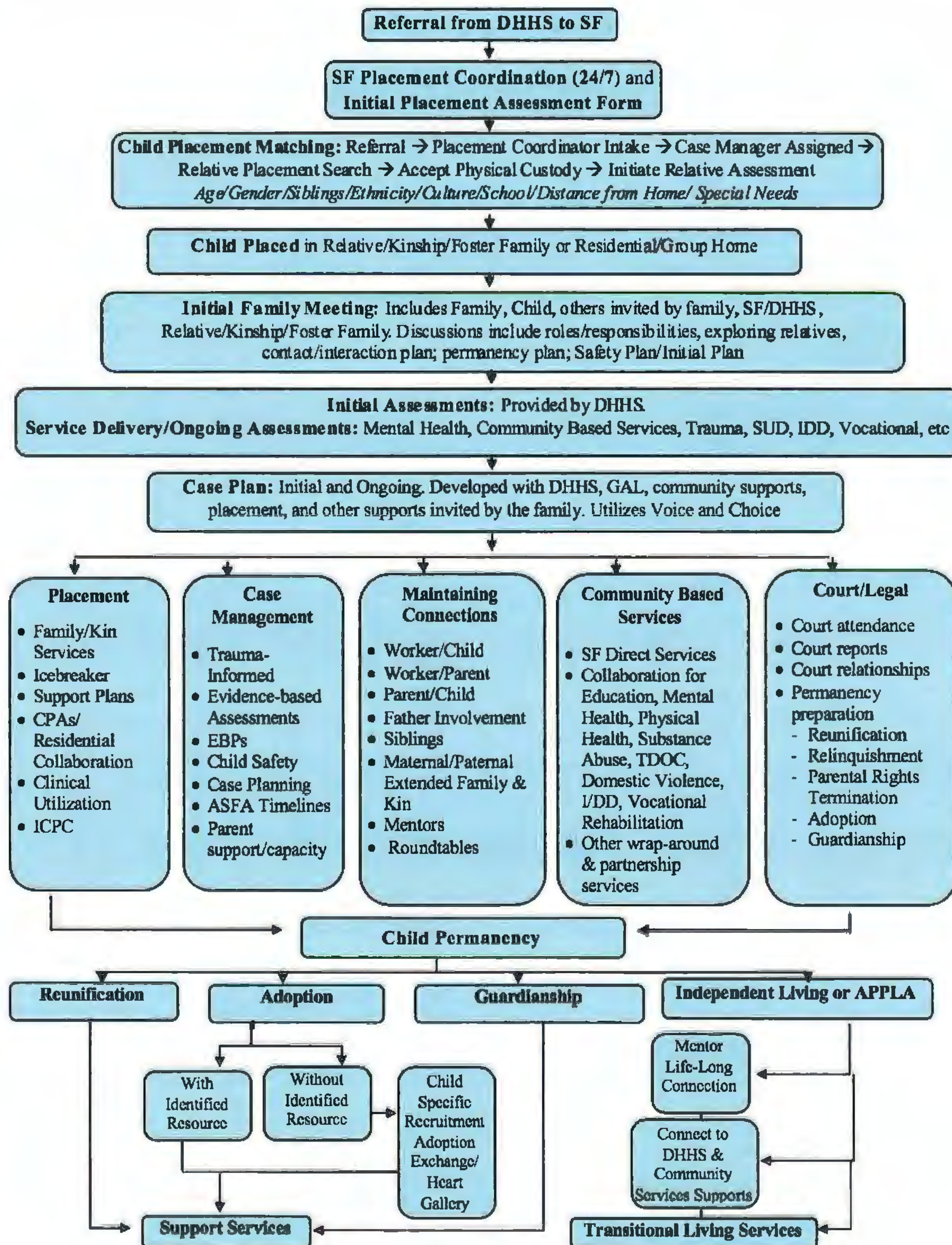
1) Transition program
    - Prepare scope for transition planning as agreed upon in exit agreement/transition plan.
2) Transition Planning
    - Agree to the main accountable managers for each transition work stream.
    - Agree to plan within timelines and success measures to transition all in-scope services from Saint Francis to successor agency, utilizing artefacts and agreements provided during the exit planning/ transition planning phases.
    - Conduct workshop between DHHS, Saint Francis, and successor agency ensuring all parties understand and agree to the exit/transition plan and the governance of such.
3) Knowledge Transfer
    - Successor agency review of necessary Saint Francis processes and procedures. Saint Francis will answer questions resulting from review.
    - Execute knowledge transfer phase as defined in the transition plan agreed between all parties.
    - Joint agreement of completion of knowledge transfer phase of the transition plan.

ii. An outline of service model components that clearly explain service structure and evidence-based practices implemented at or during subaward.

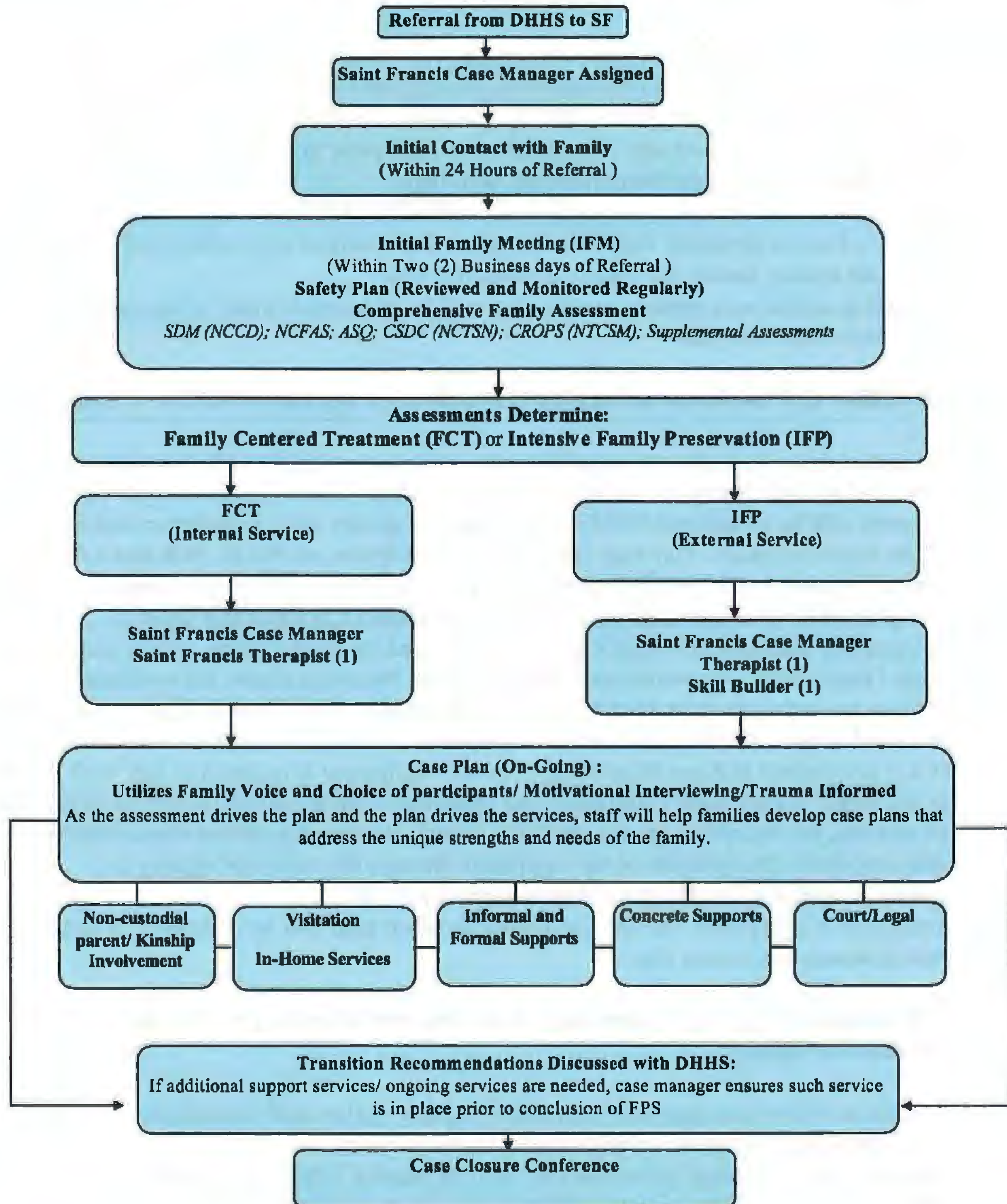
Saint Francis will utilize our RFCA (reunification, foster care, and adoption) Service Delivery Model and our Family Preservation (in home services) Service Delivery Model to provide quality ongoing Full Service Case Management as referenced in RFP 5995 Z1 in the Eastern

Service Area. These models are pictured below on pg. 150 and pg. 151, respectively. We look forward to delivering these quality services to children and families in Nebraska. For detailed information regarding service structure, case management services, and the implementation of evidence-based practices, please see sections CSM-1 to CSM-4.

Saint Francis RFCA Service Delivery Model



Saint Francis Family Preservation (In Home Services) Service Delivery Model



iii. An outline and implementation plan that addresses:

a. An outline and implementation plan that addresses staffing turnover:

- Saint Francis workforce members will remain with Saint Francis to perform transition activities until such time that the transition is completed and approved by all parties.
- As part of implementation plan agreed by appropriate parties, the new contractor will ensure its workforce is on site the agreed upon days prior to transition completion to allow adequate time to perform transition activities.
- Saint Francis Human Resource department staff will collaborate with the successor agency's Human Resource department to transition qualified and willing staff to the successor agency during the specified transition stage.
- A staffing outline and implementation plan will be addressed as part of the exit agreement/transition plan.

b. An outline and implementation plan that addresses use and transition of equipment:

- As part of the exit agreement/ transition plan agreed upon by all parties, equipment furnished by DHHS or government entity that provides Saint Francis with government property will be turned into DHHS or government agency upon completion and approval of the transition phase. This may include laptop computer, all PEDs, flash and external hard drives, and employee ID badges. All electronic devices will be re-imaged by government IT personnel and reissued by government IT to successor agency.
- All property belonging to Saint Francis or purchased by Saint Francis will be turned into Saint Francis upon completion and approval of the transition phase. All electronic devices belonging to Saint Francis will be re-imaged by Saint Francis IT personnel and re-issued to appropriate Saint Francis employees.
- If it is determined that any Saint Francis owned equipment is required to stay with DHHS or successor agency upon completion and approval of the transition to prevent disruption of services, the successor agency and Saint Francis contracting officer representatives will coordinate procurement of the equipment through the successor agency or government agency's procurement management process.
- Transition of equipment out line and implementation plan will be addressed as part of the exit agreement/transition plan

c. An outline and implementation plan that addresses transition of case management to successor agency.

- Transition of case management to successor agency outline and implementation plan will be addressed as part of the exit agreement/transition plan.
- Assistant Vice President of Services for Eastern Service Area: Coordinate activities between branches of Saint Francis Eastern Service Area services, DHHS, and successor agency to develop a timeline for activities for transition implementation of case management services and oversees execution of timeline for activities for transition implementation and conclusion of case management services .

- A transition plan will be developed during the start-up period with the State and successor that will outline responsibilities and timeframe throughout the agreed upon transition phase for transition of the case work and files.
- DHHS will work collaboratively with the successor and the state in executing the new provider's transition plan by providing data, assisting with staff transition to a new provider and program case specific information including completed case files.
- Tasks, activities, timeframe, scope of work, and objectives addressed and identified in transition and implementation plans. Agreed upon by all parties.
- Tasks and activities completed as specified in transition plan. All parties agree that work has been completed.

d. An outline and implementation plan that addresses migration of data owned by DHHS.

- Migration of data owned by DHHS from Saint Francis outline and implementation plan will be addressed as part of the exit agreement/transition plan.
- IT Transition leads will be assigned by Saint Francis, DHHS, and the Successor agency to ensure IT activities are completed during transition, document IT processes, tasks, and activities for transition.
- Tasks, activities, timeframe, scope of work, and objectives addressed and identified in transition and implementation plans. Agreed upon by all parties.
- Tasks and activities completed as specified in transition plan. All parties agree that work has been completed.

e. An outline and implementation plan that addresses dispute resolution between DHHS and Saint Francis in regard to cases, caseloads, and reimbursement for services.

- Dispute resolution between DHHS and Saint Francis in regard to cases, caseloads, and reimbursement for services outline and implementation plan will be addressed as part of the exit agreement/ transition plan.
- Appropriate exit/transition governance team identified and assigned for project implementation and oversight.
- Tasks, activities, timeframe, scope of work, and objectives addressed and identified in transition and implementation plans. Agreed upon by all parties.
- Tasks and activities completed as specified in transition plan. All parties agree that work has been completed.

IVE Title IV-E and Eligibility

IVE- 1: Describe Saint Francis's knowledge of federal statutes and regulations related to funding for child welfare and a plan of how it will comply with current federal statutes and regulations and maximize the availability of Title IV-E funding.	Comply: X

Response:

The Title IV-E Foster Care Program is an entitlement program that reimburses states for a portion of costs associated with the following services for eligible children:

a) maintenance payments that cover the costs of shelter, food, and clothing for eligible children;
b) child placement services and administrative costs (including costs associated with candidates for foster care and information technology costs) related to foster care for eligible children; and
c) expenses related to the training of staff and foster parents for eligible children.

Children who are eligible for the Title IV-E Foster Care Program include those in out-of-home placements who would have been considered financially "needy" in the homes from which they were removed, based on measures in place in 1996 under the Aid to Families with Dependent Children (AFDC) program; have entered care through a judicial determination or voluntary placement; and are in a licensed or approved foster care placement[72].

Nebraska reported Title IV-E waiver expenditures in SFY 2016 with a 46% decrease from SFY 2014[73]. "Nebraska was unable to report expenditures for the Title IV-E Chafee Foster Care Program for Successful Transition to Adulthood and Education and Training Vouchers in SFY 2016. Therefore, the reported Title IV-E amount may be understated[74]".

Our knowledge regarding federal funding is extensive and Saint Francis references the Child Trends reports to educate our teams. Saint Francis has extensive experience in assisting state partners in gathering the documentation necessary to determine Title IV eligibility and provide updated information for re-determinations.

Saint Francis is aware that the largest federal source for states is Title IV-E of the Social Security Act, which is composed of the following:

• **Foster Care Program:** Covers costs related to providing foster care for eligible children, including administrative and training costs. States can claim Title IV-E funds as reimbursement for foster care maintenance, adoption assistance, and guardianship assistance payments.
• **Adoption Assistance Program:** Covers costs related to providing adoption assistance for eligible children, including administrative and training costs;

[72] Child Trends, Child Welfare Financing SFY 2016: Title IV-E, www.childtrends.org/wp-content/uploads/2018/12/TitleIVESFY2016_ChildTrends_December2018.pdf
[73] Child Trends, Child Welfare Agency Spending in Nebraska, https://www.childtrends.org/wp-content/uploads/2018/12/Nebraska_SFY2016-CWFS_12.13.2018.pdf
[74] Ibid 73

• **Guardianship Assistance Program:** Covers costs related to providing kinship guardianship assistance for eligible children, including administrative and training costs;
• **Chafee Foster Care Program for Successful Transition to Adulthood/Education and Training Vouchers:** Provides assistance for youth transitioning out of foster care to adulthood;
• **Waiver demonstration projects:** Allows states to waive specific Title IV-E requirements to promote innovation in the design and delivery of child welfare services.
There are additional federal funding streams available to states which include Title IV-B, Medicaid, TANF, Social Service Block Grants, Community Based Child Abuse Prevention and Children's Justice Acts. Child welfare agencies may use a variety of additional federal funding streams, such as the Child Abuse Prevention and Treatment Act and the Adoption Opportunities Program.

Saint Francis is aware of state and local funds that support child welfare.

IVE- 2: Describe a plan of how Saint Francis will collect, validate and submit eligibility-related documentation.	Comply: X

Response:

Saint Francis strives to get the families we serve the supports and services they need through excellent case management. At the initial referral, a Family Support Worker is assigned to the family to assist the case management team in coaching parents, identifying services, and providing intensive support work to families to build resilience, promote positive social connections, identify resources, build rapport, and identify relatives and others as support options.

Within our current Nebraska contract, Saint Francis has successfully worked to ensure that relative and kinship foster parents referred by Nebraska DHHS complete licensing activities in order to maximize IV-E federal funding. We **will continue to comply** with federal and state policy and procedures to maximize federal funding, as well as partner with waiver demonstration projects. In reviewing the LB820 Final Legislative Report, efforts with judicial findings and licensure of kinship homes were key projects to increase IV-E penetration rates.

PPF Maximizing Public and Private Funding

PPF-1: Describe Saint Francis's knowledge of public and private funding options available for the population served including program rules and the application process and a plan to maximize public and private funding operations.	Comply: X

Response:

Saint Francis provides a wide array of services or assists parents in accessing them. Such services may include family therapy, individual therapy, substance use treatment, parenting classes (Strengthening Families Program, Parenting for Change (PMTO Group model)), parent support groups, healthy relationship training, conflict resolution training, family mediation, budgeting, financial planning, behavior modification techniques, nutrition, home management,

child care, boys and girls clubs, mentoring programs, tutoring, visitation centers, driver's education, life skills training, and many everyday supports that will enhance the skills of the family.

When external service needs are identified and agreed upon, Saint Francis assists families in making connections to the community, including agencies that provide for physical and mental health, substance use, vocational rehabilitation, disability services, education, or other identified needs. Case management teams assist families in utilizing health care benefits such as private insurance or Medicaid. When these resources are not in place, case management teams assist parents in applying for such benefits. Case management teams assist parents in applying for and accessing social security or SSI benefits.

Saint Francis teams find innovative ways to ensure children and families receive appropriate services and supports. If the cost is one that the birth parent is expected to pay, we assist the family in accessing services that are free of charge, have minimal fees, or accept sliding fee scales; identifying community funding sources; budgeting for the expense; and completing any related applications. Case management teams assist families in accessing churches, non-profit agencies, civic organizations, and other community supports as available and needed. As case management teams explore available resource options, the case worker uses this time as a teaching method to show the parent how to conduct these searches and connect to services. This empowers families to identify and complete this work with the case management team's assistance and increases the family's resiliency and ability to succeed in multiple areas.

Our teams encourage families to utilize services from the Salvation Army, NE 2-1-1, FoodBank for the Heartland Snap Outreach, Domestic Violence Associations, Health Departments, and many other community organizations when available. They educate families on the availability and use of a wide variety of community resources. The overall goal is to empower children, youths, and families to achieve their goals and maintain permanency by strengthening or creating family and community networks that will support them beyond their work with the agency.

For more information concerning our current community engagement efforts, and our community engagement plan, to connect families with resource providers in Douglas and Sarpy Counties, please see ENG-1.

Our case management teams have become very knowledgeable of available sources, program rules and the application process in order to teach families about concrete supports and community resources, and how to engage these services. As team members learn of external sources, those sources are shared at weekly team meetings.

A few of Nebraska Eastern Area resources include:

- **ACCESSNebraska:** Community Partners website listing such services and agencies as the American Red Cross, Assure Women's Center, CHI Health Community Benefit, Douglas County General Assistance, Family Housing Advisory Services, Lutheran Family Services, Maximus - Employment First, Salvation Army, SNAP Outreach at Food Bank for the Heartland, and Youth Emergency Services.
- **Iowa/Nebraska 2-1-1 (http://211iowa.org/):** An excellent resource for financial assistance, income and employment, crisis services, food, clothing, hygiene, and household goods,

health care, housing, transportation, child care, legal assistance, mental health and substance use disorder care.

- **Nebraska Counseling, Outreach and Mental Health Therapy Project (COMHT):** Funded by Nebraska DHHS, COMHT provides up to five (5) cost-free, confidential mental health counseling visits for Nebraskans who do not have coverage, have used their EAP visits or have high deductibles that are not yet met. It is a 2 minute phone call to be approved. Individuals just needs proof of residence (i.e. driver's license or a piece of mail with name and address on it).
- **Omaha Bridges out of Poverty, Inc.:** Provides Get Ahead classes for under-resourced individuals with a 75% success rate. They have life skills coaches for Getting Going which helps people reach their goals by building resources that will result in a stable lifestyle
- **Project Harmony Training Institute**: Has the goal of ending the cycle of child abuse and neglect through education designed to increase awareness and promote understanding of the impact of abuse and neglect. They offer all types of training on trauma there which is free to DHHS case workers and the current caseworkers.

PPF-2: The bidder should describe a plan of how it will assist eligible families with accessing the services and supports offered through DHHS's Division of Children and Family Services Economic Assistance Programs such as SNAP; LIHEAP; Medicaid, TANF, and EA.	Comply: X

Response:

Our qualified Family Support Workers make appropriate referrals for economic and employment services. Staff review financial selection options with the family and assist them in accessing DHHS's Division of Children and Family Services Economic Assistance Programs, and then in completing the application process for TANF, SNAP, utilities assistance, emergency assistance, daycare assistance or other subsidies or process their request for organization reimbursement.

Families may be eligible for DHHS Financial Assistance[75] Programs including:

- AABD (Assistance to the Aged, Blind, or Disabled)
- ADC (Aid to Dependent Children)
- Cancer Drug Repository Program
- Child Care Support (Subsidy)
- Child Support Enforcement
- CSFP (Commodity Supplemental Food Program)
- EBT (Electronic Benefits Transfer)
- EA (Emergency Assistance)
- Employment First
- LLIHEAP (Low Income Home Energy Assistance Program)
- Every Woman Matters
- Financial Services Administration
- Food Distribution Program
- Supplemental Nutrition Assistance Program (SNAP)

[75] DHHS's Division of Children and Family Services Economic Assistance Programs Eastern Service Area, 402-595-1258, 8-5 Monday -Friday. http://dhhs.ne.gov/children_family_services/Pages/fia_fiaindex.aspx

- Homeless
- In-home Services (SSBG)
- CHIP (Children's Health Insurance)
- Medicaid / Medicare
- Refugees
- SSI (Supplemental Security Income)
- WIC (Women, Infants & Children Program)

PPF-3: Plan to ensure an application is made through ACCESSNebraska for both public assistance and Medicaid	Comply: X

Response:

Saint Francis understands that Nebraska's DHHS administers and manages eligibility for Medicaid and Economic Assistance programs through ACCESSNebraska. Case Management Teams will work with and assist families in applying for benefits and handling their Medicaid and Economic Assistance needs through the ACCESSNebraska website[76].

As Saint Francis has done in other states, we will work diligently to develop relationships with Nebraska's Managed Care Organizations (MCO): CoventryCares (owned by Aetna), UnitedHealthcare Community Plan, and Arbor Health (owned by AmeriHealth Caritas) and will identify contact people in each of the organizations to collaborate and coordinate services. We have a Medicaid liaison who assures benefits are accessible to the child and the care provider for that child. Case management teams will have MCO desk aids to help them navigate each of the MCOs to facilitate coordination of services.

Our case management teams will help the families connect with ACCESSNebraska and work through the self-screening to determine the programs for which they are eligible to apply and will then assist them in completing the online application.

Higher-needs children and youth are assigned a Clinical Utilization member to work directly with the Medicaid Managed Care Organization care coordinator to assure the child and youth are able to access the care and treatment they need to support daily functioning. Our Clinical Utilization staff use a centralized referral process to work with the child's case management team, private and mental health providers, and GROs/RTCs who can provide the needed level of care.

PPF-4: Describe a plan to ensure a complete and accurate application is made to Social Security and the DHHS Division of Developmental Disabilities for children or adults who are disabled.	Comply: X

[76] AccessNebraska https://dhhs-access-neb-menu.nc.gov/start/?tl=en

Response:

When Saint Francis receives an initial referral for out-of-home/in home services, documentation is reviewed to determine the need to apply to the Social Security Administration (SSA) and DHHS Division of Developmental Disabilities for children or adults who may meet eligibility requirements following SSA Guidelines. Initial Requests are made within 30 days of referral for the following clients if they not already receiving Social Security Services:

- Children who have a documented diagnosis in the referral
- Children who have documented physical disabilities
- Drug exposed newborns
- Parents who have a documented diagnosis in the referral

When diagnoses are made by qualified professionals within 30 days of the initial referral from DHHS, case teams will seek qualifying documentation and submit the application to DHHS and SSA for determination.

The application is made for the qualifying child/parent including documentation from the DHHS intake and medical/mental health diagnosis. Case teams will request medical and mental health documentation from all known providers if information is not initially provided with the referral to Saint Francis. The case file will be available for review with the case team continually sending updated information, as needed, by professionals completing assessment and service delivery. Names of agencies and or professional individuals and contact information will be provide to the determining agency to gather additional information as needed. Parents and Caretakers will be contacted to ensure information is accurate. The agency will ensure the application is completed in its entirety. If information is unknown, the case team will make needed contacts to ensure the application is fully completed.

Saint Francis teams will work with parents when children are in the home to complete and submit the application to the required authorities. Assistance will be provided by the support staff as need to help parents navigate the process.

The following documents will be submitted along with any additional documents to start the determination process:

- Journal entry of court ruling for DHHS custody and out of home placement
- Documentation supporting the reason for referral for services
- Referral and Claim Form
- Medical Documentation

Support Staff will track the referral process starting with when the application was submitted, receipt of the submission, letters of determination, requests for documentation, and the date of determination and outcome.

If there is a need for training on the process, Saint Francis will reach out to the appropriate parties to administer the training component or help create a component with Saint Francis training staff.

If resources exceed the identified amount on the last day of a month, which makes a client ineligible for SSI the following month, per the SSI Admin, Saint Francis will work with the required agency and representative to spend the funds and provide receipts upon purchase.

PPF-5 Identify strategies for raising private dollars and /or grants to support its operations. As part of its explanation, specify if Saint Francis is recognized as a Title IV-E recipient in any other States or within any other tribes.	Comply: X

Response:

Throughout our seven (7) decades in operation, Saint Francis has continuously sought long-term fiscal and programmatic sustainability to serve the 13,753[77] children and youth that we see each day across the five (5) states we serve.

Saint Francis's Board of Trustees and the leadership team are committed to serving children who are at risk of being removed from their homes or have entered state custody. Saint Francis is investing the human resources, expertise, and proven track record to assist these children. We work adamantly to assure the success of our diverse programs.

In 2016, Saint Francis went the next step and created the Saint Francis Foundation to build financial support for Saint Francis's mission of provide healing and hope to children and families. Within the Foundation, the Development Office is engaged in relationship building (including church relations), endowment futures and generous supportive partnerships. We continually work to diversify our funding to meet the needs of children and youth who require safety from life-harming experiences, assurances that someone will be there for them, and direction on preparing for life.

Below is an outline of Development Office's Cultivation Strategies (Building Relationships):

The purpose of cultivation is:

1) To add prospects to our donor base and develop them to become active supporters and regular major gift donors.
2) To improve relationships with current board members, donors, volunteers, and other friends of Saint Francis Ministries to build a greater understanding of how they can help our agency achieve its mission.
   Donor and volunteer recognition are critical to the cultivation process. Cultivation needs to be discussed regularly at board meetings to encourage each board member to become part of the cultivation process.
3) Identifying and qualifying donors, acquisition of new donors to increase donor base.
   - Increase acquisitions by 20%

Each team member maintains a portfolio of donors and are held accountable for:

- number of personal visits each year
- number of solicitations each year

[77] Ibid 4

Team members are assigned a region and are responsible for:

- Identification
- Qualification
- Cultivation
- Solicitation
- Stewardship of donors

I. Solicitation Strategies

A. Personal Solicitation Campaign

1. Board Solicitation

Time Frame:	September-December 2019
# of Prospects:	3
Goal: 100% giving; $3,000	
Method:	Personal solicitation. Request amounts based on donor history (one-time annual giving in lieu of multiple direct mail solicitations; these individuals will, however, get notice of special events)
Solicitors:	President of Saint Francis Foundation and Director of Development

2. Individual Solicitation

Time Frame:	July 2018 – Dec 2018
# of Prospects:	25-30 top individual donors, family trusts/foundations
Goal: $700,000;	60% renewals, 15% gift upgrades (received/pledged for FY 2018)
Method:	Personal solicitation by Development
Solicitors:	Associate Directors of Development (Four team members)

3. Individual Solicitation

Time Frame:	Jan 2019 – June 2019
# of Prospects:	25-30 top individual donors, family trusts/foundations
Goal: $700,000;	60% renewals, 15% gift upgrades (received/pledged for FY 2018)
Method:	Personal solicitation by Development
Solicitors:	Associate Directors of Development

B. Special Events through the Development Offices Events Coordinator.

1. Annual Event Name:

Time Frame: FY 2019-2020

# of Attendees: TBD

Goal: TBD

Method: TBD

2. Sponsor Night Name:

Time Frame: Fall 2019

# of Prospects: 250

Goal: 250

Method: Invite/host reception

C. Direct Mail

Each direct mail will have a different theme to encourage multiple gifts and to reach individuals with varied interests. Direct mail is the responsibility of finance director and fundraising assistant.

1. Christmas for Kids (DIRECT MAIL)

Letter to previous donors through Christmas for Kids (CFK), state/province, and CFK campaigns to encourage renewal in the 2019 campaign and possible gift upgrade

Time Frame: August-December 2019

# of Prospects: 10,000

Goal: $60,000 Cash $160,000 in kind

Method: Multiple Mail Appeals; newsletter articles, TV, publicity in workplaces

2. Kidz Kamp (DIRECT MAIL)

Time Frame: April 2019

# of Prospects: 1000

Goal: $32,000

Method: Multiple Mail Appeals X2; newsletter articles, radio, development

3. Gift Planning Marketing Appeal

Time Frame: Fall 2018/Spring 2019

# of Prospects: 1000

Goal: $100,000 Deferred

Method: Multiple Mail Appeals X2; development follow up

II. Strategic Goals (non-monetary goals impacting success of plan)

- Develop plan for ongoing recruitment/training of fundraising volunteers. Recruit a minimum of three (3) non-board volunteers to work in fund development (Development Council).
- Develop new prospects for both the personal solicitation campaign and direct mail solicitation; cultivate family foundations/trusts.
- Strengthen donor cultivation program and board and staff understanding of the purpose and process of cultivation.
- 100% giving by Saint Francis Community Services, Inc. and Foundation board, executive director, and key staff.
- 100% participation by board in some fundraising task, including cultivation of donors.
- Enhanced communications regarding fund development within the board and with prospects, including regular presentations at board meetings by fund development director.
- Actively involve Saint Francis staff in special events and fundraising activities.
- Strengthen coordination between Marketing, Church Relations, and Fund Development departments to further support fundraising efforts.
- Maintain systems for ongoing monitoring/evaluation of progress in all areas of fund development.

The Development team has identified and has been working with a pipeline of qualified individuals who have high capacity and affinity for the mission of Saint Francis. Our development team has immersed themselves in the communities they serve; they participate in civic groups, public events, and assume leadership roles in community organizations.

Saint Francis's Church Relations team engages churches of all denominations and shares the important work that is being done by Saint Francis. In return, several churches have hosted fundraisers, awarded grants, and directly given to programs and projects within Saint Francis.

Our eight-member Grants and Research Development Team actively seeks and is awarded federal, state, local, foundation, and corporate funding through successful grant applications. They have worked with state universities to research federal ACF and SAMHSA to assure best practices within child welfare and substance use disorders of parents of children in state custody.

The Grants team has worked with foundations in the Grant Island and North Platte area. They are actively learning the funding environment in the Eastern Service Area. According to the Foundation Center's Funding Directory[78], in the Omaha Metropolitan area alone there are 361 foundations.

[78] Foundation Directory Online, https://fconline.foundationcenter.org/fdo-search/

Saint Francis is a Title IV-E subrecipient in our Nebraska DHHS contract. We work to ensure that relative and kinship foster parents referred by DHHS complete licensing activities in order to maximize IV-E federal funding.

YTH Youth Service

YTH- 1 Specific strategies and interventions utilized to ensure young people nearing the age of majority (age 16 and above) are prepared to transition to adulthood.	Comply: X

Response:

Saint Francis's case management teams connect with Independent Living and Education Coordinators to develop services and strategies that engage youth in life skills trainings to prepare them for a successful transition to adulthood. Life skills development is important for youth in our care, and learning these skills becomes a major component of the youth's Case Plan as they reach the age of majority. Our philosophy is that learning life skills is a continual process adaptable to numerous environments in relative/foster care, residential living, or a permanent family.

We believe life skills are more easily learned when connected with practical and familiar everyday experiences and when learned with the support of relative/foster families or caring adult mentors. When the youth turns 14, case management teams help the youth develop a Learning Plan to begin teaching him or her the life skills needed for transition out of foster care. At this time, the Casey Life Skills Assessment (CLSA) is administered to guide the plan's development. The CLSA is for youth ages 14 and older, regardless of permanency goal, to provide a baseline upon which a Learning Plan and subsequent Transition Plan can be developed. The CLSA will outline areas to strengthen for independent living as well as skills that need to be prioritized and developed. The case management team will then work with the youth and their caregivers to identify tasks and goals to be completed that will address the youth's needs and increase their skill level. The CLSA is re-administered annually, or as needed, to track progress and make changes to the Learning Plan and/or Transition Plan that address the youth's skill development and new areas of focus.

The Transition Plan is guided by the youth's individual goals, the CLSA and other assessments, and the progress the youth has made in their Learning Plan. Each youth has the opportunity to develop a Transition Plan with a team of professionals to help him or her identify their goals and a strategic plan to reach those goals. Case management teams develop these plans in concert with the youth, their caregivers, biological parents if applicable, Independent Living and Education Coordinators, and their assigned PALS Specialist (from Central Plains) if applicable. It is important that the youth participate in developing their Learning and Transition Plan so that tasks and goals accurately reflect the youth's voice, choice, and goals. This empowers the youth to begin, with the guidance of positive adults in their lives, to make the decisions that will prepare them for successful adulthood.

Saint Francis has identified eleven domains that will help youth and caregivers work together to accomplish life skills tasks:

- Daily Living Skills and Home Maintenance
- Housing and Community Resources
- Mental Health Resources
- Money Management
- Health, Medical Care, and Personal Hygiene
- Personal Safety
- Work and Study Skills
- Personal Development
- Relationships and Communication
- Technology Access and Internet Safety
- Secondary Education Planning

The case management team will work with the youth and youth's care giver to identify domains in which the youth may improve. The caregiver can then work with the youth to develop these areas and review this improvement with the case manager. These hands-on activities and tasks can be provided as part of the monthly provider report sent to the youth's case management teams. Furthermore, a youth's life skills plan checklist and accomplishments, as well contact information to positive adults and others important to the youth, will be compiled and given to the youth or caregiver after permanency is achieved and can be referenced by the youth to review life skills strategies when needed.

In order to attend postsecondary educational programs, it is critical that young people preparing to leave foster care have their Driver License, their Social Security Number with card, Social Security benefits when eligible, and their FAFSA completed. Saint Francis Independent Living Coordinators will work closely with PALS Specialists from Central Plains Center for Services, the current provider for Nebraska John H. Chafee Independent Living and Education and Training Voucher (ETV), to ensure youth have these documents and have applied for educational funding opportunities.

Saint Francis staff will collaborate with the community to identify and develop local resources that promote independent living skills. These resources are detailed in the following subsections. Saint Francis case management teams, IL Coordinators, and Education Coordinators will also utilize programs and practices that provide evidence-based, trauma informed strategies to engage youth in healthy development of these skills. Utilized strategies, services, and programs include, but are not limited to, the following:

- *Trauma Systems Therapy (TST)-* designed for children and families for whom trauma is not only part of the past, but an ongoing part of their present and everyday life. It is designed for children and families facing ongoing stress in poverty, family and community violence, parental mental illness, and substance use. Frequently, these children receive care in service systems that are frayed and fragmented.
- *Youth Thrive-* Youth Thrive offers financial literacy curriculum for youth as well as opportunities to save money through a matching program. Youth Thrive teaches youth to open a savings/checking account, establish emergency funds, maintain credit score, and budget for items and activities. Also helps recruit support families and support systems.

- *Your Money Your Goals-* Developed by the Consumer Financial Protection Bureau. Prepares staff to answer youth's questions about financial responsibility.
- *The Opportunity Passport Program-* Provides education and incentives for youth to save money and develop healthy spending habits. Programs include teaching youth how use bank services, set financial goals, maintain positive credit history, rent housing, and smart purchasing and provides a 2:1 savings match rate for youth so that they may save money to purchase a car, make repairs, pay for education, or other items.
- *Youth Advisory Council)-* Monthly meeting facilitated by IL Coordinator. Youth who have already transitioned out of foster care can meet with those who are in the transitioning process. Meetings provide insight into service gaps or programs that could be developed to help youth succeed.
- *Healthy Empowerment Adolescent Relationship Training (HEART)-* An evidence-based skill-building program for youth ages 10-18 that educates youth about healthy relationships. This curriculum enhances the youth's five core competencies of social and emotional learning: Self-Awareness, Self-Management, Social Awareness, Relationship Skills, Responsible Decision Making.
- *Senior Services/Fatherhood Initiative Program-* Programs for pregnant or parenting teams to teach positive parenting skills and provide mentoring services.
- *Bridges to Independence (B2i)-* Coordinated by DHHS for young people between 19 to 21 years of age who are aging out of foster care. Provides a dedicated Independence Coordinator for qualifying youth, Health Care insurance if eligible through the Affordable Care Act or through Medicaid, and a monthly maintenance payment. Helps youth access resources available through DHHS.
- *Project Everlast-* Project Everlast is a grassroots effort that promotes using community resources to improve a youth's opportunities and networks for housing, transportation, health care

a. Exposure to employment opportunities

Saint Francis provides skilled and professional staff to connect youth in our care to education and employment opportunities in the community. Education and IL Coordinators partner with the youth's case management team to ensure that those in our care have maintained the required academic record to graduate high school, complete the GED, and explore college and other certificate or trade programs. Education and IL Coordinators connect with local and other resources as well as provide case management teams with the information and tools needed to guide youth in achieving their post-secondary education and employment goals (please see below for more details).

Employment life skills goals and tasks will be included in the youth's Case Plan. The case management team will work with the youth, the caregivers, and other natural supports and positive adults in the youth's life to develop an employment life skills plan that uses the youth's voice and choice to set goals and establish tasks to achieve those goals. This process begins with an employment assessment that determines the youth's aptitude and interests and includes work readiness tasks to promote skill development. Case management teams may assist in job searches, application and resume development, interview preparation (including professional attire and mannerisms), finding transportation options, promptness, filling out tax forms, and fulfilling job duties.

IL Coordinators and other Saint Francis staff will connect youth and their caregivers to appropriate community resources that will aid in their achieving employment and other independent living goals. Saint Francis has collaborative working relationships with many community providers that connect youth to employment services in Nebraska, and we will continue to make these connections. These resources include, but are not limited to, workforce centers, youth friendly employers, disability services, job readiness programs, Project Everlast, and PAL services.

Saint Francis staff will also connect youth who may have cognitive, physical, or other disabilities to community-based resources that offer specialized employment prep services and other programs not readily available in traditional job readiness programs. To provide employment services to this population, Saint Francis staff and IL Coordinators will be trained to work with DHHS to fulfill the roles and responsibilities outlined in the Nebraska Department of Education Vocational Rehabilitation and Opportunity Act of 2014.

Case management teams will refer youth ages 14 and older who have a disability and/or who are receiving services under an IEP based upon disability to appropriate education and employment resources as specified in the federal Workforce Innovation and Opportunity Act (WIOA) guidelines.

b. Driving and obtaining a driver's license

Learning to drive is an important and traditional rite of passage for most individuals transitioning into adulthood, and we believe that youth in foster care should experience this same opportunity. Obtaining a driver's license or being able to secure transportation on their own empowers youth to become self-sufficient adults capable of facilitating their own goals of independence. Urban areas often have a greater variety of transportation options, such as a bus system, while those in more rural areas rely on driving and car access to get to a job, important appointments, and other activities. Because of this, Saint Francis staff will work with youth to enhance their ability to use various forms of transportation, from public transportation to maintaining a driver's license, car, and car insurance as needed.

Saint Francis supports youth age 14 and older, who are legally and functionally able to do so, in obtaining a driver's permit or license as appropriate to their age and independent living goals.

Obtaining a driver's license can be difficult for youth in foster care. Often, youth do not have a car to practice with, and the cost of adding a teen driver to an insurance policy can be prohibitive for most caregivers.

IL Coordinators will assist case management teams to help youth enroll for driving programs offered in high schools or private driving schools, as well as work with the youth's natural support system, such as foster families, relatives, mentors, and other positive adult connections to facilitate the youth in accomplishing this task. As mentioned above, Saint Francis staff will help youth compile and secure the necessary documentation required to obtain and maintain their driver's licenses.

Examples of community-based resources that help facilitate youth in obtaining their driver's licensing and/or transportation include, but are not limited to, public school and private driver's education classes, the Nebraska Department of Motor Vehicles, Project Everlast, Opportunity Passport, Your Money Your Goals, Youth Thrive and other Home and Community Based Services (HCBS).

c. Laundry, cooking, hygiene

It is important for youth to learn basic, everyday living skills like cooking, cleaning, laundry, hygiene, and home repairs. Youth who aren't in foster care learn these skills through their family members as they grow up. Youth in foster care, especially those who have experienced multiple placements, may have had more difficulty in learning the basic life skills that most of us take for granted. We believe that learning these skills in a natural setting with the help of caregivers, like their peers who are not in foster care, can greatly help youth develop self-sufficiency in the home.

Saint Francis case management teams will collaborate with youth and caregivers to cultivate environments in which the youth has several opportunities to practice basic life, experiential, and social skills. This promotes the youth's ability to care for his or her self and function in the community. Caregivers and case managers may demonstrate these skills in the home or at local community resources such as laundry mats and grocery stores to promote hands-on training in the appropriate settings. The youth's skill level and areas of focus are determined by assessments such as the CLSA, observation during Worker/Child visits, and caregiver and youth feedback.

Saint Francis has worked with foster youth alumni to take part in a "life skills workgroup" to develop life skills checklists categorized by age that reflect their experiences in learning and applying life skills after transitioning out of foster care. This list can be shared with caregivers, foster parents, residential providers, and kinship and birth families. These checklists will ensure that the youth is receiving life skills education through hands-on activities that strengthen the youth's understanding of and competency in completing day to day tasks. The checklist can be updated and incorporated into the case management team's monthly provider report as well as become a part of the youth's "Life Book" (see CSM-1 for details on "Life Books").

d. Instruction on banking, checking, debt, and general financial capability knowledge

Nebraska is blessed to have a number of financial literacy opportunities available to young people preparing to transition out of foster care. Through Nebraska John H. Chafee Independent living and Education and Training Vouchers, young people will have an opportunity to participate in the Jim Casey Youth Opportunity Initiative and Opportunity Passport, a matched savings program that helps older youth and young adults improve their financial ability through financial literacy training. They can participate in Consumer Financial Protection Bureau's Your Money, Your Goals, a program designed to improve young people's financial empowerment through financial case management. Saint Francis will work closely with the PALS Specialists to engage young people in these training opportunities.

Financial literacy is a component of the youth's learning and transition plans and is developed by a Saint Francis IL case management team composed of an IL Case Manager, IL Support Worker, and IL Coordinator. The youth's financial knowledge is initially gaged using the Casey Life Skills Assessment, and necessary tasks to advance and develop financial skills can be updated and adapted to reflect the youth's age and functioning level, individual goals, and accomplishments. Saint Francis case management teams will connect with Central Plains Center for Services PALS Specialists to provide youth in our care to a variety of community resources, programs, and supports that increase financial literacy and empower youth to make positive financial decisions. Each program emphasizes the correlation between budgeting and stability and will provide the following:

- Encouragement of youth of working age to obtain a savings/checking account;
  - To overcome potential barriers posed by the need for co-signors, we seek out financial institutions that allow minors to open accounts without co-signors and refer youth to those institutions.
  - Youth are often assisted with saving money by our requiring them to save a certain percentage of their pay and hold the money for them until they discharge from their facility, so the youth has actual savings. This is great since youth do not always naturally want to save money.
- Assistance to children/youth who have an income source to:
  - Establish a savings plan and, if available, a savings account to manage independently (>14 years old)
  - Obtain a savings or checking account with a financial institution (18-22 years old); and
- Financial Literacy education and support that includes:
  - Obtaining and interpreting (and protecting, repairing, and improving) a credit score;
    - Saint Francis IL staff will assist each child 14 years or older in obtaining a consumer credit report. This will reoccur on an annual basis until the youth has achieved permanency.
  - Avoiding predatory lending practices;
  - Saving money and accomplishing financial goals through prudent financial management;
  - Using basic banking and accounting skills, including balancing a checkbook;
  - Using debit and credit cards responsibly;
  - Understanding a paycheck and items withheld from a paycheck; and
  - Protecting financial, credit, and identifying information in personal and professional relationships.

IL Coordinators will connect and collaborate with other local community resources and settings that offer financial education and hands-on trainings. Case managers and placement providers may use these tools and resources to educate and model life skills to youth. Such settings include banks, utility companies, grocery stores, auto sales and repair shops, apartments, and other venues. These presentations will be made available to youth on a frequent basis so that they may demonstrate and apply their learned skills in specific situations.

e. Housing

IL Coordinators will connect case management teams to tools that will help youth research and apply for housing resources as well as help the youth locate a safe place to live. Case management teams will help the youth plan and research various communities in which the youth is interested in living as a young adult so that the youth may become readily aware of the suitable and affordable housing options available to them. Case management teams will help the youth establish a housing plan several months ahead of the youth's exit from foster care so that he or she may have time to locate and complete housing applications. Case management teams will also assist in completing Section 8 housing applications ahead of time to help the youth get onto waiting lists.

IL Coordinators engage a variety of community stakeholders to provide youth with access to local resources that promote finding and maintaining safe and stable housing. In Nebraska we will work closely with the following organizations to help youth in our care achieve their housing goals: continuum of care committee, Department of Housing and Urban Development (HUD), PALS Services, B2i Program, and Project Everlast.

In Wichita, Kansas, we have worked closely with the Continuum of Care Committee to apply for HUD funding to house homeless youth and plan to do so in Nebraska as well. This group is a gathering of agencies interested in improving resources and access to those struggling to find safe and secure housing. If the Continuum of Care Committee is not developed in the Eastern Service area, Saint Francis will work with existing community resource groups to ensure adequate housing is available to young people aging out of foster care.

For young people to be self-sufficient, they need to know how to get assistance when they need help. This is particularly true for those young people who age out of foster care without a supportive adult in their lives. Project Everlast, through their Central Navigation and referral system, can help refer young people to resources that will help them secure appropriate housing and receive assistance in finding employment or even food. Saint Francis will work closely with Project Everlast and other community resources to educate young people in foster care about where to go to find housing, education, a job and resources for food, transportation, healthcare and mental health resources when they are on their own.

Natural resources for housing are also discussed with the youth, such as living with a relative, former foster parent, or trusted adult. When appropriate, our Kinship Workers will work in concert with DHHS to locate, engage, and assess natural family and kinship supports the youth may choose to live with after they leave our care. Please see CSM-1 for more details.

f. Contact information for relatives and supportive adults

Youth need the support and guidance of permanent supportive adult connections long after they exit from foster care to be successful in their adult lives. Saint Francis is dedicated to supporting youth in continuing and/or building those relationships; it is to the youth's benefit to have as many supportive connections as possible within their support network. This may include biological parents, relatives, former foster parents, teachers, coaches, and others with whom they have formed a positive relationships.

In Kansas's Wichita Region, we have succeeded in finding at least one responsible adult connection for 90.6% of youth aging out of foster care in FY18[79]. We will bring this same level of diligence to the Eastern Service Area as we strive to find a suitable mentors and positive adult connections for youth in our care.

Case management teams explore potential kinship and family caregivers upon referral if necessary, and we continue to perform kinship searches throughout the life of the case as needed, to connect youth in our care to stable influences. We encourage positive adults to participate in the youth's case management tasks and goals, and case managers have methods in which to engage supportive adults in the youth's transition process so that these connections may be maintained and continue beyond foster care.

[79] Ibid 3

Elements of the HEART (Healthy Emotions and Attitudes in Relationships) curriculum will be used during the life skills development training with youth and placement providers. Practicing the skills learned through the HEART program may help the youth recognize and maintain healthy relationships with positive adults and others important to him or her.

When maintaining relationships with biological family members is unattainable, Saint Francis uses strategies similar to kinship searches to connect youth to other community resources that promote positive family-like relationships.

Foster families are encouraged to become mentors, guides, and supportive presences in the lives of the youth coming into their homes. Youth are also given opportunities to expand their horizons and make connections through church, the Fostering in Faith program, YMCA, school activities, sports, 4-H, camps, Big Brothers Big Sisters, CASA, youth advisory councils, and others. Positive adult role models and mentors willing to support the youth throughout their adolescence and adulthood are often found in these community connections.

g. Physical and mental health

Saint Francis connects youth to necessary physical and mental health resources as part of their Case Plan. It is important that youth be able to stay connected to these services as they transition to adulthood as well as be familiar with the process of locating and acquiring other services to address their medical needs after they leave our care.

To maintain a youth's connection to medical services, Saint Francis staff will begin providing information about the Bridge to Independence (B2i) program offered through DHHS, and we will attend meetings with youth and B2i employees. This program assigns an Independence Coordinator to those young people who age out of foster care. The Coordinator will help young people enroll in Medicaid or help them find insurance through the Affordability Care Act so they can access health care for medical and mental health needs.

Young people will also receive education regarding accessing help through the Central Navigator in Project Everlast so that they may utilize this resource after leaving our care. Saint Francis will assist the youth in the basic skills needed to locate and schedule medical appointments, manage medication, complete paperwork to prevent lapses in medical coverage, and understand their medical rights and responsibilities.

For youth with identified complex needs, a Clinical Care Coordinator is assigned to support access to needed services. The Clinical Care Coordinator's role is to assist case management teams in assessing for and assuring appropriate referrals through a mental health liaison as well as collaborating with MCOs, CMHCs, vocational rehabilitation, or applicable providers that can serve the youth's identified needs. Children and youth with profound disabilities or other special needs that limit their ability to achieve age-appropriate life skills and self-sufficiency as adults, or those with debilitating conditions requiring long-term or life-long care plans, are referred to specialized community resources. Clinical Care Coordinators ensure youth are also assessed for HCBS waivers if applicable, refer youth for SSI, and coordinate with APS when transitioning to adult community support services.

Youth with intellectual/developmental disabilities who may be in need of a guardian and adult services are served by case management teams and IL coordinators who have extensive knowledge of the paperwork and timeframe requirements to move through this intricate process as quickly as possible.

The case management team and IL Coordinators work with the youth to complete an aged out medical application within the last few months prior to their exit from foster care and submit it immediately upon their release to avoid a lapse in medical coverage for the youth. These and other documents are secured and given to the youth or caregiver when exiting foster care. The youth are taught the appropriate way to maintain these documents for future use.

Pregnancy and parenthood are realities for some youth during their adolescence. Saint Francis staff supports the health of pregnant teens and their children by making sure they receive prenatal care. Saint Francis may utilize maternity group homes or foster homes that are trained to serve pregnant and parenting teens and can provide nurturance and guidance to new mothers.

Saint Francis offers support to young fathers through the Fatherhood Initiative program. Young fathers may also participate in a fatherhood program through the Mental Health Association.

h) Opportunities to visit colleges, explore certificate or trade programs, and complete the FAFSA

Education is a significant stepping stone on a youth's path toward self-sufficiency. Educational goals may be different for each youth depending upon their career interests, and their educational goals may change as they mature and expand their experiences. Saint Francis emphasizes the importance of graduating from high school and works with community resources to support that goal. Saint Francis staff strive to connect youth to secondary education programs that reflect and support the youth's individualized independent living goals, whether those be a community college or university, certificate or trade program, or other program that promotes professional skill development.

In order to attend postsecondary educational programs, it is critical that young people preparing to leave foster care have their driver's license, their Social Security Number with card, Social Security benefits when eligible, and their FAFSA completed. Saint Francis Independent Living Coordinators will work closely with PALS Specialists from Central Plains Center for Services, the current provider for Nebraska John H. Chafee Independent Living and Education and Training Voucher (ETV), to ensure youth have these documents and have applied for educational funding opportunities.

Education Coordinators work closely with the youth's case management team, actively participating in case planning and staffing as needed, to ensure that appropriate educational services are provided for youth age 13 and older. The Education Coordinator's role includes, but is not limited to, the following:

- Advocating for the youth to assure that proper educational services are provided during out of home placement
- Attending IEP's, 504 meetings, and other educational planning processes
- Maintaining educational data in case management systems
- Tracking and monitoring grades and credits for youth 17 and older
- Providing training for reintegration staff related to educational services and advocacy
- Assisting youth in arranging for GED and post high school education services.

Education Coordinators provide information to and consult with case management teams to provide services and supports to help the youth achieve academic success; they work to help youth maintain and track pre-graduation credits and academic accomplishments so that they may

graduate and be prepared to enter post-secondary schools and/or other training programs that promote professional skill development and employment stability. Education Coordinators may also assist the case management team or youth in filling out the appropriate paperwork, such as FAFSA or other enrollment forms, to apply for education services.

IL Coordinators will work with Central Plains PALS Specialists to facilitate and conduct visits and tours to colleges, trade or certification schools, and other post-secondary education sites; obtain and distribute resources and scholarship information to case management teams; and maintain working relationships with community-based resources that provide job skills training.

Saint Francis greatly values and understands the importance of both education and training in creating a stable home and achieving safety and well-being. We strive for every young person referred to our care to finish high school or complete the GED. We ensure that youth have the opportunity to attend college, vocational/trade school, or a specific career skill development training program. Youth who seek alternative education and non-traditional education settings are assisted in locating and obtaining the resources necessary to assure their academic success.

Saint Francis will work closely with Central Plains Center for Services to explore postsecondary opportunities for young people and to identify youth who qualify for services from Central Plains. We will also collaborate with Central Plains PALS Specialists to connect youth to programs and services that assist them in financing their education and succeeding in their chosen career as well as connect them to other employment opportunities in their communities. Such programs and services include, but are not limited to,

- Education and Training Vouchers (ETV) Program
- Opportunity Passport
- Youth Thrive
- Tutoring support service
- Authentic Youth Engagement
- Your Money, Your Goals
- Preparation for Adult Living Services Programs (PALS)
- Partnership for Youth Development and the Work Force Initiative and Opportunity Act (WIOA)
- Goodwill Industries

With these programs and services, eligible youth will be able to transition from foster care aware of employment and education options that will help them establish stability and develop professional skills that will promote their success as adults.

YTH- 2 Plan of how Saint Francis will administer and report on the National Youth in Transition Data (NYTD) Survey	Comply: X

Response:

As subrecipient, Saint Francis will report data for the National Youth in Transition Database (NYTD) for youth in our care beginning at age 17. Saint Francis Independent Living Coordinators will have this responsibility. The IL Coordinators have years of experience in

administering the survey in Kansas and ensuring the data is accurately reported. Newly hired IL Coordinators will be trained by experienced staff to make efforts to locate youth to ensure survey completion on youth required to be reported to the NYTD as well as cooperate with DHHS to administer, complete, and report NYTD surveys during each designated survey collection period.

YTH- 3 Development, implementation, and management of data for youth who are being provided independent living services.	Comply: X

Response:

Saint Francis currently utilizes an electronic Child Management and Information Systems (CIS/CMS) for data collection of placements and trend management, including placement needs. This custom-designed, intuitive, and user-friendly data management system is a cloud-based system that assures security and access regardless location across geographical locations. The CIS/CMS system is ideal for staff out in the field, as the system can be easily utilized via portable devices, and digitized forms will provide easy migration to other data systems, such as N-FOCUS, for ease of reporting for compliance with DHHS requirements and for the completion of Court reports. Saint Francis's Information Technology team is currently developing a secure, state-of-the-art electronic data management system for our services that is expected to launch mid-2019.

The Saint Francis Information Technology team, in conjunction with our Quality Assurance and Performance Improvement Departments, are able to modify our reporting system to comply with the standards and expectations of the State of Nebraska, this RFP, and N-FOCUS reporting methods (please see IST-1 for more details). This allows Saint Francis staff to capture information regarding case planning, service delivery, assessments, case review, and other needs, as well as communicate contract specific outcomes and provide Performance and Continuous Quality Improvement (please see CQI-1 for more details).

As stated in the Nebraska Full Service Case Management for Child Welfare Services RFP 5995 Z1, Section V.C.2.h, Saint Francis will develop and implement a system to record and report necessary information to ensure that youth transitioning into adulthood are provided the appropriate Independent Living Services. Saint Francis will submit a system plan and report template within thirty (30) days after award of subaward to record and report on the following:

- Number of youth referred to Saint Francis that are receiving IL Services
- Number of youth referred to a subcontractor/second tier Subrecipient for IL Services
- Number of youth eligible for IL services but who are not receiving IL services and the reasons for not providing services.
- IL services that each eligible youth is receiving each month
- Monthly summary of any community planning the Subrecipient participates in to prepare youth to become self-sufficient.

Saint Francis is familiar with the reporting requirement and the expectations of the State of Nebraska. We successfully manage reporting requirements for services that we currently provide in Nebraska, including Intensive Family Preservation, Intensive Family Reunification, Family Support and Visitation, and Agency Supported Foster Care. We will ensure that our data

system is compatible with this contract and will be programmed for the specific requirements of this contract.

YTH- 4 Understanding of normalcy activities, the activities' importance, and strategies that promote normalcy for youth in its care through the use of the Reasonable and Prudent Parent Standard [Preventing Sex Trafficking and Strengthening Families Act, at 5 U.S.C. §§ 552, 20 U.S.C. § 1001, 25 U.S.C. § 450b, 28 U.S.C. § 1738B and 534, 42 U.S.C. §§ 1301, 1315] when making decisions involving the participation of the youth in age or developmentally-appropriate activities that provide opportunities for youth to grow emotionally, socially, and developmentally and to have the most family-like experience possible.	Comply: X

Response:

Saint Francis works to help youth transition from foster care into successful adulthood by providing opportunities in which youth can engage in developmentally and age-appropriate experiences that strengthen healthy emotional and social development. Saint Francis understands the federal Preventing Sex Trafficking and Strengthening Families Act of 2014, and we will implement "Reasonable and Prudent Parenting Standards" to train foster parents on the appropriate way to make decisions affecting youth in their care regarding extracurricular, enrichment, cultural, social, sporting, and other normalcy activities.

The Saint Francis Supported Foster Care program currently works with DHHS local staff to develop Foster Care Recruitment and Retention Plans that are reflective of the types of foster parents needed to meet the unique needs of foster care youth. Saint Francis trains all affiliated foster homes on the Reasonable and Prudent Parenting Standards. We will use and train any subcontractors to use a "Reasonable and Prudent Parent Standard" to decide whether a child may participate in an unsupervised activity. Activities may include, but are not limited to:

- Participation in academic and non-academic extracurricular activities within the child's school;
- Allowing the child to visit with friends or attend regular social and recreational events;
- Supporting a child's employment efforts; and
- Participating in other activities agreed upon by the caregiver and the child, without the need to seek initial approval.

Saint Francis requires care givers and staff members to complete normalcy training prior to working with clients. Normalcy training includes information as to how and when to apply this standard and emphasizes how important it is for children in care to participate in age-appropriate activities and experiences that allow for healthy development and well-being. Through normalcy training, foster care families and other caregivers learn the importance of providing appropriate social and educational opportunities for youth so that they may grow emotionally, socially, and developmentally within the most family-like experience possible.

Youth in foster care should, as much as possible, have the same opportunities to experience the same childhood and adolescent milestones as other youth. This includes participation in such activities as sports and other extra-curricular events, school dances, employment and traditional high school graduation celebrations. Foster youth are also given the opportunity to develop community leadership skills and participate in youth councils.

We believe that young people taking an active role in their community is an activity that enhances self-advocacy and enables youth to enact positive social and programmic changes that may benefit their lives. Community involvement empowers youth to develop leadership skills as well as grow socially and emotionally. Working with adults to promote an idea or solve a problem enhances the protective and success factors for young adults. Facilitating youth who have transitioned from foster care in becoming peer mentors to younger youth in foster care through YOUTH ADVISORY COUNCIL meetings can help offer support to those struggling to gain independence also creates a self-supportive and compassionate community geared toward success.

Saint Francis offers other trainings, programs, and services that promote the understanding of normalcy activities and their effect on youth in foster care. Parent Resource Information, TIPPS-MAP and Healthy Empowerment Adolescent Relationship Training (HEART) are such trainings and programs. These resources teach skills that help caregivers build stable and culturally humble family-like environments as well as help case management teams and caregivers promote the social and emotional development of youth.

EDO Educational Outcomes

EDO- 1: Describe a plan of how Saint Francis will maintain and achieve educational outcomes for children it serves.	Comply: X

Response:

Saint Francis will provide the children and families of Nebraska's Eastern Service Area with a full continuum of care, not only related to foster care but also to prevention services aimed at strengthening families, thus the incidence of removal of Nebraska children from their homes. Whether the child remains in his/her home or is in out of home placement, Saint Francis endeavors to facilitate the best possible educational outcomes for children served. Assessments and close work with the family help ensure children will receive an education to meet their needs. More on this is explained in YTH-1.

Related internal data collection is a shared responsibility between Saint Francis Case Management teams, Provider Relations, Performance Improvement/Quality Assurance (PI/QA) staff, and IT. Please see CQI-1 to learn more about Saint Francis's data collection and analysis related to the Well-being Outcomes in the RFP and Operation Manual that are most directly related to this proposal section—"School Stability," "Completed 12th Grade," "Children receive adequate services to meet their needs," "Families have enhanced capacity to provide for their children's needs"—along with all outcomes related to the performance of this contract. Additionally, Saint Francis tracks the following related measure for children served in out of home placement (OOH), regardless of contract:

- <u>Educational Progression</u>
  Children in OOH placement for 365 days or longer will progress to the next grade level.

a. Foster Care/Out of Home Placement and Maintaining Home School

The children and families served deserve to have their voices heard in identifying and considering choices for relative/kinship placement and preserving the child's enrollment in his/her home school when possible. This is in line with mandates to place the child in the least restrictive and intrusive manner possible and strengthen families by involving them in the placement process to increase the likelihood that the child will be placed in a home with familiar caretakers who are in tune with the child's culture, lifestyle, and needs, and with whom the child already has a relationship.

As described in sections CSM-1 to CSM-4 and PLC-1 to PLC-3, Saint Francis recognizes the imperative to place children in the most familiar environment that can best meet the child's unique needs, in addition to increasing the chances for permanence and staying within their own home communities and schools, to reduce the potential for further trauma and provide as high of a degree of normalcy as possible. To this end, Case Management Team members will work with children and families to identify potential kindship/relative resources as placement options and prioritize the child's school home school placement when evaluating placement options, unless it it's determined that the child's home school doesn't meet the child's needs.

In the absence of appropriate kinship options, Placement Coordinators review available openings with foster families in the child's home community and school (or preschool) catchment area. The process considers a multitude of factors, including gender, race, ethnicity, culture, language, school needs (e.g. special education), community/family support systems, behavioral issues, supervision needs, daycare, after-school programs, health and dental care, medication management, access to mental health resources, self-sufficiency needs, and potential for permanency. Saint Francis's goal is to make the child's first placement the only placement until permanency is achieved.

Placing children in their home communities requires a healthy local foster and out of home care system that addresses the individual needs of children. Saint Francis will work with existing providers and develop a process to recruit and retain safe foster care families in Nebraska's Eastern Service Area. The community-based care network will work together recruit and retain foster families who are willing and able to maintain a child's cultural and ethnic connections, care for sibling groups, care for older youth, and care for children and youth with high emotional, mental, and behavioral challenges.

Since 2014, Saint Francis has participated in meetings with the National Center for Diligent Recruitment and has assisted in the development of the Diligent Recruitment Plan. As stated on their website, "diligent recruiting is a systematic process through which child welfare agencies recruit, retain and support foster and adoptive families that reflect the ethnic diversity of children awaiting placement." Saint Francis staff will continue to actively participate in future workgroups associated with the plan. Our approach to foster care home recruitment focuses on directly communicating the needs of children in out of home care to specific communities, potential adoptive families, local leaders, and stakeholders. Community engagement and foster parent recruitment are thoroughly discussed in ENG-1 and PLC-1 to PLC-3, respectively.

In situations where the child cannot be kept in his/her home school because it's not in the child's best interest, Saint Francis will assure that the child is enrolled in his/her new school immediately. Although Saint Francis cannot legally transfer school records to other schools, the child's Educational Coordinator will assist in coordinating the transfer of school records, to help assure the new school has all educational records as they become available. If the child's home school does best serve the child's needs and placement resources are not available within the school attendance/transportation boundary, Saint Francis will arrange for transportation so the child's school placement can be maintained. Case management teams will work closely with the child's school and the State to make this determination. Transportation arrangement is described in table EDO-1.A below.

EDO-1.A. Arranging Transportation
Steps taken to arrange transportation so that the child can remain in his/her home school—if in the child's best interest—include: • Working with the child's placement, to see if they can transport. They're paid mileage. • Collaborating with the school system to see if there is a way to get kids to the nearest bus route. • Coordinating with other resources, such as any local transportation programs. More on arranging transportation can be found in the next section, EDO-2.

Regardless of whether the child remains in his/her home school or is transferred to a school that meets the child's needs, Saint Francis will generate, and assure the child's school receives, the DHHS School Notification Letter both when a child becomes a state ward and when wardship ends. This helps assure that the school is notified of the child's situation and can collaborate with us regarding the child's needs and provisions for the child's safety. Likewise, when applicable, Saint Francis will complete the Educational Court Report attachment so the court remains apprised of educational matters that are of interest to the court.

Saint Francis Case Management Team representatives will attend all Individual Education Plan (IEP) or Multi-Disciplinary Team (MDT) meetings regarding the child and will review and include in the case file all grades, report cards, progress reports, IEP reports, etc. to document and help meet the child's educational needs. When applicable, we will also complete the Early Childhood Development referral and follow through with recommended services/assessments.

b. Unique Educational Needs

As outlined in section CSM-1, children entering care are assessed, via various methods, to determine a full battery of unique needs, including those related to education, and that information is used to create and update service plans. This is extremely important to furthering educational outcomes for youth served, as a child has a higher likelihood of being able to concentrate on educational pursuits if his/her other, more basic and priority, needs are identified and met. Those assessments are regularly reviewed by a case management team that includes an Education Coordinator, whose focus is on the educational outcome facet of children's needs and

gathering copies of the child's case plans, and birth certificate, as well as medical and educational/school information and other relevant details (see YTH-1).

The case management team also helps the child maintain a "Life Book," which is akin to a scrapbook and includes glimpses into the more intimate aspects to caring for the child. The Life Book typically contains items and information that is personal or meaningful to the child, such as photographs of family and friends, awards earned in school, notes and cards, artwork, and the like. The school information included in the Life Book can help give the child a sense of continuity and connected across possible school and/or family placement moves, providing them with valuable reminders of successes at school and of their academic potential, and giving the child's caregiver a personal foundation on which to keep building the child's confidence to remain engaged in school despite current circumstances. More on Life Books can be found in CSM-1. Per the Operation Manual, we will provide to the placement and care agency a "Statement of Disclosure" of all known information specific to the child, including medical, behavioral, and educational information, that is signed by the foster parent and retained in the child's file. This is yet another tool in the child's caregiver's collection to help ensure that education is promoted accordingly.

c. Furthering Educational Outcomes—Beyond Current School Attendance

As educational outcomes involve more than the child's current schooling, the following table EDO-1.B highlights how various services/activities within Saint Francis's full-service continuum contribute to improved educational outcomes for children/youth in foster care/out-of-home placement, while in care and beyond.

EDO- 2: Describe Saint Francis's knowledge of the Every Student Succeeds Act and how we will meet the requirements of this act	Comply: X

Response:

According to the DOE Non-Regulatory Guidance: Ensuring Educational Stability for Children in Foster Care, the educational needs of foster care are sobering:

> *"Children and youth in foster care represent one of the most vulnerable student subgroups in this country. Of the approximately 415,000 children in foster care in 2014, nearly 270,000 were in elementary and secondary schools. Studies find that children in foster care are much more likely than their peers to struggle academically and fall behind in school. Students in foster care at age 17 are also less likely to graduate from high school, with only 65 percent graduating by age 21compared to 86 percent among all youth ages 18 to 24. A recent study found that children in foster care in California scored lower on assessments and showed less progress in scores over time compared to peers of similar backgrounds who were not in foster care.*
>
> *Children in foster care experience much higher levels of residential and school instability than their peers; one study showed that 75 percent of children in foster care made an unscheduled school change in one school year, compared to less than 40 percent for children not in foster care. Unplanned school changes may be associated with delays in*

children's academic progress, leaving highly mobile students potentially more likely to fall behind their less mobile peers academically. Children experiencing this type of instability, including many students in foster care, are thus more likely to face a variety of academic difficulties."

According to the National Youth in Transition Database (NYTD) maintained by the U.S. Office of the Administration for Children and Families, Children's Bureau, the State of Nebraska experiences similar, but slightly lower, educational outcomes as described above, with 55% of youth aged 21 in Fiscal Year 2015 reporting a HS Degree or GED. Unplanned school changes are a hazard inherent in foster care placement, but Nebraska's insistence that the child only be moved from his/her home school if it's in the child's best interest to be placed in a different school, should facilitate fewer unplanned school changes than the national average.

a. Every Student Succeeds Act (ESSA)

To help address those sorts of disparities, Title IX Education for the Homeless Part A, Homeless Children and Youths was implemented in 2016-2017. According to the Act, reauthorized McKinney-Vento Homeless Assistance Act:

- Consideration should be given for children to remain in their same school when they are moved out of the catchment area;
- Transportation shall be arranged if it is in the best interest of the child to stay in the same school;
- Students will receive the credit accrual requirements for work completed; and
- There will be mandatory professional development for liaisons.

Saint Francis staff will work with the school system to ensure children in care receive educational resources according to individual need, which is a reflection of ESSA. The coordination shall include a discussion of how to ensure the child's stable placement in school, and if needed, how transportation will be provided to assure the child can stay in the same school.

All school-age children in foster care shall attend school as required by state law. The school shall be accredited by the Nebraska Department of Education. Saint Francis staff, the child's parents, and the child's foster, adoptive, or relative/kinship placement shall help children in care achieve the highest level of formal education the child is capable of completing.

As described in the previous section (EDO-1), continued enrollment in the child's current home school will be prioritized. When placed in foster care initially, or for subsequent foster care placement changes, school-age children shall be maintained in their own school unless the child's needs would be best met by transferring schools. The child's case management team collaborates with the appropriate parties to determine what school will be the most appropriate based on the best interest of the child. Placement in foster care shall take into consideration the child's proximity to their school of origin (sending school), the appropriateness of the educational placement, and whether transportation to the child's home school is necessary to achieve educational stability for the child.

When Saint Francis staff are informed of a child's placement change, which may involve moving from the child's home school, we will make the necessary contacts to start the BID process.

We will use the State and Federal Guidelines to implement a process required by the law. Kansas has been active in participating in the BID process and are a part of a Kansas Statewide workgroup with DCF Administration and Kansas Department of Education to continue to improve the process. We currently have a process in place in Kansas that helps the educational advocate and case team know who the point of contact is at each school and that a BID is needed.

A Best Interest Determination (BID) staffing, as defined in the *Every Student Succeeds Act* (ESSA), shall occur with the child's home school prior to each move to ensure educational stability and decide whether it is in the best interest of a child to remain in their home school.

The staffing will include a member of the case management team and the school district Point of Contact, or designee for the school district, along with other parties, as appropriate, to discuss what is needed to ensure educational stability based on the needs and the best interest of the child.

Additional persons with knowledge pertinent to the child's case may be invited to participate in the BID staffing in person or by providing written input to be considered.

The additional persons may include those shown in table EDO-2.A below:

EDO-2.A. BID Staffing – Additional Persons (as applicable)	
Biological parents, if parental rights are still intact	Educational Advocate
Foster Parents	Nebraska DHHS Staff
Guardian ad Litem	Court-Appointed Special Advocate

Participants in the BID staffing consider many factors, such as those shown in EDO-2.B below:

EDO-2.B. BID Staffing – Considerations	
Length of Time Enrolled in School of Origin	Participation in Extra-Curricular Activities
Learning Behaviors/Disabilities	Distance of New Placement from School of Origin
Safety Factors	EP or 504 Plan Services
Child Preference	Parent Preference, if parental rights are still intact
Child's Attachment to School of Origin	Placement of Siblings
Influence of School Environment/Climate	Availability and Quality of Services

CQI Continuous Quality Improvement

CQI-1: Describe Saint Francis's understanding of continuous quality improvement principles and its Continuous Quality Improvement approach to monitor and evaluate the quality of services, including services provided by subcontractors.	Comply: X

Response:

Continuous Quality Improvement (CQI) is a data driven program designed to evaluate processes and outcomes to ensure that the organization is achieving desired results. The CQI program utilized by Saint Francis contains the components of Quality Assurance (QA) and Performance Improvement (PI) and is continuously woven throughout Saint Francis's work and will be applied to all aspects of our work within Nebraska Eastern Service Area. These processes are overseen our Vice President of Innovation and System Improvement. QA and PI staff are independent of the case management teams and do not act as service providers; these employees will not have direct supervision, contact, oversight, or consultation on cases reviewed to avoid any conflict of interest.

Saint Francis QA systematically monitors and reports performance metrics to internal and external stakeholders. This process design allows for validation of quality work as well as the determination of processes or outcomes that are not producing desired or expected results. The QA team works with stakeholders to effectively define performance metrics and communicates with stakeholders through the production of reports that are tracked and trended overtime with the desired results or benchmarks. This approach allows for a quick response if results begin to decline, if a decline is noted in an area that is critical to quality, a PI process will be implemented.

Saint Francis's PI process is built on the foundation of the Lean Six Sigma (LSS) methodology. Lean Six Sigma is a process improvement strategy that aims to decrease waste and variance to produce consistent results through continuous quality improvement. Saint Francis retains a team of LSS certified Green Belts to act as consultants to address complex situations where the solution is unknown. Using a collaborative approach, the Green Belts can use their training and experience to provide an in depth look at the factors contributing to results and allow for interventions to be explored, implemented, and monitored for effectiveness.

For subcontractors, Saint Francis completes QA audits with providers to assess for compliance offering agreed upon services and for environment of care issues. If there are issues identified during this process, Saint Francis will work with the provider to develop an appropriate Action Plan to address the deficiencies.

CQI- 2: The bidder should describe how Continuous Quality Improvement will be used to meet or exceed state and federal performance indicators and outcomes that are detailed in Section V, subsection L of this RFP.	Comply: X

Response:

The QA process is responsible for the monitoring, evaluating, and reporting of performance metrics. Those metrics are agreed upon and defined in collaboration with state partners. QA staff partners with internal IT services to ensure that data is easily accessible to staff and delivered in an understandable format that allows for staff at every level to improve their performance. QA staff also act as a liaison with state-governed contracting entities and external partners to provide oversight and ensure that quality services are being provided. The PI process is responsible for engaging the workforce when desired outcomes are not being met.

To maintain environments of efficiency, compliance, and regulatory adherence, Saint Francis values the ability of Quality Assurance and Performance Improvement (QA/PI) and the use of data and information compiled from data to make program improvement decisions. Designated QA/PI staff systematically review and monitor program data, trends, and regional demographics on a regular basis. Daily, weekly, and monthly automated reports related to outcomes are distributed and reviewed with social workers, supervisors, directors, and members of management for use in supervision, program development, and performance improvement. Reports are organized by directors, offices, supervisors, and social workers so that data can be utilized for individual, local, and systemic decision-making that pertains to common issues/conditions and to shape training, practice, and performance improvement.

In the same manner as the other states Saint Francis is serving children in, we will utilize Nebraska's described outcomes listed in Section V, subsection L to build processes and reports. Those reports will then be distributed and made available to program staff who will use these reports to monitor the success of the program in meeting performance indicators and outcomes. When a performance measure or outcome is in decline, or when improvements are desired, a PI process is implemented. Using Lean Six Sigma methodologies, processes are examined to reduce waste and variance. Best practices are identified and implemented across the organization, results are monitored, and changes are made as needed utilizing a Plan–Do–Check–Act cycle (Figure 1).

Figure 1

UTZ Utilization Management

UTZ -1: Describe Saint Francis's understanding of Utilization Management and our approach to building a utilization management system within our organization.	Comply: X

Response:

a. Utilization of Care Review

Saint Francis employs consultation review meetings to evaluate the organization's most vulnerable children to ensure that children and families are receiving the best services and supports offered. Supports are tailored to meet the individual needs of each child and family. A three-tiered consultation approach is used, focusing time and energy in evaluating needs. At each consultation meeting, individuals familiar with the child's case come together as a team to actively plan for the next 90 to 180 days. Along with the consultation review process, a child's level of service is reviewed every 90 to 180 days.

The case management supervisor will determine what tier of review the child needs to achieve permanency in a safe, stable environment. The following levels of review are available:

1. **Placement Stability**

Goal:

1. Preserve the current placement of a child or sibling set – prevent disruption.
2. Prepare for planned move for child with disruptive behaviors.

Placement stability involves a conference call including, but not limited to, the following individuals: case manager, supervisor, foster parent, foster care worker, Director, Placement Coordinator, and Education Coordinator. The conference call will be facilitated by the Clinical Utilization Specialist. After reviewing the current situation, a plan of action will be distributed to all parties with tasks assigned. The plan will continue to be reviewed bi-monthly for two (2) months to monitor progress towards the identified goals. The case management team supervisor will be responsible for ensuring that there is progress made toward identified goals.

2. **Care Management Coordination (CMC)/Level of Service Review**

Goal:

1. Review of child's overall functioning based on a standardized assessment (Client Screening Tool or Medically Fragile Scoring Tool).
2. Review of the caregiver's service response based on a standardized assessment (Nebraska Caregiver Responsibility - NCR Tool)
3. Strategize possible interventions to improve overall functioning
4. Evaluate the appropriate level of service as it pertains to Level of Service payment to foster families.

Saint Francis respects and appreciates the challenges a youth presents, and the support foster parents provide for children in foster care. To that end, a two-pronged approach is used when

determining a Level of Service. A Client Screening Tool or Medically Fragile Scoring Tool within the last 30 days is essential for the review process in evaluating the needs of a child. Another essential to the review process is a completed NCR Tool. This tool evaluates the supports a foster family provides for the child.

The Case Manager, Team Supervisor, Director, Data Support Staff Supervisor, Placement Coordinator, Independent Living/Education Coordinator, Clinical Care Utilization Supervisor, CPA Foster Care Worker and Provider Relations/Clinical Utilization Coordinator participate in the review process. The Provider Relations/Clinical Utilization Coordinator will facilitate the meeting. A plan of action will be completed during the review process. The Placement Coordinator/designee will be responsible for taking notes during this process and sending the notes out to all parties that participated in meeting. These notes will be emailed to the participants of the meeting within 24 hours. The Team Supervisor will be responsible for ensuring the tasks on the plan of action are completed.

b. Level of Service/Rate Range Review

Essential – every 365 days, unless disputed by the sponsoring agency

Enhanced and Intensive – every 90 days

If a child has maintained placement for ninety (90) days at a particular level of service, the case will qualify for a review in their level of service. Provider Relations/Clinical Utilization staff monitor length of stays and level of service monthly as part of the consultation review meeting process.

Team Supervisors and Directors receive monthly spreadsheets with children placed at enhanced and intensive levels of service that need to be reviewed within the next month. Any siblings that are currently separated at time of consultation monthly review meeting will be staffed every 90 days as well.

Three (3) weeks before the scheduled consultation review date for each team, the provider relations staff will notify the Team Supervisor(s) and Director of those children needing a Level of Service Review. A notification will also be sent to the CPA for any foster family caring for a child that is being reviewed during that month.

The Child Screening Tool or the Medically Fragile Scoring Tool are essential tools used in the consultation review process. It is important that the trained individual assigned to complete the Child Screening Tool, or Medically Fragile Scoring Tool gets information regarding the child's needs and behaviors within the last 90 days. This includes gathering information from the Foster Home and/or facility the child has been placed with for the last 90 days. All parties involved with directly caring for the child within the last 90 days, will need to give their input as well. This includes, but not limited to, the Case Management Team, Foster Care Worker and Therapist.

The Nebraska Caregiver Responsibility Tool (NCR) is an essential tool used in the consultation review process. It is important that the trained individual assigned to complete the NCR Tool get information regarding the foster parent's services within the last 90 days. This includes gathering information from the Foster Home and the foster home's worker. All parties involved with or aware of the caregiver's response within the last 90 days, will need to give their input as well. This includes, but not limited to, case management team, Foster Care Worker and Therapist. It is the CPA's responsibility to inform the Foster Home and Foster Care Worker that the child's

level of service may be changing due to the combined score of the Child's Screening Tool or the Medically Fragile Scoring Tool score and the NCR.

If the child has been approved to be leveled down/up, Saint Francis will notify the placement provider with a letter via email providing them with a fourteen (14) day notice that the child's level of service change will be authorized.

3. High Acuity Clinical Care Consultations

Goal:

1. Provide clinical direction to a case to support the goal of permanency, evaluating the need and effectiveness of service provision.

Our Clinical Utilization team is involved in complex case staffing involving high-needs children and higher-acuity youth. Consultations are face to face meetings with the Clinical Utilization Specialist designed to be an in-depth discussion of the elements of a case and evaluation of services. The participants of the consultation are open to all parties involved in the case which could include the Case Manager, Supervisor, Director, Foster Care Worker, Foster Care Parent, and others. The Clinical Utilization Specialist will facilitate the meeting.

c. Subcontractor Network Affiliation and Utilization Review

In a concerted effort to monitor the safety and well-being of vulnerable youth in congregate care, we actively seek partnerships with an effective network of subcontractors. Our electronic management system links information from a child's placement history, monthly report and critical incident reports to a child's profile for rapid access. This proactive approach to working through challenging placement issues has minimized the confusion of subcontractors and strengthened the resolve to safely care for youth in out of home care.

As a child transitions to a new placement, the organization ensures placements are made minimizing trauma. To maximize the positive supports of residential placements and minimize time in congregate care, we are cultivating networks of relationships between residential placement providers and CPAs to jointly develop transition plans supporting efforts to successfully move children to family based care.

Saint Francis's reputation for supporting both CPAs and Residential Providers is steadfast. Partnering agencies receive a copy of our Provider Manual which will comply with Nebraska Administrative Regulations. Our organization has a Provider Relations unit of staff specifically dedicated to collaborating and assessing accountability with all subcontractors.

d. Respondent's Credentialing

Continually monitoring the providers caring for the children in out of home placement is essential to ensuring they receive the best possible care. There are two components of Saint Francis's on-site reviews. The first step is, 1) a file review of the records on the child and family personnel, and 2) an evaluation of applicable policy and procedures. This review will meet the established standards of DHHS.

The second step is an assessment of the physical site of the residential facility. Announced on-site reviews will occur annually for established providers; on-site reviews take place semi-annually, announced or unannounced, during the initial year of service for new providers. This

review will meet the established standards of DHHS. Saint Francis will conduct on-site assessments of residential care facilities and CPAs subcontracted with our organization.

Accountability visits will occur as needed with all providers in the network. This meeting is designed to strengthen partnerships through the review of both outcomes and risk management concerns.

Both on-site reviews and the accountability visits will result in a comprehensive report identifying trends and opportunities for improvement. If concerns arise related to the safety or stability of children, a Corrective Action Plan may be developed and monitored by Saint Francis for compliance. Our processes for the credentialing of on-site assessments are outlined in table UTZ-1.A. below.

UTZ-1.A. Saint Francis's Steps of Credentialing On-Site Assessments
All new providers go through an application process that is Saint Francis vetted in addition to the current Nebraska regulatory oversight agencies
Application packet includes enrollment application, copies of all applicable licenses, copies of any accreditations, certifications and DHHS provider agreement, copies of all liability insurance certificates, mission and program descriptions, and a completed W-9 form
Documentation is reviewed, site visit occurs, and if passing inspection, the following occurs:
• Draft agreement
• Copy of the Saint Francis Provider Manual (includes claims submission and processing manual, Saint Francis Critical Incident policy, Saint Francis Emergency Contact Phone Listing, and the Monitoring Tool developed by Saint Francis utilized to conduct quality reviews) is provided
• Rates and term negotiations are conducted
Contract agreed upon and signed
The process includes:
• A list of all critical incidents over the past year is reviewed by Provider Relations staff to pull trends
• Review of any resolved concerns and actions plans for the last year
• Review of any active concerns
• On site review of the environment, case reads of 10% of files, interviews
• Conversation over any situations of the last year
Following the site audit, provider receives a formal audit summary. The sum scores of file reads must result in a 90% or greater score; if below the 90%, an Action Plan is created with the provider to complete to resolution.

During the on-site visit, providers must provide the following documentation to pass file review:

- DHHS License
- All Notice of Survey Findings from DHHS since Saint Francis's last audit, including any Corrective Action Plans or summaries of finding from any notifications of noncompliance that were to be addressed
- Profession and General Liability Insurance
- Copies of:

- Insurance Card for each vehicle transporting Saint Francis youth
- Policy and Procedure manuals
- Youth Handbook
- Posted Behavior Management System
- Previous month's activity schedule
- Previous month's food menu
- Fire drill logs and posted evacuation route
- Tornado drill logs and posted tornado shelter area
- Current floor plan

Concerns of non-compliance resulting in an Action Plan will be developed with a timeline and dates for resolution of the concerns. When a Corrective Action Plan is developed, member roles and responsibilities for the activities to take place will be assigned. Saint Francis will work with the placement provider to complete the Action Plan and resolve any concerns by determining the root cause of the problem, helping to maintain assignments and timelines as needed, and providing ongoing feedback on the provider's progress in the plan. The plan is executed upon development.

When a Corrective Action Plan has not seen satisfactory progress, Saint Francis's Provider Relations staff will conduct a follow-up review to ensure unsatisfactory performance findings have been corrected. If performance improvements have not been made following the second audit, a Performance Improvement Plan will be submitted to the placement coordinator for consideration of further placements.

e. On-going Assessment of Subcontractors' Facilities & Quality of Care

In managing a network of providers, Saint Francis must have assurances that the children and families being served are receiving the best possible services and care. This starts with the development of trusting provider partnerships. Providers must be assured that Saint Francis is a true partner in seeking the best alternatives for the children and families served. Frequent contact with each provider will assist in managing services that are outcome-driven, data-informed, and performance-based. Saint Francis will implement a network-wide service management and outcomes measurement system, allowing evaluation of case progress and service program effectiveness. This system has proven effective in the other five states where we work with subcontractors.

New providers entering into partnership with the community-based care network will receive semi-annual site visits with regular and on-going training opportunities for their staff. Through the regular submission of data, they will receive performance monitoring and quality management. Quarterly site visits will include a review of the physical environment of the living arrangement and a review of 10% of the case files to ensure DHHS standards are met. If these standards have not been met, a Corrective Action Plan will address any shortcomings. The provider will be expected to formulate a plan to address any failures, and Saint Francis will monitor the plan to the satisfaction of both DHHS and our organization.

Saint Francis's Provider Relations Department's purpose is to work with all subcontractors providing placement and family services for children and families referred for services. The Provider Relations Department is in charge of securing safe, appropriate placements for children based on their needs as well as assuring quality family based services are provided to

maintain/reunify children safely in their homes. Eastern Service Area's Provider Relations Department is scheduled to be housed in Omaha. The staff are in charge of quality assurance for existing and new providers; steps for the Quality Assurance process regarding providers are outlined in table UTZ-1.B. below.

UTZ-1.B. Steps of the Quality Assurance Process
Periodic Audits are initiated throughout the agreement year as needed. Reasons for such reviews include, but are not limited to:
• Significant changes in the provider's service provision model
• Changes in the level or type of service provided
• Patterns of concerns that indicate questionable quality of services for children/families
• Significant incident that results in an injury or removal of a child
• Any action plan that is recommended or implemented by DHHS or any other state entity and/or accreditation body
These situations may be brought to the attention of the Provider Relations staff by the provider or any of the above noted agencies.
• Critical Incidents occurring during a provider placement/service
• All providers are required to report critical incidents to Saint Francis staff involving Saint Francis children/families as outlined in the Provider Manual
Provider Relations staff are informed in several ways:
• Saint Francis Risk Management department forwards all Critical Incidents to Provider Relations that occur in a subcontracting provider program
• The provider of the placement/family service may inform Provider Relations more directly
• Case Management staff will notify Provider Relations
• Depending on the nature of the critical incident, the frequency of critical incidents, and/or patterns per the provider, child placed, or family served, Provider Relations staff may conduct an audit by phone, written communication, or require a site audit.
Failure to Comply
• Failure to comply with developed actions plans, recommendations, or concerns surrounding a standard of care may result in suspension of referrals and/or removal of existing children until concerns are corrected.

f. Subcontractors' Data Collection

Data collection within our organization is a shared responsibility between case management teams, Provider Relations, QA/PI staff, and IT. Employees responsible for the collection of data include support staff and the various members of the case management teams. Thirty-day progress reports will document each child's adjustment in the home, provider facility and/or family services and will include, among other things, the following information: school performance (when applicable); medical, dental, vision and mental health appointments;

medication; critical incidents reported; employment progress; independent living documentation; interactions/visitation with parents; interventions; and any other significant events or issues related to the child, family and/or placement. Documentation will be attached to the monthly report when the child has experienced any of the following: medical, dental, or vision exams, other medical appointments, school IEP, school report cards, or a Safety Plan with the foster or biological parent regarding the child.

The 30-day progress reports shall be submitted to the Saint Francis Provider Relations Department no later than the 15th of each month following the reporting month, for all children who are in placement more than 15 days. Saint Francis will document all behavior concerns and behavior management interventions.

As the 30-day progress reports are gathered, information is collected and uploaded into the child management information system (CMS) and Child Placement System (CPS). Staff will have immediate access to updated information as soon as it is manually entered. This information will serve as the basis for each subcontractor's outcomes assessment. Saint Francis will monitor outcomes and trends monthly. Outcomes selected for monitoring will be directly related to the performance outcomes of the DHHS Contract, and/or those that affect the safety or care of a child in provider homes or facilities or show indications of problems with the subcontractor's standard of care. Each provider will be expected to participate in a monthly review of the outcomes and trends during individual monthly meetings as requested by the Saint Francis. We may request a performance improvement plan to address concerns.

g. Re-Credentialing Process

Quality assurance audits are conducted annually with subcontractors after the initial credentialing process, and results will be shared with compliance monitors to ensure that all subcontractors are meeting the terms of the Contract. The re-credentialing audit will consist of an on-site review of the program and a review of relevant documentation demonstrating the program is operating and in good standing (described previously above). Saint Francis staff will tour facilities, monitor the environment of care, and review a sample a minimum of 10% of all Saint Francis client files. Through this review, Saint Francis will determine if providers are offering the services outlined in their respective program descriptions. Saint Francis will review copies of licenses, accreditations, certifications and new compliance issues noted during the previous review period. Saint Francis will request an updated copy of the subcontractor's liability insurance coverage.

h. Complaints

For non-abuse/neglect complaints brought against the subcontractor, Saint Francis Provider Relations staff will gather all relevant information from the aggrieved parties and work with the subcontractor to determine the validity of the claim. If the subcontractor is found to be at fault through a violation of the contractual agreement, Saint Francis will seek to remedy the situation through a Performance Improvement Plan and monitor the plan's status through completion. As with Corrective Action Plans, roles and responsibilities of the plan's activities and prescribed timelines will be decided during the development of the plan, which will be implemented immediately upon finalization of the plan. Should the complaint not have merit, Saint Francis will share results of the inquiry with the aggrieved party and close the matter. In either case, DHHS will be informed of the determination of the complaint. If the complaints rise to a level

which compromises the safety of the parties involved, the Saint Francis Risk Management Team will intervene and will make immediate decisions regarding client placement, as well as continued use of the subcontractor in the immediate and extended future.

For more information on the complaint/grievance process, please see C&G-1 in the Complaint/Grievance Process section of this proposal.

In the event that a subcontractor issues a complaint related to a Saint Francis action, staff, or policy, administrators of both agencies will enter a dispute-resolution process to remedy the situation. Saint Francis will utilize Provider Relations staff, whose department is designed to assure quality delivery of service and timely receipt of complaints, to gather information and communicate results with the subcontractor through completion of the process. Level of Service disputes will be addressed through the Saint Francis Placement Coordination team in conjunction with a DHHS administrator to ensure appropriate levels of care for children in Saint Francis's care.

i. Results from Quality Reviews/Quality Assurance/Licensing Processes

Biannual quality assurance audits are conducted with subcontracting child placement agencies, placement facilities, and family service providers. The results are shared with DHHS annually. The audit includes an on-site review of the program and a review of relevant documentation demonstrating the program is operating and in good standing. These audits will include a review of the physical environment of the living arrangement. Saint Francis Provider Relations staff tour the subcontractors' facilities, monitor the environment of care, and review a sample of Saint Francis client files using standardized monitoring tool.

By reviewing a minimum of 10% of client files, Saint Francis can determine if subcontractors are offering the services and their ensuing processes outlined in program descriptions. Saint Francis reviews copies of licenses, accreditations, certifications, all recent regulatory survey results, and receives a copy of current liability insurance coverage.

Following the site audit, the subcontractor receives a summary of the review. If concerns of non-compliance are cited during a site review, a Corrective Action Plan is developed with a timeline and dates for resolution of the concerns. Saint Francis works with the subcontractor to complete the Action Plan and resolve any concerns. If necessary, Provider Relations conducts a follow up review to ensure that unsatisfactory performance findings are corrected. If performance improvements have not been made following the second audit, Provider Relations staff report the findings to the Vice President of Children and Family Services. DHHS may also be informed of the Corrective Action Plan's status at this time. Additional corrective measures including but not limited to discontinuation of service agreements may be considered as warranted.

Saint Francis monitors quarterly trends that may affect the safety and care of a child in subcontractor homes and facilities or show indications of problems with the agency's standard of care. If concerns are noted between quarterly monitoring, a report is run to address the subcontractor in question. After a risk assessment of critical incidents is reviewed by Provider Relations staff, Saint Francis will work with the subcontractor to develop a plan to address the concerns or challenges and help resolve the issues. Failure to complete or correct audit recommendations or standard of care findings may result in the suspension of referrals and/or removal of existing placements until the concerns are corrected.

A quarterly risk management conference call will be held between Saint Francis and the provider to assess the safety of children in a provider's care. A review of critical incident reports where a child is harmful to themselves or others, and the accompanying Provider response, is essential to ensure the safety of the children being served. If standards for care are not being met, a Corrective Action Plan, as detailed in Respondent's Credentialing above, may be implemented to ensure consistency in care of the children.

C&G Complaint/Grievance Process

C&G -1: Describe Saint Francis's complaint/grievance process.	Comply: X

Response:

Saint Francis's wealth of child welfare experience across multiple states is illustrative of our ability to:

- Provide quality service in compliance with state and federal legal and regulatory requirements, including those related to Civil Rights;
- Address concerns raised about service provision and quality; and
- Become fluent in state-specific requirements which may vary considerably from each other and from federal requirements.

a. Responsiveness to Concerns

Saint Francis is diligent in developing, implementing and adhering to organization-wide and program-specific policies that ensure client (children, youth, and families) rights are preserved, compliance with federal and state requirements, and adherence to our own standards of quality service.

These polices set forth guidelines for clients' rights to things that include rights to things such as:

- A clean, safe and healthy environment; respect and consideration; safety;
- Religious choice;
- Freedom from discrimination;
- Self-expression;
- Privacy;
- Informed consent; and
- Access to services.

Additionally, no one will be denied or delayed, service based on failure/inability to pay fees or contribute to the cost of that service. We also strive to create and maintain an environment in which affected individuals feel free to express concerns and grievances without fear of retribution or reprisal by those that are our subrecipients, second-tier recipients, or foster parents (Neb. Rev. Stat. § 81-603).

Upon award, the process that is described in this section will be tailored so that it is Nebraska-specific. This guidance will then be distributed to families and Foster/Kinship/Relative Family care providers, to let them know how they may lodge grievances related to the service provided by Saint Francis and/or its subrecipients or second-tier recipients.

As published in Saint Francis materials and posted in our offices, concerns may be reported via the state agency, phone call to Saint Francis's Customer Care Department (866-671-4735), the Saint Francis website (www.saintfrancisministries.org), or in-person communication.

We view addressing consumer concerns as an opportunity to correct problems which may be barriers to family reunification, permanence, and the safety/well-being of children. Our goal is to engage meaningfully in order to achieve the satisfaction of all stakeholders, including the child, birth families, kin, foster/adoptive parents, child welfare.

Community partners, direct care staff, and supervisors are encouraged to resolve concerns immediately at the lowest level, to facilitate communication and solicit feedback. They are empowered to make decisions in the best interest of the child and family, within a limited scope, in order to swiftly address concerns ahead of the official grievance process, and we assure their understanding of related requirements in relevant contracts.

Saint Francis's legal team is well-versed in federal and state requirements and communicating the same to Saint Francis organizational leaders and department/program staff, for dissemination to their employees. These individuals will assure that consumers are made aware of their Civil Rights and are provided the contact information for the relevant State of Nebraska and federal contracts, in the event the consumer wishes to file a related complaint directly with those agencies.

Regardless of with which agency the consumer grievance/complaint is filed, Saint Francis will collaborate to the extent possible with DHHS and any other investigating entities in the investigation and disposition of the complaint as well as designing and implementing related preventative measures.

We will notify DHHS, via the prescribed method and within the required time frame, of any Civil Rights complaint relating to our performance. We will do the same in such matters involving our subrecipients and any second-tier recipients as we become aware. Likewise, if and when we receive information regarding any suspected case of abuse, neglect, or exploitation we will promptly (within 24 hours) report those suspicions to the appropriate authority.

Saint Francis is committed to resolving the concerns of stakeholders and strives to respond as expeditiously as possible. Our typical goal is to follow up—in attempt to resolve the complaint and request additional information, if needed—within 24 hours. However, this time period is often much shorter, such as within a few hours or the same day. Therefore, Saint Francis is fully prepared and able to meet the ten (10) State business day time limit for responses to grievances, even if related investigation is still pending.

After a prompt, thorough review of the circumstances surrounding the concern, a formal response will be given. Documentation of the complaint and disposition process, including responses thereto, are stored electronically.

See IST-1 for more information on Saint Francis's data storage practices.

Following, on pg. 194 is Saint Francis's Consumer Response Model.

CONSUMER RESPONSE MODEL

CONCERN RECEIVED IN-HOUSE

SF notified of concern

SF contacts consumer within 24 hours.
Is the concern resolved?

Yes

Information is tracked and forwarded to:

- Local SF office
- SF Management
- Performance Imp. Team

No

SF Administrator/Customer Service Designee facilitates contact with all parties involved.
Is the concern resolved?

Yes

Information is tracked and forwarded to:

- Local SF office
- SF Management
- Performance Imp. Team

No

Individuals are advised of formal grievance procedures.

DHHS is advised.

CONCERN REFERRED FROM DHHS

Concern is generated through DHHS

SF is notified of the concern and due date of concern to DHHS

SF contacts consumer within 24 hours or sooner if needed.
Is the concern resolved?

Yes

Information is tracked and forwarded to:

- Local SF office
- SF Management
- Performance Imp. Team

DHHS will receive email notification of resolution within 5 working days or sooner if requested

No

SF Administrator/Customer Service designee facilitates contact with all parties involved
Is the concern resolved?

Yes

No

Individuals are advised of formal grievance procedures.

DHHS is advised

DHHS will receive email notification of outcome

b. Risk Management

Saint Francis's rigorous Risk Management System throughout all of its organizational levels, including individual programs, includes a database for managing data, reporting, and follow-up, and for investigating the root causes of adverse events. This system and process facilitates Saint Francis's monitoring and continuous improvement of service provision by Saint Francis and its subcontractors and second-tier recipients. Each program under the Saint Francis umbrella is expected to follow established policy and supporting procedures for reporting Serious Incidents to the Risk Management Department.

c. Organizational Structure

Our policies are designed to meet federal and state reporting requirements (regarding incidents, client care concerns, or sentinel/adverse events) applicable in all geographic locations where Saint Francis provides services.

Saint Francis has established a monthly Program Committee and quarterly Board Risk Management Committee, whose responsibilities include the following, as outlined in table C&G-1.A.

C&G-1.A. Responsibilities – Program Committee (monthly) & Board Risk Management Committee (quarterly)
Collecting, organizing, and measuring the performance of high-risk processes
Identifying and managing sentinel events
Facilitating changes that improve performance and client safety and reduce the risk of sentinel events
Managing safety risks in the environment of care

d. Responsibility

Saint Francis's Risk Management Department oversees all risk management activities for each program. Each program's administrative director is responsible for coordinating with the Risk Management Department by directly reporting, and ensuring that their staff directly report critical, significant or unusual incidents, and by reviewing any serious incidents/events occurring in that program.

e. Reporting

Understanding the behaviors of a child while in placement is essential to providing the best services to children and families. When a Critical Incident transpires, placement providers (residential and foster care agencies) are expected to communicate efficiently and effectively with Saint Francis's staff. All concerns and responses will need to be documented on either critical/significant/unusual incident reporting forms, as well as the child's monthly report as required.

Staff will assess if immediate action is needed to address the incident and will notify their supervisor when the incident is severe, significant, or has the potential for an adverse outcome. The supervisor will directly telephone contact the Risk Management Coordinator or the Director

of Risk Management and the program's Vice President. Staff will immediately notify the appropriate authorities of any allegation of abuse or neglect.

Staff enter the critical significant/unusual incident directly into the client's CIS/CMS database. This is completed as soon as possible after the incident or knowledge of incident. This data will be managed (stored, maintained, retained, etc.) according to DHHS and other IT-related requirements referenced in IST-1.

Upon learning of investigations by DHHS, the child's placement provider will notify Saint Francis immediately. If the allegation indicates a situation that threatens the well-being of a child, the foster family or residential facility will be placed "on hold" for placements.

Saint Francis will notify the child placement agency by email of the hold within 24 hours of the hold being placed. Saint Francis will not resume placement with the foster family or residential facility under investigation before receiving the following documentation:

a. All DHHS Findings
b. Staffing notes that include the following:
    i. Review date
    ii. Date and time of incident
    iii. Person(s) involved
    iv. Description of incident
    v. Identify harm or potential harm to the child(ren)
    vi. Precautions taken to minimize future incidents
    vii. Signatures of all staffing participants (one participant must be a licensed individual)

Additionally, pursuant to Attachment 2 – Eastern Service Area Operation Manual, Saint Francis will report to DHHS any licensing complaints or violations. In addition to working those complaints through the process described in this section, we will also "develop a corrective action plan as needed and document compliance of said plan on N-FOCUS." In situations where children in care go missing, Saint Francis will immediately inform DHHS and law enforcement and complete and deliver to a central office, a Protective Service Alert template.

The system review process is outlined in the below, table C&G.1.B.

C&G-1.B. System Review Process
Risk Management Department receives and reviews the critical/significant/unusual incident report in the CIS/CMS database.
A case number is assigned to each report.
Risk Management Department will transfer all information to a critical/significant/ unusual incident follow-up report for a system review when it appears that the standard of care was not met or requires an immediate notification.
Risk Management will designate one or more persons to conduct a peer review of the situation. This person(s) may or may not be a staff at the location in question. The peer review is completed by an employee with the same licensing, degree, or training as the employee listed as "responsible or observing the client" when the incident occurred.

C&G-1.B. System Review Process
Staff cannot perform their own peer review.
The peer review is intended to be an unbiased account of the incident in which documentation and interviews with the client or staff are detailed to provide a review of the system and therefore ultimately look for ways to improve client care by decreasing the likelihood of re-occurrence.
The critical/significant/unusual incident follow-up findings are entered into the database and presented to the Risk Management program committee.

In addition to the above description, the critical/significant/unusual incident reporting can deliver the critical incidents sorted by identifiers such as client, type, staff, site, and program. This allows for the administrative directors of programs to analyze the data in various ways to best improve case/treatment planning and program/service delivery.

Saint Francis is prepared to abide by all criteria and requirements included with, and referenced in, the RFP and, ultimately, contained in our contract with the State of Nebraska. We will provide DHHS with a monthly reports all grievances about the performance or actions of the Subrecipient made by children, families or constituents and stand ready to collaborate with DHHS to the extent possible regarding data monitoring and analysis related to the service of Saint Francis and its subcontractors that may indicate the need for intervention.

PBC Performance-Based Contracting

PBC- 1: The bidder should provide a plan on how it will enter into performance-based contracts with subcontractors to incentivize improved performance outcomes. The bidder must state a percent of the expenditures that will be performance-based.	Comply: X

Saint Francis will enter into performance-based contracts with subcontractors that include the determined performance outcomes outlined in the contract. Performance data will be maintained by Saint Francis through case specific case reads and outcome data gathering. Saint Francis's performance improvement team will monitor outcome compliance and trends. Development of performance improvement plans with the subcontractors will continue throughout the life of the contract to meet or exceed the standards. As we measure outcomes and quality of services, Saint Francis will partner with subcontractors to develop cost efficiency plans for implementation. Saint Francis will need to utilize the continuous improvement process to determine financial incentives for subcontractors. At this point in time, we do not have sufficient data to make a fair determination. If an award is presented to Saint Francis, we respectfully request that the percentage of expenditures that are performance-based will be negotiated for the subcontractors based upon their input, Saint Francis, and the State's experience and knowledge with the subcontractor's compliance.

Attachment 4
Business Associate Agreement

Saint Francis Ministries • 509 E. Elm Street • Salina Kansas 67401
785-825-0541 • Toll Free: 800-423-1342

ATTACHMENT FOUR

A. **BUSINESS ASSOCIATE AGREEMENT (BAA) PROVISIONS**

1. TERMS.
    a. BUSINESS ASSOCIATE. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to the party in this subaward, shall mean Subrecipient.

    b. COVERED ENTITY. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the party to this subaward, shall mean DHHS.

    c. HIPAA RULES. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

    d. OTHER TERMS. The following terms shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Unsecured Protected Health Information, and Use. The term Subrecipient shall have the meaning set forth in 2 CFR § 200.93 / 45 CFR § 75.2. Contractor as used herein shall mean the same as the term Subcontractor in the HIPAA Rules.

2. THE SUBRECIPIENT shall do the following:
    a. Not use or disclose Protected Health Information other than as permitted or required by this subaward or as required by law. Subrecipient may use Protected Health Information for the purposes of managing its internal business processes relating to its functions and performance under this subaward. Use or disclosure must be consistent with DHHS' minimum necessary policies and procedures.
    b. Implement and maintain appropriate administrative, physical, and technical safeguards to prevent access to and the unauthorized use and disclosure of Protected Health Information. Comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information, to prevent use or disclosure of Protected Health Information other than as provided for in this subaward and assess potential risks and vulnerabilities to the individual health data in its care and custody and develop, implement, and maintain reasonable security measures.
    c. To the extent Subrecipient is to carry out one or more of the DHHS' obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to DHHS in the performance of such obligations. Subrecipient may not use or disclosure Protected Health Information in a manner that would violate Subpart E of 45 CFR Part 164 if done by DHHS.
    d. In accordance with 45 CFR §§ 164.502(E)(1)(ii) and 164.308(b)(2), if applicable, ensure that any agents and contractors that create, receive, maintain, or transmit Protected Health Information received from DHHS, or created by or received from the Subrecipient on behalf of DHHS, agree in writing to the same restrictions, conditions, and requirements relating to the confidentiality, care, custody, and minimum use of Protected Health Information that apply to the Subrecipient with respect to such information.
    e. Obtain reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Subrecipient of any instances of which it is aware that the confidentiality of the information has been breached.
    f. Within fifteen (15) days:
        i. Make available Protected Health Information to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.524;
        ii. Make any amendment(s) to Protected Health Information as directed or agreed to by DHHS pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy DHHS' obligations under 45 CFR § 164.526;
        iii. Maintain and make available the information required to provide an accounting of disclosures to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.528.
    g. Make its internal practices, books, and records relating to the use and disclosure of Protected Heath Information received from, or created or received by the Subrecipient on behalf of the DHHS available to the Secretary for purposes of determining compliance with the HIPAA rules. Subrecipient shall provide DHHS with copies of the information it has made available to the Secretary.
    h. Report to DHHS within fifteen (15) days, any unauthorized use or disclosure of Protected Health Information made in violation of this subaward, or the HIPAA rules, including any security incident that may put electronic Protected Health Information at risk. Subrecipient shall, as instructed by DHHS, take immediate steps to mitigate any harmful effect of such unauthorized disclosure of

Protected Health Information pursuant to the conditions of this subaward through the preparation and completion of a written Corrective Action Plan subject to the review and approval by DHHS. The Subrecipient shall report any breach to the individuals affected and to the Secretary as required by the HIPAA rules.

3. TERMINATION.
   a. DHHS may immediately terminate this subaward and any and all associated subawards if DHHS determines that the Subrecipient has violated a material term of this subaward.
   b. Within thirty (30) days of expiration or termination of this subaward, or as agreed, unless Subrecipient requests and DHHS authorizes a longer period of time, Subrecipient shall return or at the written direction of DHHS destroy all Protected Health Information received from DHHS (or created or received by Subrecipient on behalf of DHHS) that Subrecipient still maintains in any form and retain no copies of such Protected Health Information. Subrecipient shall provide a written certification to DHHS that all such Protected Health Information has been returned or destroyed (if so instructed), whichever is deemed appropriate. If such return or destruction is determined by the DHHS be infeasible, Subrecipient shall use such Protected Health Information only for purposes that makes such return or destruction infeasible and the provisions of this subaward shall survive with respect to such Protected Health Information.
   c. The obligations of the Subrecipient under the Termination Section shall survive the termination of this subaward.

This Addendum and any attachments hereto will become part of the Contract. Except as set forth in this Addendum, the Contract is unaffected and shall continue in full force and effect in accordance with its terms.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the date of execution by both parties below.

State of Nebraska

By: ____________________

Name: ____________________

Title: Materiel Administrator

Date: ____________________

Contractor: Saint Francis Ministries Inc.

By: ____________________

Name: Thomas W. Blythe

Title: President and COO

Date: ____________________

State of Nebraska
Department of Health and Human Services

By: ____________________

Name: ____________________

Title: ____________________

Date: ____________________

Saint Francis
MINISTRIES

Attachment A
Audit

Saint Francis Ministries • 509 E. Elm Street • Salina Kansas 67401
785-825-0541 • Toll Free: 800-423-1342

Saint Francis Community Services, Inc., and Subsidiaries

Salina, Kansas

COMMUNICATION RELATING TO INTERNAL CONTROL MATTERS

June 30, 2018

K·COE ISOM

Board of Directors
Saint Francis Community Services, Inc., and Subsidiaries
Salina, Kansas

In planning and performing our audit of the consolidated financial statements of Saint Francis Community Services, Inc., a Kansas not-for-profit organization, and its wholly-owned subsidiaries (collectively, Saint Francis), as of and for the year ended June 30, 2018, in accordance with auditing standards generally accepted in the United States of America and standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, we considered Saint Francis' internal control over financial reporting (internal control) as a basis for designing auditing procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of Saint Francis' internal control. Accordingly, we do not express an opinion on the effectiveness of Saint Francis' internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of Saint Francis' consolidated financial statements will not be prevented, or detected and corrected, on a timely basis. A *reasonable possibility* exists when the likelihood of an event occurring is either reasonably possible or probable, as defined as follows:

- *Reasonably possible*: The chance of the future event or events occurring is more than remote but less than likely.
- *Probable*: The future event or events are likely to occur.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

This communication is intended solely for the information and use of management, the Board of Directors, and others within Saint Francis, and is not intended to be, and should not be, used by anyone other than these specified parties.

KCoe Isom, LLP

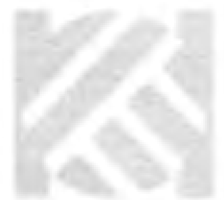
December 27, 2018
Salina, Kansas

Saint Francis Community Services, Inc. and Subsidiaries

Salina, Kansas

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION WITH INDEPENDENT AUDITORS' REPORTS

June 30, 2015



K·COE
ISOM

Saint Francis Community Services, Inc. and Subsidiaries
TABLE OF CONTENTS
June 30, 2015

	Page Number
Independent Auditors' Report	1
FINANCIAL SECTION	
Consolidated Statement of Financial Position	5
Consolidated Statement of Activities	7
Consolidated Statement of Functional Expenses	8
Consolidated Statement of Cash Flows	9
Notes to Consolidated Financial Statements	11
SUPPLEMENTARY INFORMATION SECTION	
Schedule of Expenditures of Federal Awards	27
Notes to Schedule of Expenditures of Federal Awards	29
OTHER REPORTS SECTION	
Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*	31
Independent Auditors' Report on Compliance for Each Major Federal Program and on Internal Control Over Compliance Required by OMB Circular A-133	33
FINDINGS AND QUESTIONED COSTS SECTION	
Schedule of Findings and Questioned Costs	38
Corrective Action Plan	44
Summary Schedule of Prior Audit Findings	45

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
Saint Francis Community Services, Inc. and its Subsidiaries
Salina, Kansas

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Saint Francis Community Services, Inc. (a Kansas nonprofit organization) and its wholly owned subsidiaries, which comprise the consolidated statement of financial position as of June 30, 2015; the related consolidated statements of activities, functional expenses, and cash flows for the year then ended; and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We did not audit the financial statements of HUD Projects No. 065-HD015-CA and No. 065-HD025-CA of Bridgeway Apartments, Inc., a wholly-owned subsidiary, whose statements reflect total assets of $1,085,160 as of June 30, 2015, and total support and revenues of $181,600 for the year then ended. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Bridgeway Apartments, Inc. HUD Projects No. 065-HD015-CA and No. 065-HD025-CA, is based solely on the report of the other auditors. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

INDEPENDENT AUDITORS' REPORT
(Continued)

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audit and the report of other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Saint Francis Community Services, Inc. and its wholly owned subsidiaries as of June 30, 2015, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Summarized Comparative Information

We have previously audited Saint Francis Community Services, Inc. and its wholly owned subsidiaries' consolidated financial statements as of for the year ended June 30, 2014, and we expressed an unmodified audit opinion on those audited consolidated financial statements in our report dated December 29, 2014. In our opinion, the summarized comparative information presented herein as of and for the year ended June 30, 2014, is consistent, in all material respects, with the audited consolidated financial statements from which it has been derived.

INDEPENDENT AUDITORS' REPORT
(Continued)

Other Matters

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements referred to in the first paragraph taken as a whole. The accompanying supplementary information, listed as supplementary information in the table of contents, is presented for purposes of additional analysis and is not a required part of the above consolidated financial statements. The schedule of expenditures of federal awards is required by the Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated January 8, 2016, on our consideration of Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' internal control over financial reporting and compliance.

KCoe Isom, LLP

January 8, 2016
Salina, Kansas

FINANCIAL SECTION

Saint Francis Community Services, Inc. and Subsidiaries
CONSOLIDATED STATEMENT OF FINANCIAL POSITION

June 30		2015		(Summarized) 2014
ASSETS				
Current Assets				
Cash and cash equivalents (note 2)	$	14,228,610	$	17,297,483
Accounts and contracts receivable (note 3)		8,275,266		7,820,918
Unconditional promises receivable (note 4)		247,440		583,526
Prepaid expenses		145,984		148,135
Other current assets (note 2)		394,281		480,707
Total Current Assets		23,291,581		26,330,769
Property, Plant, and Equipment (note 8)		12,418,128		8,220,551
Other Assets				
Unconditional promises receivable (note 4)		2,932		3,438
Note receivable (note 5)		59,000		59,000
Investments (notes 6 and 7)		8,329,606		8,701,114
Beneficial interest in split-interest agreements and perpetual trusts (note 7)		321,930		331,989
Land - life estate (note 19)		167,000		167,000
Other assets		891		891
Total Other Assets		8,881,359		9,263,432
TOTAL ASSETS	$	44,591,068	$	43,814,752

The accompanying notes are an integral part of these financial statements.

Saint Francis Community Services, Inc. and Subsidiaries

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
(Continued)

June 30	2015	(Summarized) 2014
LIABILITIES AND NET ASSETS		
Current Liabilities		
Accounts payable	$ 6,185,233	$ 4,901,915
Current maturities of gift annuities payable (note 11)	395	402
Accrued salaries, fringe benefits, and security deposits	2,044,743	3,061,968
Total Current Liabilities	8,230,371	7,964,285
Long-Term Obligations, less current maturities		
Gift annuities payable (note 11)	8,390	8,785
Life estate liability (notes 7 and 19)	26,001	29,714
Total Long-Term Obligations	34,391	38,499
Deferred Revenue	7,904,682	6,913,561
Net Assets		
Unrestricted	17,723,047	16,722,395
Unrestricted - board directed (note 12)	22,230	958,159
Unrestricted - board directed quasi endowment (note 12)	3,929,282	4,075,856
Temporarily restricted (note 13)	3,529,686	3,922,484
Permanently restricted (note 14)	3,217,379	3,219,513
Total Net Assets	28,421,624	28,898,407
TOTAL LIABILITIES AND NET ASSETS	$ 44,591,068	$ 43,814,752

The accompanying notes are an integral part of these financial statements.

Saint Francis Community Services, Inc. and Subsidiaries

CONSOLIDATED STATEMENT OF ACTIVITIES

Year Ended June 30	Unrestricted	Temporarily Restricted	Permanently Restricted	2015 Total	2014 (Summarized) Total
CHANGES IN NET ASSETS FROM OPERATIONS					
Operating Revenues					
Net maintenance revenue (note 15)	$89,738,259	$ -	$ -	$89,738,259	$82,438,331
Grant income	1,636,741	-	-	1,636,741	1,555,338
Total Operating Revenues	91,375,000	-	-	91,375,000	83,993,669
Operating Expenses					
Program services	82,379,716	-	-	82,379,716	77,143,188
Fundraising	608,212	-	-	608,212	488,162
Management and general	9,828,982	-	-	9,828,982	9,031,204
Total Operating Expenses	92,816,910	-	-	92,816,910	86,662,554
CHANGES IN NET ASSETS FROM OPERATIONS	(1,441,910)	-	-	(1,441,910)	(2,668,885)
NONOPERATING CHANGES					
Gifts and Bequests					
Contributions	737,519	271,082	-	1,008,601	1,313,631
Legacies and bequests	82,472	-	-	82,472	552,653
Net assets released from restrictions	387,055	(387,055)	-	-	-
Total Gifts and Bequests	1,207,046	(115,973)	-	1,091,073	1,866,284
Other Income					
Investment income	281,877	-	199	282,076	321,004
Gain on sale of assets - net	103,154	79,567	-	182,721	82,211
Change in value of securities, split-interest agreements and life estate (note 6)	(363,509)	(356,392)	(2,333)	(722,234)	948,947
Other income - net	131,491	-	-	131,491	167,777
Total Other Income	153,013	(276,825)	(2,134)	(125,946)	1,519,939
TOTAL NONOPERATING CHANGES - NET	1,360,059	(392,798)	(2,134)	965,127	3,386,223
Total Change in Net Assets	(81,851)	(392,798)	(2,134)	(476,783)	717,338
Net Assets - Beginning of Year	21,756,410	3,922,484	3,219,513	28,898,407	28,181,069
Net Assets - End of Year	$21,674,559	$3,529,686	$ 3,217,379	$28,421,624	$28,898,407

The accompanying notes are an integral part of these financial statements.

Saint Francis Community Services, Inc. and Subsidiaries
CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES

Year Ended June 30	Program Services	Fund-raising	Management and General	2015 Total	2014 (Summarized) Total
EXPENSES					
Salaries and Related Expenses					
Salaries and wages	$25,898,902	$239,220	$ 5,300,362	$31,438,484	$30,899,152
Employee health and retirement benefits	4,846,615	33,472	929,200	5,809,287	3,732,238
Payroll taxes and unemployment compensation	2,025,455	18,494	382,015	2,425,964	2,036,019
Employee moving and living allowance	1,050	-	64,153	65,203	1,841
Total Salaries and Related Expenses	32,772,022	291,186	6,675,730	39,738,938	36,669,250
Other Expenses					
Patient services	3,852,030	-	470	3,852,500	3,422,920
Program expenses	222,360	-	481	222,841	169,736
Office and communication expense	1,854,516	36,124	553,223	2,443,863	2,026,990
Advertising and direct mail	346,191	116,091	66,243	528,525	467,758
Transportation and vehicle expense	1,294,221	7,384	70,636	1,372,241	1,544,086
Staff development expense	124,323	13,555	125,033	262,911	203,936
Contract services	36,485,232	90,607	860,814	37,436,653	35,557,691
Travel and public relations	1,974,619	28,302	329,658	2,332,579	2,183,073
Board of directors	-	-	20,271	20,271	15,218
Accreditation fees	2,508	-	2,508	5,016	16,436
Occupancy	1,412,331	4,146	333,480	1,749,957	1,590,006
Insurance	742,053	4,435	200,764	947,252	850,582
Depreciation (note 8)	1,089,823	12,820	471,714	1,574,357	1,615,800
Interest	-	-	1,075	1,075	1
Miscellaneous	207,487	3,562	116,882	327,931	329,071
Total Other Expenses	49,607,694	317,026	3,153,252	53,077,972	49,993,304
TOTAL EXPENSES	$82,379,716	$608,212	$ 9,828,982	$92,816,910	$86,662,554

The accompanying notes are an integral part of these financial statements.

Saint Francis Community Services, Inc. and Subsidiaries

CONSOLIDATED STATEMENT OF CASH FLOWS

Year Ended June 30	2015	(Summarized) 2014
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from patients and third party payors	$ 90,275,032	$ 79,434,167
Cash received from grants	1,684,841	1,713,362
Receipts of gifts and bequests	1,146,781	1,068,864
Interest and dividends received	230,939	269,391
Miscellaneous receipts	169,817	142,619
Cash paid to employees and suppliers	(90,730,458)	(83,592,781)
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	2,776,952	(964,378)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of property and equipment	(5,769,439)	(2,689,168)
Purchase of investments	(5,002,110)	(4,352,623)
Proceeds from sale of property and equipment and other assets	52,915	74,436
Proceeds from sales and maturities of investments	4,873,211	4,233,786
Payments received for principal of notes receivable	-	48,681
Loan to related party	-	(59,000)
NET CASH PROVIDED BY (USED IN) INVESTING ACTIVITIES	(5,845,423)	(2,743,888)
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments of annuity obligations	(402)	(1,646)
Payment of accounts payable that financed equipment acquisitions	-	(355,756)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	(402)	(357,402)
Net Increase (Decrease) in Cash and Cash Equivalents	(3,068,873)	(4,065,668)
Cash and Cash Equivalents - Beginning of Year	17,297,483	21,363,151
Cash and Cash Equivalents - End of Year	$ 14,228,610	$ 17,297,483

The accompanying notes are an integral part of these financial statements.

Saint Francis Community Services, Inc. and Subsidiaries

CONSOLIDATED STATEMENT OF CASH FLOWS
(Continued)

Year Ended June 30		2015		(Summarized) 2014
RECONCILIATION OF CHANGE IN NET ASSETS TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES				
Change in Net Assets	$	(476,783)	$	717,338
Adjustments to Reconcile Net Earnings to Net Cash Provided By (Used In) Operating Activities				
Annuity interest reinvested		(51,331)		(51,777)
Depreciation		1,574,357		1,615,800
Provision for bad debts (recovery)		25		(945)
Noncash gifts and bequests		-		(69,538)
(Gain) loss on disposition of investments		(164,344)		(39,337)
(Gain) loss on disposition of property and equipment		(18,377)		(42,874)
(Increase) decrease in fair market value of investments		716,082		(903,848)
(Increase) decrease in fair market value of split-interest agreements and perpetual trusts		1,221		(50,539)
(Increase) decrease in fair market value of contributions receivable - Gift annuities		8,838		(5,871)
Increase (decrease) in fair market value of life estate liability		(3,713)		11,475
(Increase) decrease in:				
Accounts and contracts receivable		(454,373)		(3,945,789)
Unconditional promises receivable		336,592		(474,308)
Prepaid expenses		2,151		(40,503)
Other current assets		86,426		132,866
Increase (decrease) in:				
Accounts payable		1,246,285		1,349,307
Annuities payable		-		1,236
Accrued salaries and fringe benefits		(1,017,225)		(109,641)
Deferred revenue		991,121		942,570
Total Adjustments		3,253,735		(1,681,716)
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	$	2,776,952	$	(964,378)
SUPPLEMENTARY SCHEDULE OF NONCASH INVESTING AND FINANCING ACTIVITIES				
Noncash gifts and bequests				
Equipment	$	-	$	5,000
Securities and mineral interests		-		64,538
Total noncash gifts and bequests		-		69,538
Other noncash investing and financial activities are as follows:				
Equipment purchases financed through increases in accounts payable	$	37,033	$	-

The accompanying notes are an integral part of these financial statements.

1. NATURE OF ACTIVITIES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Activities Saint Francis Community Services, Inc. and its wholly-owned subsidiaries, collectively known as SFCS, are not-for-profit, child welfare organizations, with a mission to be an instrument of healing for children, youth, and families in spirit, mind, and body, so they live responsibly and productively with purpose and hope. SFCS currently operates in the states of Kansas, Oklahoma, Nebraska and Mississippi.

Under the terms of the bylaws and the operating agreements established by the parent and subsidiary corporations, the parent corporation, as sole member of each of the subsidiary corporations, elects the Board of Directors of each subsidiary corporation.

Income Tax Exemption SFCS is exempt from federal income taxes under the provisions of Section 501(c)(3) of the Internal Revenue Code and the entities are not private foundations. SFCS files a Federal Exempt Organization Income Tax Returns. SFCS follows the provisions of an accounting standard for accounting for uncertainty in income taxes. SFCS believes that it has appropriate support for any tax positions taken, and as such, does not have any uncertain tax positions that are material to the financial statements.

SFCS is no longer subject to U.S. Federal income tax examinations by tax authorities generally for a period of three years after filing of the tax returns.

Principles of Consolidation The accompanying financial statements include the accounts of Saint Francis Community Services, Inc. and its wholly-owned subsidiaries Bridgeway Apartments, Inc., Saint Francis Community and Residential Services, Inc., Saint Francis Community Services in Mississippi, Inc., Saint Francis Community and Family Services, Inc., Saint Francis Community Services in Nebraska, Inc. and Saint Francis Community Services in Oklahoma, Inc. All significant intercompany transactions have been eliminated in the consolidation.

Financial Statement Presentation SFCS reports information regarding its financial position and activities according to three classes of net assets:

- *Unrestricted Net Assets*: Net assets that are not subject to donor-imposed stipulations.
- *Temporarily Restricted Net Assets*: Net assets subject to donor-imposed stipulations that may or will be met by actions of SFCS and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions.
- *Permanently Restricted Net Assets*: Net assets subject to donor-imposed stipulations that they be maintained permanently by SFCS.

Use of Estimates The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash Equivalents For purposes of the consolidated statement of cash flows, SFCS generally considers all highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents.

Accounts and Contracts Receivable Accounts and contracts receivable are stated at unpaid balances, net of allowances for uncollectible accounts and contractual adjustments. The allowance for uncollectible accounts is established through provisions charged against revenue and is maintained at a level believed adequate by management to absorb estimated bad debts based on historical experience and current economic conditions. Accounts and contracts receivable are considered past due based upon payment terms set forth at the date of the related service provided.

Note Receivable Note receivable is presented at the outstanding unpaid principal balances less an allowance for credit losses. The allowance for credit losses on the note receivable is established through provisions for losses charged against revenue. The allowance for credit losses on notes receivable is maintained at a level believed adequate by management to absorb estimated probable credit losses. Management believes that the note receivable is fully collectible; therefore, there is no allowance for credit losses.

Property, Plant, Equipment, and Depreciation Property, plant and equipment acquisitions are recorded at cost if purchased or at fair market value on the date of the gift if donated. SFCS capitalizes property and equipment with a useful life greater than one year and cost in excess of $4,000. Depreciation expense is determined using the straight-line method over the estimated useful life of each depreciable asset.

Investments Investments in equities and mutual funds with readily determinable fair values are reported at their fair values in the consolidated statement of financial position. Unrealized gains and losses are reported in the consolidated statement of activities as increases or decreases in net assets.

The unrealized gains and losses are allocated to the unrestricted net assets unless specifically restricted by the donor. Short-term investments are stated at cost, which approximates fair market value.

Beneficial interest in split interest agreements and perpetual trusts Split-interest agreements, the assets of trusts that are irrevocable by the grantor, are included in the consolidated statement of financial position. The assets are recorded at the present value of the expected future cash receipts from the trusts' assets.

Donors have established charitable gift annuities with a third-party and named SFCS as the beneficiary. The present value of the expected future cash receipts from these annuities has been recorded as an asset.

Gift Annuities Payable Certain donors have entered into charitable gift annuities directly with SFCS. These annuities are accounted for using the actuarial method. Assets are recorded at the fair market value at the date of the receipt. Liabilities for future annuity payments are recorded at present value, based upon IRS life expectancy tables.

Fair Value Measurement SFCS determines the fair value of investments using three broad levels of input as defined by related accounting standards. The accounting standards define a fair value as the

price that would be received for an asset or paid to transfer a liability in an orderly transaction between market participants on the measurement date.

- Level 1 - Observable inputs - unadjusted quoted prices in active markets for identical assets and liabilities;
- Level 2 - Observable inputs - other than quoted prices included in Level 1 that are observable for the asset or liability through corroboration with market data; and
- Level 3 - Unobservable inputs - includes amounts derived from valuation models where one or more significant inputs are unobservable.

The following is a description of the valuation methodologies used for assets and liabilities to measure fair value. There have been no changes in the methodologies used during the years ended June 30, 2015 and 2014.

Equities, Mutual Funds and Other Investments: These investments are stated at fair value based on quoted prices in active markets for similar investments and other relevant information.

Annuities: Annuity contracts are value based upon the cash surrender value balance provided by the issuer of the annuity as of June 30, 2015.

Greater Salina Community Foundation: The account held at Greater Salina Community Foundation is valued based upon information provided by the Foundation. SFCS considers the measure of this account to be a Level 3 measurement within the fair value measurement hierarchy because the significant inputs are unobservable. (See note 10.)

Beneficial Interest in Perpetual Trusts: SFCS has beneficial income interests in perpetual trusts administered by third parties. The income earned from these trusts is available for organizational purposes as determined by donor restrictions. Beneficial interests are recognized in the financial statements at the fair market value of net assets held in the trusts, which approximates the present value of the future cash flows of the trusts using a discount rate of 2%. SFCS considers the measurement of its beneficial interest in the perpetual charitable trust to be a Level 3 measurement within the fair value measurement hierarchy because even though the measurement is based on the unadjusted fair value of trust assets reported by the trustee, SFCS will never receive those assets or have the ability to direct the trustee to redeem them.

Charitable Remainder Trusts and Gift Annuities: SFCS has a beneficial interest in charitable remainder trusts and charitable gift annuities administered by third parties. Charitable remainder trusts and gift annuities are valued using an income approach based on calculating the present value of the projected futures distributions expected to be received. SFCS re-measures the fair value of these investments annually and adjusts the measurement inputs based on statements received from the trustee, market conditions, and other relevant data including donor life expectancy and a discount rate of 2%.

Land – Life Estate: The fair value for the land – life estate is determined by using information for similar property.

Life Estate Liability: SFCS has a liability associated with a life estate. The value of the life estate is estimated based on donor life expectancy and a discount rate of 2.0%.

Operating Revenues, Other Income and Expenses All noncontribution revenue/income is recorded when earned/entitled and all expenses are recorded when incurred, in accordance with the accrual basis of accounting.

Financial Aid (Charity Care) SFCS provides care to youth and families who meet specific criteria under its financial aid policy without charge or at amounts less than its established rates. Because SFCS does not pursue collection of amounts determined to qualify as financial aid, they are reported as revenue and written off as financial aid in the same period.

Net Maintenance Revenue Net maintenance revenue are reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered. Revenue is recognized as services are provided.

SFCS receives payments under the Reintegration/Foster Care/Adoption contract for a period until permanency is reached as defined in the contract. SFCS is generally responsible for twelve months of aftercare once permanency is reached with no additional payments. SFCS estimates the time that services will be provided and the revenue is recognized over this time period and is reported as deferred revenue in the consolidated statement of financial position.

Contributions and Other Financial Support Contributions received are recorded as unrestricted, temporarily restricted or permanently restricted support depending on the existence and/or nature of any donor restrictions. Contributions with restrictions are required to be reported as temporarily restricted support and are then reclassified to unrestricted net assets upon expiration of the restriction. Contributions received and unconditional promises receivable are measured at their fair values and are reported as an increase in net assets in the year in which there is sufficient evidence in the form of verifiable documentation that a promise was made and received, and when the amount of the promise is ascertainable. Financial support includes legacies, bequests, and contributions from donors. SFCS reports gifts of cash and other assets as restricted financial support if they are received with donor stipulations that limit the use of the donated assets, or if they are designated as financial support for future periods. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statement of activities as net assets released from restrictions. Donor- restricted contributions whose restrictions are met in the same reporting period are reported as unrestricted financial support.

SFCS reports gifts of goods and equipment as unrestricted financial support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted financial support. SFCS reports expirations of donor restrictions when the donated or acquired long-lived assets are placed in service unless the donor has stipulated how long those assets must be maintained.

Donated Services, Goods and Facilities Donated professional services are reflected in the consolidated statement of activities at their fair value. Professional services donated for the year ended June 30, 2015, were $6,278. Materials and other assets received as donations are recorded and reflected in the accompanying financial statements at their fair values at the date of receipt.

Net Board Directed and Endowment Income The net endowment income and that income which is earned by the Board Directed/Quasi Endowment unrestricted net assets are recorded as nonoperating

gains when the income is unrestricted. Income earned by the Endowment Fund-Special Provisions investments is recorded as an addition to temporarily restricted net assets. Investment revenues are reported net of related expenses, such as custodial fees and investment advisory fees. Investment expenses totaled $53,396 for the year ended June 30, 2015.

Expenses The subsidiary corporations have contracted with SFCS for the procurement of certain supporting services. These contract service fees paid by each corporation to the parent have been eliminated in the consolidation.

Self-Insurance Beginning April 1, 2013, SFCS is self-insured with respect to group health insurance for eligible employees subject to plan guidelines with a specific maximum per participant. SFCS estimates and accrues its liability for the risks covered by the program.

Advertising Costs SFCS expenses advertising costs as the costs are incurred. Advertising expense for the year ended June 30, 2015, was $496,490.

Prior Period Financial Information The financial statements include certain prior year summarized comparative information in total but not by net asset class and do not include functional expense detail. Such information does not include sufficient detail to constitute a presentation in conformity with U.S. generally accepted accounting principles. Accordingly, such information should be read in conjunction with the financial statements for the year ended June 30, 2014, from which the summarized information was derived.

2. RESTRICTED CASH, CASH EQUIVALENTS, AND OTHER CURRENT ASSETS

As of June 30, 2015, SFCS held cash and cash equivalents of $655,663 in board designated and temporarily restricted funds.

Under regulatory agreements with the U.S. Department of Housing and Urban Development (HUD), SFCS is required to set aside specified amounts for the Bridgeway Apartments, Inc. projects for the replacement of property and other project expenditures approved by HUD. HUD-restricted deposits are held in separate accounts and generally are not available for operating purposes. As of June 30, 2015, HUD-restricted deposits of $51,768 are included in other current assets.

3. ACCOUNTS AND CONTRACTS RECEIVABLE

Accounts and contracts receivable at June 30, 2015, is net of the allowance for uncollectible accounts of $83,571.

4. UNCONDITIONAL PROMISES RECEIVABLE

Unconditional promises to give at June 30, 2015, are as follows:

		Amount
Unconditional Promises to Give Due In:		
Less than one year	$	247,440
One to three years		2,932
Total Unconditional Promises to Give	$	250,372

For the year ended June 30, 2015, SFCS has unconditional promises receivable related to the capital campaign in the amount of $31,650 and other unconditional promises to give totaling $218,722. There was no allowance for unconditional promises for the year ended June 30, 2015. SFCS does not have any conditional promises as of June 30, 2015.

5. NOTE RECEIVABLE

On June 16, 2014, SFCS loaned $59,000 to a member of management. The note is forgivable after the third year of employment at a rate of one-fifth (1/5) of the loan amount each year for the subsequent five years (5) thereafter. Full forgiveness of the note would be achieved on the eighth year of employment. If employment ends at any time before the eighth year of employment, the remaining balance will be due in five equal annual installments beginning on the date of termination or cessation of employment and the same date each year thereafter. Interest will be applied to the outstanding amount not yet repaid at the Wall Street Journal Prime Rate at the time of termination.

6. INVESTMENTS

The schedule below summarizes the investments of SFCS:

June 30		2015
Equities and mutual funds	$	6,611,468
Annuities		1,555,998
Greater Salina Community Foundation		21,734
Other investments		140,406
Total Investments	$	8,329,606

The change in value of investments, split-interest agreements, and life estate is comprised of the following:

Year Ended June 30		2015
Investments	$	(727,829)
Annuities		11,941
Perpetual trusts		(2,331)
Charitable remainder trusts and gift annuities		(7,228)
Life estate liability		3,713
Total Change in Value	$	(721,734)

SFCS invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term.

7. FAIR VALUE MEASUREMENTS

The following table sets forth by level, within the fair value hierarchy, SFCS's assets and liabilities measured at fair value as of June 30, 2015:

	(Level 1)	(Level 2)	(Level 3)	Total
ASSETS				
Equities and Mutual Funds				
Large cap growth	$ 1,103,286	$ -	$ -	$ 1,103,286
Large cap value	1,612,909	-	-	1,612,909
Small/mid cap growth	978,086	-	-	978,086
Small/mid cap value	544,162	-	-	544,162
International equity	1,315,903	-	-	1,315,903
Equities blend	184,841	-	-	184,841
Total Equities and Mutual Funds	5,739,187	-	-	5,739,187
Fixed Income Mutual Funds				
Long-term bond	253,605	-	-	253,605
Int. term bond	406,209	-	-	406,209
Short-term bond	187,228	-	-	187,228
Fixed income blend	25,239	-	-	25,239
Total Fixed Income Mutual Funds	872,281	-	-	872,281
Other Holdings				
Annuities	-	-	1,555,998	1,555,998
Greater Salina Community Foundation	-	-	21,734	21,734
Other investments	140,406	-	-	140,406
Beneficial interest in perpetual trusts	-	-	217,035	217,035
Charitable remainder trusts and gift annuities	-	-	104,895	104,895
Land - life estate	-	167,000	-	167,000
Total Other Holdings	140,406	167,000	1,899,662	2,207,068
TOTAL ASSETS	$ 6,751,874	$ 167,000	$ 1,899,662	$ 8,818,536
Liabilities				
Life estate liability	$ -	$ -	$ 26,001	$ 26,001

The change in fair value of Level 3 assets is as follows for the year ended June 30, 2015:

	Amount
Balance, June 30, 2014	$ 353,054
Transfers into Level 3	1,555,998
Total gains or losses (realized and unrealized)	(9,390)
Balance, June 30, 2015	$ 1,899,662

Investments in annuities were transferred from Level 1 to Level 3 because there are no quoted prices in active markets for identical assets.

8. PROPERTY, PLANT, AND EQUIPMENT

Property, plant, and equipment is comprised of the following:

June 30		2015
Buildings and leasehold improvements	$	7,297,408
Land improvements		431,472
Furniture and equipment		2,492,540
Transportation equipment		5,767,695
Livestock and equipment		61,905
Subtotal		16,051,020
Deduct: Accumulated depreciation		10,306,909
Subtotal		5,744,111
Land		1,128,553
Construction in progress		5,545,464
Total Property, Plant, and Equipment	$	12,418,128

Depreciation expense for the year ended June 30, 2015, totaled $1,574,357.

9. COMMITMENTS

On November 27, 2013, SFCS signed a building contract for the construction of a new Psychiatric Residential Treatment Facility (PRTF) in Salina, Kansas. The total amount of the building contract and related building commitments as of June 30, 2015, is $5,796,996. Through June 30, 2015, SFCS has been invoiced for progress on the construction of the PRTF building and for the related building commitments in the amount of $5,545,307, all of which is included in the property, plant, and equipment account on the balance sheet.

As of the year-end, June 30, 2015, the future commitments remaining for the construction of the PRTF building and for furnishing commitments totals $923,068.

10. ASSETS TRANSFERRED TO A RECIPIENT ORGANIZATION

During the year ended May 31, 2001, SFCS permanently transferred $10,000 to the Greater Salina Community Foundation (Community Foundation) for the establishment of the Saint Francis Academy Fund. The Community Foundation may make annual distributions to SFCS of an amount up to but not to exceed five percent of the fund's net fair market value. The Community Foundation has variance power over the funds as required by the Internal Revenue Service. At June 30, 2015, the fair value of this asset was $21,734. (See note 7.)

11. GIFT ANNUITIES PAYABLE

Gift annuities payable total $8,785 as of June 30, 2015. The current portion of this payable is $395 and $8,390 is long-term.

12. CHANGES IN COMPONENTS OF BOARD DIRECTED UNRESTRICTED NET ASSETS

	Board Directed		
	Unrestricted	Quasi Endowment	Total
Balance, June 30, 2014	$ 958,159	$ 4,075,856	$ 5,034,015
Investment income	-	97,795	97,795
Appropriation for expenditure	(935,929)	(97,795)	(1,033,724)
Transfer in per board authorization	-	112,158	112,158
Gain on sale of securities	-	84,777	84,777
Change in value of securities	-	(375,450)	(375,450)
Change in value of annuities	-	11,941	11,941
Donations	-	20,000	20,000
Balance, June 30, 2015	$ 22,230	$ 3,929,282	$ 3,951,512

13. TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets are subject to donor imposed stipulations that may or will be met either by actions of SFCS and/or passage of time, as presented below at June 30, 2015.

June 30	2015
Restricted for Specific Use	
Specific program items	$ 1,824,492
Restricted by Passage of Time	
Split-interest agreements	104,895
Land with life estate	140,999
HUD Capital Advance	1,459,300
Total Restricted by Passage of Time	1,705,194
Total Temporarily Restricted Net Assets	$ 3,529,686

Bridgeway Apartments, Inc. has agreements with the U.S. Department of Housing and Urban Development (HUD) whereby HUD made capital advances to Bridgeway Apartments, Inc. for Project I and Project II in the amounts of $689,000 and $770,300, respectively. The capital advances were used to finance the construction of an independent living complex for the developmentally disabled. SFCS is the sponsor organization. The capital advances bear no interest and are not required to be repaid so long as the housing remains available for very low-income persons with disabilities for at least 40 years in accordance with Section 811 of the National Housing Act. The capital advances are secured by real estate in Pearl River County, Mississippi. These advances are included in temporarily restricted

net assets. If either of the projects were to discontinue maintenance of the projects for the specified resident category, a mortgage would exist and monthly payments would be required.

14. CHANGES IN COMPONENTS OF PERMANENTLY RESTRICTED NET ASSETS

A portion of the permanently restricted net assets have special provisions which provide that income is to be temporarily restricted for specific uses presented as follows:

	Permanently Restricted		
	Special Provisions Endowment	Regular Endowment	Total
Balance, June 30, 2014	$ 474,983	$ 2,744,530	$ 3,219,513
Change in value of perpetual trusts	-	(2,333)	(2,333)
Restricted income transferred to Special Provisions	199	-	199
Balance, June 30, 2015	$ 475,182	$ 2,742,197	$ 3,217,379

15. FINANCIAL AID AND NET MAINTENANCE REVENUE

SFCS has agreements with third party payors that provide for payments to SFCS at amounts different from its established rates. In addition, SFCS maintains records to identify and monitor the level of financial aid it provides. The following information measures the amount of financial aid provided to clients and the discounts and contractual adjustments related to third party payor agreements for the year ended June 30, 2015.

Year Ended June 30	2015
Maintenance Revenue	$ 99,992,048
Less:	
Discounts and contractual adjustments	456,235
Financial aid (Charity care)	317,875
Intercompany maintenance revenue	9,479,654
Bad debt expense (recovery)	25
Total	10,253,789
Net Maintenance Revenue	$ 89,738,259

The subsidiary corporations operate residential facilities at Salina, Kansas and Picayune, Mississippi. Family Preservation, Reintegration/Foster Care/Adoption and Family Foster Care services are provided in Kansas. Therapeutic and Bridge Foster Care services are also provided in Oklahoma. Agency Supported Foster Care, Intensive Family Preservation, Family Support and Visitation Supervision are provided in Nebraska. Substantially all of the net maintenance fees are from governmental agencies (third party payors).

SFCS recognizes patient revenue associated with services provided to patients who have Medicaid, third-party, or other health insurance coverage on the basis of contractual rates for the services rendered. For uninsured patients who do not qualify for charity care, SFCS recognizes revenue on the basis of its standard rates for services provided. A portion of SFCS's uninsured patients will be unable to pay for the services provided and SFCS provides charity care to those patients who meet the eligibility requirements. The cost of providing this charity care is $288,329 for the year ended June 30, 2015.

16. ENDOWMENT ASSETS

SFCS's endowment consists of various individual funds established for a variety of purposes. Its endowment includes both donor-restricted endowment funds and funds designated by the Board of Directors to function as endowments. As required by generally accepted accounting principles, net assets associated with endowments are classified and reported based on the existence or absence of donor-imposed restrictions.

SFCS, over the long-term, expects the current spending policy to allow its endowment fund to grow. This is consistent with SFCS's objective to maintain the purchasing power of the endowment assets as well as to provide additional real growth through investment return. To achieve that objective, SFCS has adopted an investment policy that attempts to maximize total return consistent with an acceptable level of risk. Actual returns in any given year may vary from the expectations.

Investment risk is measured in terms of the total endowment fund, investment assets and allocation between asset classes. Strategies are managed to not expose the fund to unacceptable levels of risk. The Board of Directors of SFCS has interpreted the State Prudent Management of Institutional Funds Act (SPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, SFCS classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by SFCS in a manner consistent with the standard of prudence prescribed by SPMIFA. In accordance with SPMIFA, SFCS considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund;
(2) The purposes of SFCS and the donor-restricted endowment fund;
(3) General economic conditions;
(4) The possible effect of inflation and deflation;
(5) The expected total return from income and the appreciation of investments;
(6) Other resources of SFCS; and
(7) The investment policies of SFCS.

The endowment net assets composition by type as of June 30, 2015, follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowments				
Donor-restricted	$ -	$ 924,517	$ 3,217,379	$ 4,141,896
Board-directed quasi	3,929,282	-	-	3,929,282
Total Endowments	$ 3,929,282	$ 924,517	$ 3,217,379	$ 8,071,178

Changes in endowment net assets for the year ended June 30, 2015, follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment Net Assets, Beginning of Year	$ 4,075,856	$ 1,114,615	$ 3,219,513	$ 8,409,984
Investment Income	97,795	26,227	-	124,022
Contributions	20,000	-	-	20,000
Transfer In per board authorization	112,158	-	-	112,158
Net appreciation (realized and unrealized)	(278,732)	(190,098)	(2,333)	(471,163)
Restricted income transferred to special provisions	-	-	199	199
Appropriation of endowment assets for expenditure	(97,795)	(26,227)	-	(124,022)
Endowment Net Assets, End of Year	$ 3,929,282	$ 924,517	$ 3,217,379	$ 8,071,178

17. LEASES

Leases for building space have been entered into by SFCS. All of these have terms expiring over the next three years and have a provision that SFCS can terminate the leases under certain situations. Rent expense on these leases was $946,164 for the year ended June 30, 2015. The future minimum lease payments required under these operating leases with original terms in excess of one year are as follows:

Year Ending June 30	**Amount**
2016	$ 881,841
2017	804,364
2018	79,922
Total	$ 1,766,127

SFCS has also entered into leases for certain office equipment. All of these agreements are classified as operating leases and have terms expiring annually. Rent expense on these equipment leases totaled $11,767 for the year ended June 30, 2015.

18. PENSION PLANS

SFCS has the following retirement plans:

Clergy Plan Two employees who are Episcopal clergy are covered under a multi-employer plan with the Church Pension Fund that was established by the General Convention of the Episcopal Church. Under this defined benefit plan, the clergy accrue benefits that are determined by formula at the time of retirement, disability or death. These benefits do not fluctuate due to market performance. SFCS contributed 18% of cleric's total assessable compensation. The Plan also provides both life and disability benefit coverage. The report is available upon request from the Church Pension Group. The total amount contributed by SFCS for the year ended June 30, 2015, was $47,635.

401 (K) Plan Effective January 1, 2010, SFCS established the Saint Francis Community Services, Inc. 403(b) Plan and the Saint Francis Community Services, Inc. 401(k) Plan. The 403(b) Plan, which was frozen as of January 1, 2010, was terminated effective December 31, 2014. The termination was subject to the provisions of ERISA. The 151 participants in the plan as of December 31, 2014, had the opportunity to roll the funds over to the 401(k) plan, roll the funds over to an IRA, or take a lump sum cash distribution. All Plan assets were distributed by May 31, 2015. Under the 401(k) plan, SFCS makes contributions for employees who meet certain age and length of service requirements. The total amount contributed by SFCS for the year ended June 30, 2015 was $1,257,649.

19. CONTINGENCIES

During the fiscal year ended June 30, 2009, a donor established a life estate agreement naming SFCS as the beneficiary of the donor's farm land. Under the terms of the agreement, the donor would continue to use the land as long as the donor is living. At the time of the donor's death, the gift would become unrestricted. The asset's market value of $167,000 and a corresponding liability of $26,001 have been recorded.

20. CONCENTRATION OF BUSINESS RISK

The State of Kansas has "privatized" out of home placements for youth in the custody of the Kansas Department for Children and Families (formerly known as Kansas Department of Social and Rehabilitation Services (SRS)). Saint Francis Community and Family Services, Inc. was awarded the Reintegration/Foster Care/Adoption Services and Family Preservation Services contracts for the West and Wichita regions in Kansas through the period ending June 30, 2017, with two (2) additional (2) year renewals(s) by written agreement of the parties.

Total revenue for the year ended June 30, 2015, was $88,037,073 from state agencies for these and other contracts. Referrals and fees for services are received from other social service agencies.

21. CONCENTRATIONS OF CREDIT RISK

The corporations have demand deposits, repurchase agreements and money market funds on deposit with various financial institutions. Balances with certain financial institutions were in excess of the federal insurance limitation during the year ended June 30, 2015.

22. CERTAIN SIGNIFICANT ESTIMATES

Significant estimates used in preparing these consolidated financial statements are described below:

Allocation of Functional Expenses Functional expenses are charged to the specific purpose when readily determinable and allocated proportionately to a multi-purpose function.

Deferred Revenue Deferred revenue is related to the Reintegration/Foster Care/Adoption Services and Family Preservation Services contracts. The significant estimate in the Reintegration/Foster Care/Adoption Services and Family Preservation Services deferred revenue is based upon the amount of time that SFCS expects to serve the client. Management reviewed program results of the current year and made an estimate of the future services that will be provided to the children and families in the programs. Management reviewed subsequent payments and based upon their knowledge and experience with the program, arrived at an estimated amount to reflect the deferred revenue for the Reintegration/Foster Care/Adoption Services and Family Preservation programs.

It is at least reasonably possible that the significant estimates used will change within the next year.

23. BRIDGEWAY APARTMENTS, INC.

Bridgeway Apartments, Inc., located in Picayune, Mississippi, operates a 13 unit apartment project (Phase I) and a 12 unit apartment project (Phase II), collectively known as the Projects, for persons who are developmentally disabled. These Projects are operated under Section 811 of the National Housing Act and regulated by the U.S. Department of Housing and Urban Development (HUD) with respect to rental charges and operating methods. Under the regulatory agreement, the Projects may not increase rents charged to tenants without HUD approval. Use of the residual receipts account is contingent upon HUD's prior written approval.

The Projects' operations are concentrated in the multi-family real estate market. In addition, the Projects operate in a heavily regulated environment. The operations of the Projects are subject to the administrative directives, rules and regulations of federal, state and local regulatory agencies, including, but not limited to, HUD. Such administrative directives, rules and regulations are subject to change by an act of Congress or an administrative change mandated by HUD. Such changes may occur with little notice or inadequate funding to pay for the related cost, including the additional administrative burden, to comply with a change.

24. SUBSEQUENT EVENTS

SFCS has evaluated subsequent events through January 8, 2016, the date which the financials were available to be issued. There were no events which require disclosure.

SUPPLEMENTARY INFORMATION SECTION

Saint Francis Community Services, Inc. and Subsidiaries
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Pass-Through Entity Identifying Number/Contract	Federal Disbursements/ Expenditures
U.S. Department of Health and Human Services - TANF Cluster			
Passed Through Kansas Department for Children and Families			
Temporary Assistance for Needy Families	93.558	Reintegration FY15-West	$ 5,206,533
Temporary Assistance for Needy Families	93.558	Reintegration FY15-Wichita	4,375,901
Temporary Assistance for Needy Families	93.558	Family Preservation FY15-West	895,644
Temporary Assistance for Needy Families	93.558	Family Preservation FY15-Wichita	778,650
Total CFDA #93.558 - TANF Cluster - Passed Through Kansas Department for Children and Families			11,256,728
Other U.S. Department of Health and Human Services Programs			
Passed Through Kansas Department for Children and Families			
Social Services Block Grant	93.667	Reintegration FY15-West	4,420,139
Social Services Block Grant	93.667	Reintegration FY15-Wichita	3,717,186
Total CFDA #93.667 - Passed Through Kansas Department for Children and Families			8,137,325
Passed Through Kansas Department for Children and Families			
Foster Care_Title IV-E	93.658	Reintegration FY15-West	1,750,613
Foster Care_Title IV-E	93.658	Reintegration FY15-Wichita	1,523,865
Foster Care_Title IV-E	93.658	Family Preservation FY15-West	152,153
Foster Care_Title IV-E	93.658	Family Preservation FY15-Wichita	133,315
Total CFDA #93.658 Passed Through Kansas Department for Children and Families			3,559,946
Passed Through Kansas Department of Health and Environment / Children's Alliance of Kansas (some match from the Kansas Department for Children and Families)			
Foster Care_Title IV-E	93.658	MAPP Training Contract 36160	32,996
Total CFDA #93.658 Passed Through Kansas Department of Health and Environment / Children's Alliance of Kansas			32,996
Passed Through Nebraska Department of Health and Human Service			
Foster Care_Title IV-E	93.658	1501NE1401	624,305
Total CFDA #93.658 Passed Through Nebraska Department of Health and Human Services			624,305
Passed Through Oklahoma Department of Human Service			
Foster Care_Title IV-E	93.658	8309021444	520,759
Foster Care_Title IV-E	93.658	522828 & 538185	40,710
Total CFDA #93.658 Passed Through Oklahoma Department of Human Services			561,469
Total CFDA #93.658			4,778,716
Passed Through University of Kansas Center for Research, Inc.			
Child Welfare Research Training or Demonstration	93.648	Subcontract No. FY2011	952,443
Child Welfare Research Training or Demonstration	93.648	Subcontract No. FY2012	133,918
Total CFDA #93.648 - Passed Through University of Kansas Center for Research, Inc.			1,086,361
Passed Through University of Kansas Center for Research, Inc.			
Adoption Services	93.652	Subcontract No. FY 2014-032	38,675
Total CFDA #93.652 - Passed Through University of Kansas Center for Research, Inc.			$ 38,675

Saint Francis Community Services, Inc. and Subsidiaries

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

(Continued)

Federal Grantor/Pass-Through Grantor/Program Title	CFDA Number	Entity Identifying Number/Contract	Disbursements/ Expenditures
Other U.S. Department of Health and Human Services Programs			
Passed Through University of Kansas Center for Research, Inc.			
Enhance Safety of Children Affected by Substance Abuse	93.087	Subcontract No. FY2015-084	$ 3,349
Total CFDA #93.087 - Passed Through University of Kansas Center for Research, Inc.			3,349
Passed Through Kansas Department for Children and Families			
Affordable Care Act (ACA) Abstinence Education Program	93.235	1001KSAEGP	90,000
Total CFDA #93.235 - Passed Through Kansas Department for Children and Families			90,000
Passed Through Kansas Department for Children and Families			
Stephanie Tubbs Jones Child Welfare Services Program	93.645	Family Preservation FY15-West	41,223
Stephanie Tubbs Jones Child Welfare Services Program	93.645	Family Preservation FY15-Wichita	37,748
Total CFDA #93.645 - Passed Through Kansas Department for Children and Families			78,971
U.S. Department of Agriculture - Child Nutrition Cluster			
Passed Through Kansas State Board of Education			
National School Lunch Program	10.555	X-0921	43,559
Total CFDA #10.555 - Passed Through Kansas State Board of Education			43,559
Passed Through Kansas State Board of Education			
School Breakfast Program	10.553	X-0921	21,826
Total CFDA #10.553 - Passed Through Kansas State Board of Education			21,826
Total Child Nutrition Cluster			65,385
TOTAL FEDERAL AWARDS			$ 25,535,510

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting The accompanying schedule of expenditures of federal awards includes the grant activity of Saint Francis Community Services, Inc. and its wholly owned subsidiaries and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations.*

2. ABBREVIATIONS

For purposes of the schedule of expenditures of federal awards, the following abbreviation was used:

CFDA - Catalog of Federal Domestic Assistance.

3. MULTIPLE ENTITIES

The schedule of expenditures of federal awards includes the federal disbursements and expenses of the following entities:

- Saint Francis Community and Family Services, Inc.
- Saint Francis Community and Residential Services, Inc.
- Saint Francis Community Services, Inc.
- Saint Francis Community Services in Oklahoma, Inc.
- Saint Francis Community Services in Nebraska, Inc.

The *Government Auditing Standards* and *OMB Circular A-133 Compliance Supplement* requirements for Bridgeway Apartments, Inc. were included in the report audited by other auditors, Maddox & Associates, APC for the year ended June 30, 2015.

OTHER REPORTS SECTION

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Directors
Saint Francis Community Services, Inc.
Salina, Kansas

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statement of Saint Francis Community Services, Inc. (a Kansas not-for-profit organization) and its wholly-owned subsidiaries, which comprise the consolidated statement of financial position as of June 30, 2015, and the related consolidated statements of activities, functional expenses, and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated January 8, 2016. Our report includes a reference to auditors who audited the financial statements of Bridgeway Apartments, Inc., as described in our report on Saint Francis Community Services, Inc.'s consolidated financial statements. This report does not include the results of the other auditors' testing of internal control over financial reporting or compliance and other matters that are reported on separately by those auditors.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of Saint Francis Community Services, Inc. and subsidiaries' internal control. Accordingly, we do not express an opinion on the effectiveness of the Saint Francis Community Services, Inc. and subsidiaries' internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*
(Continued)

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of consolidated financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

KCoe Isom, LLP

January 8, 2016
Salina, Kansas

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB CIRCULAR A-133

To the Board of Directors
Saint Francis Community Services, Inc. and its Subsidiaries
Salina, Kansas

Report on Compliance for Each Major Federal Program

We have audited Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Circular A-133 *Compliance Supplement* that could have a direct and material effect on each of Saint Francis Community Services, Inc. and its wholly owned subsidiaries' major federal programs for the year ended June 30, 2015. Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal program.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of Saint Francis Community Services, Inc. and subsidiaries' major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*; and the provisions of the Kansas Department of Social and Rehabilitation Services *Recipient Monitoring Policy* approved July 9, 2009. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' compliance.

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB CIRCULAR A-133
(Continued)

Basis for Qualified Opinion on the Temporary Assistance for Needy Families (CFDA No. 93.558) and Social Services Block Grant (CFDA No. 93.667)

As described in item 2015-001 in the accompanying schedule of finding and questioned costs, Saint Francis Community Services, Inc. and its wholly-owned subsidiaries did not comply with requirements regarding CFDA No. 93.558 Temporary Assistance for Needy Families and 93.667 Social Services Block Grant for allowable costs/cost principles. Compliance with such requirements is necessary, in our opinion, for Saint Francis Community Services, Inc. and subsidiaries to comply with the requirements applicable to those programs.

Qualified Opinion on the Temporary Assistance for Needy Families (CFDA No. 93.558) and Social Services Block Grant (CFDA No. 93.667)

In our opinion, except for the noncompliance described in the Basis for Qualified Opinion paragraph, Saint Francis Community Services, Inc. and its wholly-owned subsidiaries complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2015.

Other Matters

Saint Francis Community Services, Inc.'s consolidated financial statements include the operations of Bridgeway Apartments, Inc. HUD Projects No. 065-HD015-CA and 065-HD025-CA, which has $1,575,006 in federal awards expenditures, which are not included in the schedule of expenditures of federal awards for the year ended June 30, 2015. Our audit, described below, did not include the operations of Bridgeway Apartments, Inc. HUD Projects No. 065-HD015-CA and 065-HD025-CA because those Projects' statements were audited by other auditors.

Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' response to the noncompliance findings identified in our audit is described in the accompanying schedule of findings and questioned costs. Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' response was not subjected to the auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

Management of Saint Francis Community Services, Inc. and its wholly-owned subsidiaries is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered Saint Francis Community Services, Inc. and its wholly-owned

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB CIRCULAR A-133
(Continued)

subsidiaries' internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program as a basis for designing auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Saint Francis Community Services, Inc. and its wholly-owned subsidiaries' internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, as discussed below, we identified a certain deficiency in internal control over compliance, as described in the accompanying schedule of findings and questioned costs as items 2015-001 that we consider to be a significant deficiency.

Saint Francis Community Services, Inc. and wholly-owned subsidiaries' response to the internal control over compliance findings identified in our audit is described in the accompanying schedule of findings and questioned costs. Saint Francis Community Services, Inc. and wholly-owned subsidiaries' response was not subjected to the auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY OMB CIRCULAR A-133
(Continued)

Purpose of this Report

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

KCoe Isom, LLP

January 8, 2016
Salina, Kansas

FINDINGS AND QUESTIONED COSTS SECTION

Saint Francis Community Services, Inc. and Subsidiaries

SCHEDULE OF FINDINGS AND QUESTIONED COSTS
June 30, 2015

SECTION I
SUMMARY OF AUDITORS' RESULTS

1. The opinion expressed in the independent auditors' report was:

   ☒ Unmodified ☐ Qualified ☐ Adverse ☐ Disclaimed

2. The independent auditors' report on internal control over financial reporting described:

   Significant deficiency(ies) noted considered material weakness(es)?

   ☐ Yes ☒ No

   Significant deficiency(ies) noted that are not considered to be a material weakness?

   ☐ Yes ☒ None reported

3. Noncompliance considered material to the financial statements was disclosed by the audit?

   ☐ Yes ☒ No

4. The independent auditors' report on internal control over compliance with requirements applicable to major federal awards programs described:

   Significant deficiency(ies) noted considered material weakness(es)?

   ☐ Yes ☒ No

   Significant deficiency(ies) noted that are not considered to be a material weakness?

   ☒ Yes ☐ None reported

5. The opinion expressed in the independent auditors' report on compliance with requirements applicable to major federal awards was:

   ☐ Unmodified ☒ Qualified ☐ Adverse ☐ Disclaimed

6. The audit disclosed findings required to be reported by OMB Circular A-133?

   ☒ Yes ☐ No

7. The programs tested as major federal programs are as follows:

   U.S. Department of Health and Human Services

   Temporary Assistance for Needy Families — CFDA #93.558
   Passed Through Kansas Department for Children and Families

   Social Services Block Grant — CFDA #93.667
   Passed Through Kansas Department for Children and Families

SECTION I
SUMMARY OF AUDITORS' RESULTS
(Continued)

8. The dollar threshold used to distinguish between Type A and Type B programs, as described in Section .520(b), is $766,065.

9. Saint Francis Community Services, Inc. and its wholly-owned subsidiaries do not qualify as a low-risk auditee under Section .530 of OMB Circular A-133.

SECTION II FINDINGS
FINANCIAL STATEMENTS AUDIT

None

SECTION III FINDINGS
FEDERAL AWARDS AUDIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Temporary Assistance for Needy Families – CFDA No. 93.558
Social Services Block Grant – CFDA No. 93.667

Condition Personnel Activity Reports for all staff are not available for the salaries and wages for services performed under the above noted contracts with the Kansas Department for Children and Families.

Criteria OMB Circular No. A-122 establishes principles for determining costs of grants, contracts, and other agreements with non-profit organizations. This Circular requires that charges to awards for salaries and wages, whether treated as direct costs or indirect costs, will be based on documented payrolls approved by a responsible official(s) of the organization. The distribution of salaries and wages to awards must be supported by personnel activity reports, as prescribed in subparagraph (2), except when a substitute system has been approved in writing by the cognizant agency. Reports must reflect an after-the-fact determination of the actual activity of each employee. Budget estimates (i.e. estimates determined before the services are performed) do not qualify as support for charges to awards. Each report must account for the total activity for which employees are compensated and which is required in fulfillment of their obligations to the organization. The reports must be signed by the individual employee, or by a responsible supervisory official having first-hand knowledge of the activities performed by the employee, that the distribution of activity represents a reasonable estimate of the actual work performed by the employee during the periods covered by the reports. In addition, the reports must be prepared at least monthly and must coincide with one or more pay periods.

Cause Documentation and approval is available to support the time worked and a separate case activity log exists for the individuals who perform direct services but there is not a specific form that includes all documentation as noted above. During the year ended June 30, 2015, Saint Francis Community Services began implementing changes to their system to generate a personnel activity report for staff whose services included more than one program. A personnel activity report was prepared for all such individuals for the year ended June 30, 2015. For those individuals who worked only in one program, the payroll records include the specific information required for the personnel activity report, although a specific report with this title is not currently available.

Potential Effect and Context Saint Francis Community Services does require all employees who work under the contracts noted above to complete a time sheet that is approved by the employee and their supervisor. There are controls in place to determine that such approval is reviewed and approved before each payroll is paid. Most of the employees who are assigned to these contracts only work under one contract. Therefore, all of their time is allocated to the specific contract and this is determined at the beginning of each contract year. If situations change during the year, the employee or their supervisor inform the payroll department that an allocation change is required. In addition, on an on-going basis, the Contract Services Staff monitor the client cases assigned and the case activity logs to determine if an employee's

SECTION III FINDINGS
FEDERAL AWARDS AUDIT
(Continued)

allocation of time needs to be changed in the payroll system. During the year ended June 30, 2015, Saint Francis Community Services prepared a personnel activity report for all individuals who worked in more than one specific contract. This report includes all of the data for these employees.

Recommendations Since the prior year finding was reported, Saint Francis Community Services has taken extensive efforts to develop a method for capturing and documenting the information required for the personnel activity reports in one document. They did implement a process to obtain a personnel activity report for all staff that work across contracts for the year ended June 30, 2015. Saint Francis Community Services is in the process of implementing a new payroll software system that will enable them to capture the information needed for the personnel activity reports for all staff working in areas with Contract Funding. The goal is to have this implemented by January 1, 2016. In addition, the new requirements effective for the next fiscal year in the Uniform Grant Guidance 2CFR200 should be evaluated and incorporated into the process.

Views of Responsible Officials and Planned Corrective Actions In connection with Finding No. 2015-001, which is a continuation of the prior year finding, Saint Francis Community Services has worked hard to comply with all administrative and cost guidelines and has committed to complying with all state and federal requirements and is well underway in that project.

Saint Francis Community Services entered into contracts with the State of Kansas for many years to perform Family Preservation and Reintegration/Foster Care/Adoption services. During the years prior to the year ended June 30, 2014, based upon communication with the Kansas Department for Children and Families and their predecessor, these contracts were viewed as procurement contracts. Potential vendors were asked to respond to a Request For Proposal (RFP) through the Kansas Department of Administration, Procurement and Contracts division and submit bids for these services to a designated Procurement Officer. Awards were made by the Procurement Negotiation Committee and notification of such award came from the Director of Purchases. The contracts beginning July 1, 2013, were awarded as described above, however, the Kansas Department for Children and Families informed Saint Francis Community Services that Contractors were to be considered sub recipients of any Federal Awards used to fund the contracts for purposes of Circular A-133 audit requirements and that the amount for each Federal Award would be provided at the end of the fiscal year.

During previous years, Saint Francis Community Services developed a time keeping system that met requirements for tracking hours for employees that worked for grants. The time reporting requirements for the Family Preservation and Reintegration/Foster Care/Adoption contracts were met through participation in the Contractor Random Moment Time Study (RMTS) as administrated by the Kansas Department for Children and Families and submission of required encounter data.

SECTION III FINDINGS
FEDERAL AWARDS AUDIT
(Continued)

Staff were hired, trained and assigned to a specific contract to perform required services solely under that contract. Employees that work with more than one contract are generally supervisory positions and are allocated between those contracts based on their estimate of time worked for each contract. Annual certification of allocations was documented for employees working for more than one contract. Saint Francis Community Services has a salary and wage reporting process that includes multiple layers of approval and monitoring so that the time worked by employees are properly recorded.

Saint Francis Community Services understands the need for a finding of not meeting the personnel activity report requirements for all staff involved with the contracts under the Circular A-133. As noted earlier, Saint Francis Community Services states that there are systems in place to properly monitor and approve all employee salaries and wages to ensure that the proper contract or grant is being charged only allowable costs. Saint Francis Community Services does have personnel activity reports for employees who work under the contracts in multiple funding sources. Saint Francis Community Services is in the process of implementing a new payroll software system and processes that can generate the specific personnel activity reports required for the state contracts on a large scale. As noted in the prior year, because the employees that work under the Family Preservation and Reintegration/Foster Care/Adoption contracts are specifically assigned to a contract, Saint Francis Community Services submits that based upon their review and approval there are no unallowed salaries and wages being charged to the Federal Awards. In addition, the new system will meet the requirements of the Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federals Awards as issued by the office of Management and Budget (OMB).

The Corrective Action Plan for Saint Francis Community Services, Inc. and Subsidiaries has been issued as a separate letter.

PRIOR AUDIT REPORTS

Finding Number 2014-001 from the year ended June 30, 2014, is repeated as Finding Number 2015-001 for the current year for the major programs CFDA No. 93.558 and 93.667. Action taken on this prior year finding is described in Section III.

Saint Francis
MINISTRIES

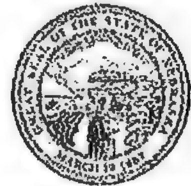
Attachment L
Nebraska Public Health
Licensure

Saint Francis Ministries • 509 E. Elm Street • Salina Kansas 67401
785-825-0541 • Toll Free: 800-423-1342

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES



Pete Ricketts, Governor

Public Health Licensure Unit
Certification of Licensure

This certificate serves as primary source verification of licensure in the State of Nebraska as of the close of the business day before 3/22/2019.

Name:	Saint Francis Community Services, Inc.
Owner:	Saint Francis Community Services, Inc.
Address:	1811 W 2 Street Suite 105, Grand Island, NE
Type:	Child Placing Agency
Number:	CPA036
Status:	Active
Issued:	09/09/2011
Expiration:	09/09/2019

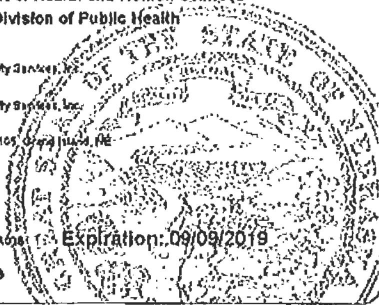
Inspection and Investigation Information:

Documentation may not be available online prior to 2010. If prior documentation is needed, please call our office at (402) 471-9278

Disciplinary/Non-Disciplinary Information:

No disciplinary/non-disciplinary actions taken against this license.

If you have questions about this information, please contact the Licensure Unit at (402) 471-2115 or DHHS.LicensureUnit@nebraska.gov.



State of Nebraska

Department of Health and Human Services
Division of Public Health

Saint Francis Community Services, Inc.

Saint Francis Community Services, Inc.

1811 W 2 Street Suite 105, Grand Island, NE

Child Placing Agency

License #: CPA0[illegible] **Expiration:** 09/09/2019

Status: Active

Certificate of Good Standing

Saint Francis
MINISTRIES

Attachment G
Certificate of
Good Standing

STATE OF NEBRASKA

United States of America, } ss.
State of Nebraska }

Secretary of State
State Capitol
Lincoln, Nebraska

I, Robert B. Evnen, Secretary of State of the State of Nebraska, do hereby certify that

SAINT FRANCIS COMMUNITY SERVICES IN NEBRASKA, INC.

incorporated on May 6, 2011 and is duly incorporated under the law of Nebraska;

that all fees, taxes, and penalties owed to Nebraska wherein payment is reflected in the records of the Secretary of State and to which nonpayment affects the good standing of the corporation have been paid;

that its most recent biennial report required by section 21-19,172 has been delivered to the Secretary of State;

that Articles of Dissolution have not been filed.

This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's financial condition or business activities and practices.

In Testimony Whereof, I have hereunto set my hand and affixed the Great Seal of the State of Nebraska on this date of

March 13, 2019

Robert B. Evnen

Secretary of State

Verification ID 19410da has been assigned to this document. Go to ne.gov/go/validate to validate authenticity for up to 12 months.

Nebraska Secretary of State

✔ This is a valid Certificate of Good Standing issued by the Nebraska Secretary of State's office on March 13, 2019 at 10:45:03 AM for SAINT FRANCIS COMMUNITY SERVICES IN NEBRASKA, INC.

View certificate

Enter the Verification ID found on the bottom of the certificate to validate authenticity of a Certificate of Good Standing.

Verification ID:

19410da

Additional Online Services

Saint Francis
MINISTRIES

Attachment J
Job Descriptions

Saint Francis
Community Services
Serving Children and Families Since 1945

JOB DESCRIPTION	
Job Title: Assistant Vice President of Services	Last Revision: March 2019
Program: Nebraska	Reports To: Vice President of Children and Family Services Classification: Exempt

MISSION STATEMENT
Saint Francis, providing healing and hope to children and families.

BASIC PURPOSE OF THE JOB
The Assistant Vice President is responsible for administering and managing the Regions service delivery and contract outcomes.

JOB REQUIREMENTS	
Minimum Education and Licensure/ Certifications	➢ Master's degree in Social Work or related degree.
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	➢ Demonstrates competence and continues training in age-specific competencies for infant through adult clients.
Minimum Work Experience	➢ 5 years of child welfare direct service experience.
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Receives training in trauma informed practice and incorporates knowledge in day-to-day practice ➢ Ability to work flexible schedule including being available during after-hours ➢ Understanding of family-centered practice, child welfare, the state system, and behavioral health care delivery systems ➢ Understanding of child and adolescent development and family systems ➢ Demonstrates effective written and verbal communication skills ➢ Understanding of budget development and implementation ➢ Ability to travel ➢ Consistently exercises discretion and independent judgment in performance of duties in conformance with applicable policies, procedures, statutes, rules and regulations ➢ Handles multiple priorities ➢ Able to relate, communicate and work with multiple and diverse constituencies, within and external to SFCS ➢ Ability to build, manage, direct, oversee and coordinate multiple and complex function, projects and relationships ➢ Manages stress appropriately ➢ Works alone effectively ➢ Works in close proximity to others and/or in a distracting environment ➢ Works with others effectively/teamwork ➢ Understands and practices Universal Precautions ➢ Demonstrates strong leadership skills in the below areas: **Developing Direct Reports**: The extent to which one can guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans. **Innovation Management**: Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas. **Motivating Others**: The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards. **Strategic Agility:** The ability to look at internal and external trends and

	adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. **Building Effective Teams:** The ability to assemble and lead strong, high-functioning teams to solve organizational issues of all sizes. Shares successes with the team and organization and fosters an open dialogue. **Managing Vision and Purpose:** The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do.
Essential Functions	➢ Designs, develops and implements the child welfare programs according to DHHS contracts. ➢ Monitors program to assure compliance with contract, regulatory, licensing and accreditation standards. ➢ Advises Vice President of critical trends, problems or events in assigned areas. ➢ Monitors program to assure compliance with established administrative, financial and personnel policies procedures and protocols. ➢ Provides leadership, guidance and direction for program, to ensure compliance with outcomes and performance standards. ➢ Assists in development and implementation of performance improvement strategies to achieve program outcomes. ➢ Provides supervision for Child Welfare Program Directors, ➢ Assists in strategic planning processes with the Vice President. ➢ Develops and maintains positive relationships with regional and state stakeholders, including DHHS, the courts, and other community partners, to facilitate accomplishing program outcomes. ➢ Collaborates with local agencies to determine community needs and develop a full continuum of services for children and families. ➢ Coordinates relationships with staff, providers, consumers and the program. ➢ Develops, implements, and ensures compliance with SFCS policies and follows directives as required. Follows and adheres to all pertinent SFCS Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms. ➢ Is knowledgeable of and follows all safety procedures. ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels. ➢ Ensures clients' rights are protected.
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year. ➢ Other duties as assigned.
Job Specific Core Competencies *(As observed by supervisor/ evaluator)*	➢ Job knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/ evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance ➢ Leadership

JOB DESCRIPTION	
Job Title: Technology Coordinator	Last Revision: March 2019
Program: Nebraska	Reports To: Chief Information Officer Classification: Exempt

MISSION STATEMENT
Saint Francis, providing healing and hope to children and families.

BASIC PURPOSE OF THE JOB
The Technology Coordinator will serve as the primary contact between Saint Francis and DHHS to address IT related issues.

JOB REQUIREMENTS	
Minimum Education and Licensure/ Certifications	➢ Bachelor in IT, Computer Science or related field
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	N/A
Minimum Work Experience	➢ 10 years working in technology sector ➢ Supervisory experience preferred
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Ability to work flexible schedule ➢ Understanding of budget development and implementation ➢ Ability to travel ➢ Consistently exercises discretion and independent judgment in performance of duties in conformance with applicable policies, procedures, statutes, rules and regulations ➢ Handles multiple priorities ➢ Able to relate, communicate and work with multiple and diverse constituencies, within and external to Saint Francis ➢ Ability to build, manage, direct, oversee and coordinate multiple and complex function, projects and relationships ➢ Manages stress appropriately ➢ Works alone effectively ➢ Works in close proximity to others and/or in a distracting environment ➢ Works with others effectively/teamwork ➢ Understands and practices Universal Precautions

Essential Functions	➢ Purchasing, installing, configuring and managing all hardware and software, all computer hardware support, hardware and software upgrades, the movement of all computer equipment, needed network support, server and LAN printer support and software installation and configuration of information systems owned by Saint Francis for the performance of responsibilities associated with this award. ➢ Understanding the requirements for use of wireless laptops under this award under the conditions that the disk is encrypted and the appropriate safeguards are in place. ➢ Notifying DHHS of any lost or stolen hardware that may have been used to access, process or store information. ➢ Providing DHHS with a detailed security plan of any network infrastructure connecting to the organizational network. ➢ Understanding remote or home office sites may be permitted provided each location meets compliance requirements, ensuring all agents, employees, interns and subcontractors take reasonable actions to ensure such worksites meet these compliance requirements when accessing DHHS information. ➢ Performing and documenting annual physical site reviews for al remote office and home office locations to ensure the security controls are met and documenting any noted deficiencies, recommendation and actions to address noted deficiencies, making this information available upon request to DHHS. ➢ Coordinates relationships with staff, providers, consumers and the program. ➢ Develops, implements, and ensures compliance with Saint Francis policies and follows directives as required. Follows and adheres to all pertinent Saint Francis Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms. ➢ Is knowledgeable of and follows all safety procedures. ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels. ➢ Ensures clients' rights are protected.
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year. ➢ Other duties as assigned.
Job Specific Core Competencies *(As observed by supervisor/ evaluator)*	➢ Job knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/ evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance ➢ Leadership

JOB DESCRIPTION	
Job Title: Director - Adoption	Last Revision: March 2019
Program: Nebraska	Reports To: Assistant Vice President of Services Classification: Exempt

MISSION STATEMENT
Saint Francis, providing healing and hope to children and families.

BASIC PURPOSE OF THE JOB
The Director of Adoption provides administrative leadership and operational oversight for the service delivery and contract outcomes in the Adoption department.

JOB REQUIREMENTS	
Minimum Education and Licensure/Certifications	➢ Master's Degree in Social Work or related degree
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	➢ Demonstrates competence and continues training in age-specific competencies for infant through adult clients.
Minimum Work Experience	➢ 4 years of child welfare direct service experience
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Receives training in trauma informed practice and incorporates knowledge in day-to-day practice ➢ Able to relate, communicate and work with multiple and diverse internal and external constituents, including staff, clients, DHHS, community agencies and the court systems ➢ Team player that supports corporate decisions and SFCS' vision, mission and ministry ➢ Demonstrates strong leadership skills in the below areas: ***Developing Direct Reports:*** The extent to which one can guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans ***Innovation Management:*** Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas ***Motivating Others:*** The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards ***Strategic Agility:*** The ability to look at internal and external trends and adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. ***Building Effective Teams:*** The ability to assemble and lead strong, high functioning teams to solve organizational issues of all sizes. Shares successes with the team and organization, and fosters an open dialogue ***Managing Vision and Purpose:*** The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do. Understanding of child and adolescent development and family systems

Required Skills, Knowledge, and Abilities	➢ Understanding of family-centered practice, child welfare, the state system, and behavioral health care delivery systems ➢ Understanding of budget development and implementation ➢ Understanding of management information systems ➢ Able to work flexible schedule including after hours ➢ Demonstrate effective written and verbal communication skills ➢ Ability to travel throughout the State ➢ Handles multiple priorities ➢ Independent discretion/decision making within the scope and responsibility of the position ➢ Manages emotions and can make decisions under pressure ➢ Manages stress appropriately ➢ Works alone effectively ➢ Ability to work with diverse population ➢ Understands and practices Universal Precautions
Essential Functions	➢ Monitors and evaluates program ensuring the quality and effectiveness of program, while assuring that outcomes are met. ➢ Manages program within budget, monitoring results monthly to assure fiscal goals are met. ➢ Responsible for reviewing and evaluating effectiveness/satisfaction data and implementing necessary changes to improve program quality and achieve established outcomes. ➢ Participates in strategic planning process with Leadership team to develop program growth. ➢ Provides direct supervision and support to the Supervisors, including completion of annual performance evaluation. ➢ Develops and oversees the completion of performance expectations. Conducts corrective counseling, provides guidance and recommends termination when necessary ➢ Arranges for coverage when a Supervisor is absent. ➢ Hires staff in coordination with Human Resources and Supervisor. ➢ Assists in maintaining safety for the physical office environment. ➢ Liaison with DHHS, the courts, and community partners, assessing community needs and assuring positive relationships. ➢ Assures that record documentation and management information data is complete and accurate. ➢ Advises Vice President of critical trends, problems or events in Reintegration. ➢ Implements SFCS policies and follows directives as required. Follows and adheres to all pertinent SFCS Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms. Ensures clients' rights are protected. ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels. ➢ Ensures clients' rights are protected. ➢ Is knowledgeable of and follows all safety procedures.
Non-Essential Functions	➢ Prefer a minimum 40 hours in-services education per year. ➢ Other duties as assigned.
Job Specific Core Competencies *(As observed by supervisor/evaluator)*	➢ Job knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance

JOB DESCRIPTION	
Job Title: Director – Independent Living	Last Revision: March 2019
Program: Nebraska	Reports To: Assistant Vice President of Services Classification: Exempt

MISSION STATEMENT

Saint Francis, providing healing and hope to children and families.

BASIC PURPOSE OF THE JOB

The Director of Independent Living provides administrative leadership and operational oversight for the service delivery and contract outcomes in the Independent Living department.

JOB REQUIREMENTS

Minimum Education and Licensure/Certifications	➢ Master's degree in Social Work or related degree.
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	➢ Demonstrates competence and continues training in age-specific competencies for infant through adult clients
Minimum Work Experience	➢ 4 years of child welfare direct service experience.
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Receives training in trauma informed practice and incorporates knowledge in day-to-day practice ➢ Able to relate, communicate and work with multiple and diverse internal and external constituents, including staff, clients, DHHS, community agencies and the court systems ➢ Team player that supports corporate decisions and SFCS' vision, mission and ministry ➢ Demonstrates strong leadership skills in the below areas: ***Developing Direct Reports:*** The extent to which one can guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans ***Innovation Management:*** Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas ***Motivating Others:*** The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards ***Strategic Agility:*** The ability to look at internal and external trends and adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. ***Building Effective Teams:*** The ability to assemble and lead strong, high functioning teams to solve organizational issues of all sizes. Shares successes with the team and organization and fosters an open dialogue ***Managing Vision and Purpose:*** The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do. Understanding of child and adolescent development and family systems

Required Skills, Knowledge, and Abilities	➢ Understanding of family-centered practice, child welfare, the state system, and behavioral health care delivery systems ➢ Understanding of budget development and implementation ➢ Understanding of management information systems ➢ Able to work flexible schedule including after hours ➢ Demonstrate effective written and verbal communication skills ➢ Ability to travel throughout the State ➢ Handles multiple priorities ➢ Independent discretion/decision making within the scope and responsibility of the position ➢ Manages emotions and can make decisions under pressure ➢ Manages stress appropriately ➢ Works alone effectively ➢ Ability to work with diverse population ➢ Understands and practices Universal Precautions
Essential Functions	➢ Monitors and evaluates program ensuring the quality and effectiveness of program, while assuring that outcomes are met. ➢ Manages program within budget, monitoring results monthly to assure fiscal goals are met. ➢ Responsible for reviewing and evaluating effectiveness/satisfaction data and implementing necessary changes to improve program quality and achieve established outcomes. ➢ Participates in strategic planning process with Leadership team to develop program growth. ➢ Participates in Statewide Independent Living Statewide meetings and executes tasks related to those meetings. ➢ Provides direct supervision and support to the Supervisors, including completion of annual performance evaluation. ➢ Explores community resources and identifies services to meet the needs of older youth. ➢ Develops and oversees the completion of performance expectations. Conducts corrective counseling, provides guidance and recommends termination when necessary ➢ Arranges for coverage when a Supervisor is absent. ➢ Hires staff in coordination with Human Resources and Supervisor. ➢ Assists in maintaining safety for the physical office environment. ➢ Liaison with DHHS, the courts, and community partners, assessing community needs and assuring positive relationships. ➢ Assures that record documentation and management information data is complete and accurate. ➢ Advises Vice President of critical trends, problems or events in Reintegration. ➢ Implements SFCS policies and follows directives as required. Follows and adheres to all pertinent SFCS Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms. Ensures clients' rights are protected. ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels. ➢ Ensures clients' rights are protected. ➢ Is knowledgeable of and follows all safety procedures.
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year ➢ Other duties as assigned
Job Specific Core Competencies *(As observed by supervisor/evaluator)*	➢ Job knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance

JOB DESCRIPTION

Job Title: Director - Reintegration	Last Revision: March 2019
Program: Nebraska	Reports To: Assistant Vice President of Services Classification: Exempt

MISSION STATEMENT

Saint Francis, providing healing and hope to children and families.

BASIC PURPOSE OF THE JOB

The Director of Reintegration provides administrative leadership and operational oversight for the service delivery and contract outcomes in the Reintegration department.

JOB REQUIREMENTS

Minimum Education and Licensure/Certifications	➢ Master's degree in Social Work or related field.
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	➢ Demonstrates competence and continues training in age-specific competencies for infant through adult clients.
Minimum Work Experience	➢ 4 years of child welfare direct service experience
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Receives training in trauma informed practice and incorporates knowledge in day-to-day practice ➢ Able to relate, communicate and work with multiple and diverse internal and external constituents, including staff, clients, DHHS, community agencies and the court systems ➢ Team player that supports corporate decisions and SFCS' vision, mission and ministry ➢ Demonstrates strong leadership skills in the below areas: ***Developing Direct Reports:*** The extent to which one can guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans ***Innovation Management:*** Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas ***Motivating Others:*** The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards ***Strategic Agility:*** The ability to look at internal and external trends and adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. ***Building Effective Teams:*** The ability to assemble and lead strong, high functioning teams to solve organizational issues of all sizes. Shares successes with the team and organizaion and fosters an open dialogue ***Managing Vision and Purpose:*** The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do. Understanding of child and adolescent development and family systems

Required Skills, Knowledge, and Abilities	➢ Understanding of family-centered practice, child welfare, the state system, and behavioral health care delivery systems ➢ Understanding of budget development and implementation ➢ Understanding of management information systems ➢ Able to work flexible schedule including after hours ➢ Demonstrate effective written and verbal communication skills ➢ Ability to travel throughout the State ➢ Handles multiple priorities ➢ Independent discretion/decision making within the scope and responsibility of the position ➢ Manages emotions and can make decisions under pressure ➢ Manages stress appropriately ➢ Works alone effectively ➢ Ability to work with diverse population ➢ Understands and practices Universal Precautions
Essential Functions	➢ Monitors and evaluates program ensuring the quality and effectiveness of program, while assuring that outcomes are met. ➢ Manages program within budget, monitoring results monthly to assure fiscal goals are met. ➢ Responsible for reviewing and evaluating effectiveness/satisfaction data and implementing necessary changes to improve program quality and achieve established outcomes. ➢ Participates in strategic planning process with Leadership team to develop program growth. ➢ Provides direct supervision and support to the Supervisors, including completion of annual performance evaluation. ➢ Develops and oversees the completion of performance expectations. Conducts corrective counseling, provides guidance and recommends termination when necessary ➢ Arranges for coverage when a Supervisor is absent. ➢ Hires staff in coordination with Human Resources and Supervisor. ➢ Assists in maintaining safety for the physical office environment. ➢ Liaison with DHHS, the courts, and community partners, assessing community needs and assuring positive relationships. ➢ Assures that record documentation and management information data is complete and accurate. ➢ Advises Vice President of critical trends, problems or events in Reintegration. ➢ Implements SFCS policies and follows directives as required. Follows and adheres to all pertinent SFCS Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms. Ensures clients' rights are protected. ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels. ➢ Ensures clients' rights are protected. ➢ Is knowledgeable of and follows all safety procedures.
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year ➢ Other duties as assigned
Job Specific Core Competencies *(As observed by supervisor/evaluator)*	➢ Job knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance

Saint Francis
Community Services

JOB DESCRIPTION	
Job Title: Director of PI/QA	Last Revision: March 2019
Program: All Programs	Reports To: Vice President-Innovation & Quality Classification: Exempt

MISSION STATEMENT

Saint Francis, providing healing and hope to children and families

BASIC PURPOSE OF THE JOB

The Director of PI/QA administers and manages quality assurance, data and contract outcomes in the QA/PI department. Manages continuous quality improvement.

JOB REQUIREMENTS

Minimum Education and Licensure/Certifications	➢ Master's degree in Social Work, organizational leadership or related degree.
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	➢ Demonstrated competence and continues training in age-specific competencies for infant through adult clients
Minimum Work Experience	➢ 4 years child welfare of other direct service or QA/PI experience
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Coaching, Mentoring and Teaching skills ➢ Demonstrates effective written and verbal communication skills ➢ Demonstrates strong leadership skills in the below areas: ***Developing Direct Reports:*** The extent to which one is able to guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans ***Innovation Management:*** Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas ***Motivating Others:*** The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards ***Strategic Agility:*** The ability to look at internal and external trends and adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. ***Building Effective Teams:*** The ability to assemble and lead strong, high functioning teams to solve organizational issues of all sizes. Shares successes with the team and agency, and fosters an open dialogue ➢ ***Managing Vision and Purpose:*** The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do. Understanding of child and adolescent development and family systems ➢ Must posses a high level of computer literacy – proficient in developing spreadsheets, with aptitude or ability/interest to master Access, PowerPoint ➢ Must be able to work a Flexible schedule dependent upon evolving priorities and methodology ➢ Ability to work under tight deadlines and handle multiple/detail-

	oriented tasks ➢ Change agent with the ability to influence at all levels of the organization ➢ Strong business acumen, judgment and maturity with the ability to differentiate strategic vs. non-strategic opportunities ➢ Ability to travel throughout the State ➢ Must be a team player ➢ Handles multiple priorities ➢ Independent discretion/decision making within the scope and responsibility of the position ➢ Manages emotions and can make decisions under pressure ➢ Manages stress appropriately ➢ Works alone effectively ➢ Works in close proximity to others and/or in a distracting environment ➢ Works with others effectively/teamwork ➢ Ability to work with diverse population ➢ Understands and practices Universal Precautions
Essential Functions	➢ Oversees Quality Assurance projects established for the Foster Care Reintegration, Family Preservation and Residential contracts and outcomes established by DHHS to comply with CMS guidelines ➢ Attends Regional meetings with DHHS and completes the Performance Improvement Plans (PIP) as required by DHHS ➢ Oversights contract reconciling process ➢ Works with individual SFCS offices to develop performance improvement plans and monitor those plans ➢ Provides the highest level of internal and external customer service ➢ Compiles data from surveys and provides a report detailing recommendations for improving client/family care ➢ Facilitates multiple improvement teams in applying Performance Improvement techniques to achieve results ➢ Assists in data collection methodologies and quantification on financial impact of results. ➢ Provides one on one support and consultation to programs. ➢ Provides technical (quality tool) and statistical expertise to program ➢ Provides process improvement know how, methods and conceptual expertise to programs. ➢ Provides PI training to program ➢ Identifies application opportunities for the technical/statistical tools of quality/process improvement ➢ Assist in presenting data and conclusions clearly ➢ Works with performance improvement committees as necessary to address barriers to success ➢ Responsible for supervising other Quality Assurance staff ➢ Implements SFCS policies and follows directives as required. Follows and adheres to all pertinent SFCS Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms ➢ Is knowledgeable of and follows all safety procedures
Non-Essential Functions	Prefer a minimum of 40 hours in-service education per year ➢ Other duties as assigned
Job Specific Core Competencies. *(As observed by supervisor/ evaluator)*	➢ Job Knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/ evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance

JOB DESCRIPTION	
Job Title: Director of Support Services	Last Revision Date: March 2019
Program: Nebraska	Reports To: Assistant Vice President of Services Classification: Exempt
MISSION STATEMENT	
Saint Francis, providing healing and hope to children and families.	
BASIC PURPOSE OF THE JOB	
The Director for Support Services is responsible for administering and managing the support team to help the program teams accomplish the ability to provide service delivery and contract outcomes.	
JOB REQUIREMENTS	
Minimum Education and Licensure/Certifications	➢ Master's degree in Social Work or related degree.
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	➢ Demonstrates competence and continues training in age-specific competencies for infant through adult clients
Minimum Work Experience	➢ 4 years of child welfare direct service experience.
Required Knowledge, Skills, and Abilities	➢ Mandated Reporter ➢ Receives training in trauma informed practice and incorporates knowledge in day to day practice ➢ Demonstrates effective written and verbal communication skills ➢ Able to relate, communicate and work with multiple and diverse internal and external constituents, including staff, clients, DHHS, and community agencies ➢ Team player that supports corporate decisions and SFCS' vision, mission and ministry ➢ Ability to build, manage, direct, oversee and coordinate multiple and complex functions, projects and relationships ➢ Possesses strong organizational skills ➢ Able to work flexible schedule ➢ Demonstrates effective leadership and interpersonal skills ➢ Understanding of child and adolescent development ➢ Understanding of budget development and implementation ➢ Understanding of management information systems ➢ Ability to travel throughout the State ➢ Ability to handle multiple priorities ➢ Independent discretion/decision making within the scope and responsibility of the position ➢ Manages emotions and can make decisions under pressure ➢ Manages stress appropriately ➢ Works alone effectively and efficiently ➢ Works in close proximity to others and/or in a distracting environment ➢ Understands and Practices Universal Precaution ➢ Demonstrates strong leadership skills in the below areas: ***Developing Direct Reports:*** The extent to which one is able to guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans ***Innovation Management:*** Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas

Required Skills, Knowledge, and Abilities	***Motivating Others:*** The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards ***Strategic Agility:*** The ability to look at internal and external trends and adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. ***Building Effective Teams:*** The ability to assemble and lead strong, high functioning teams to solve organizational issues of all sizes. Shares successes with the team and organizaion and fosters an open dialogue ***Managing Vision and Purpose:*** The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do. Understanding of child and adolescent development and family systems
Essential Functions	➢ Direct supervision of Support Staff Supervisor and front desk and building oversite. ➢ Develops and oversees the completion of performance expectations. Conducts corrective counseling, provides guidance and recommends termination when necessary ➢ Oversees community partnership programs ➢ Arranges for Supervisors coverage when absent ➢ Hires staff in coordination with Human Resources and Supervisor ➢ Assists with overseeing and maintaining the physical office environment. ➢ Monitors and evaluates programs, ensuring the quality and effectiveness of programs, while assuring that outcomes are achieved, and safety is maintained ➢ Manages programs within budget, monitoring results monthly to assure fiscal goals are accomplished ➢ Assures that record documentation and management information data is complete and accurate ➢ Reviews and evaluates effectiveness/satisfaction of data and implementing necessary changes to improve program quality and achieve established outcomes ➢ Advises Assistant Vice President of critical trends, problems or events ➢ Participates in strategic planning process with Leadership team to develop program growth ➢ Liaison with Program Supervisors/Directors and other departments to ensure effective communication among the supportive programs ➢ Communicates with community partners in a positive and respectful manner about the services Saint Francis provides ➢ Assists with tracking and monitoring key functions of the Program ➢ Assesses and implements efficient practices for all support staff ➢ Attends and participates in internal meetings specific ➢ Supports the day to day operations of the office ➢ Implements SFCS policies and follows directives as required. Follows and adheres to all pertinent SFCS Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms ➢ Is knowledgeable of and follows all safety procedures ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels ➢ Ensures clients' rights are protected ➢ Assures program compliance with all licensing and accreditation standards and all federal, state, and local rules, statutes and regulation and terms of DHHS contract
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year ➢ Other duties as assigned
Job Specific Core Competencies *(As observed by supervisor/evaluator)*	➢ Job Knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance

JOB DESCRIPTION	
Job Title: Director-Foster Care Homes	Last Revision: March 2019
Program: Nebraska	Reports To: Assistant Vice President Classification: Exempt

MISSION STATEMENT
Saint Francis, providing healing and hope to children and families

BASIC PURPOSE OF THE JOB
The Director of Foster Care Homes provides support to foster care homes, develops recruitment strategies to secure additional foster care homes

JOB REQUIREMENTS	
Minimum Education and Licenses/Certifications	➢ Master's degree in Social Work or related degree
Minimum Work Experience	➢ 4 years of child welfare or Foster Care Homes experience.
Age of Client Population Served	➢ Demonstrates competence and continues training in age-specific competencies for infant through adult clients
Minimum Job Requirement	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Coaching, Mentoring and Teaching skills ➢ Demonstrates effective written and verbal communication skills ➢ Demonstrates strong leadership skills in the below areas: o ***Developing Direct Reports:*** The extent to which one is able to guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans o ***Innovation Management:*** Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas o ***Motivating Others:*** The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards o ***Strategic Agility:*** The ability to look at internal and external trends and adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. o ***Building Effective Teams:*** The ability to assemble and lead strong, high functioning teams to solve organizational issues of all sizes. Shares successes with the team and organization, and fosters an open dialogue o ***Managing Vision and Purpose:*** The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do. Understanding of child and adolescent development and family systems ➢ Must possess a high level of computer literacy – proficient in developing spreadsheets, with aptitude or ability/interest to master Access, PowerPoint ➢ Must be able to work a Flexible schedule dependent upon evolving priorities and methodology ➢ Ability to work under tight deadlines and handle multiple/detail-oriented tasks ➢ Change agent with the ability to influence at all levels of the organization ➢ Strong business acumen, judgment and maturity with the ability to differentiate strategic vs. non-strategic opportunities ➢ Ability to travel throughout the State ➢ Must be a team player

Required Skills, Knowledge, and Abilities	➢ Handles multiple priorities ➢ Independent discretion/decision making within the scope and responsibility of the position ➢ Manages emotions and ca make decisions under pressure ➢ Manages stress appropriately ➢ Works alone effectively ➢ Works in close proximity to others and/or in a distracting environment ➢ Works with others effectively/teamwork ➢ Ability to work with diverse population ➢ Understands and practices Universal Precautions
Essential Functions	➢ Provides resources for foster care recruits with prospective and current foster care families ➢ Develops and maintains relationships with referring agencies, including lead or subcontracting agencies, DHHS and other stakeholders ➢ Develops and implements a foster care recruitment plan ➢ Assists in recruiting foster families through mailings, newspaper, radio and television advertisements, contacts and speaking engagements with referring agencies, community service organizations and community activities ➢ Liaison with directors and recruiters to coordinate and supervise recruiting, licensing, etc. ➢ Assists with the development and implementation of foster parent satisfaction survey and compiles results ➢ Develops support systems and resources for foster families/children and assists them in utilizing those services ➢ Ensures that all foster families meet licensing and qualifications for the level of children placed in their care ➢ Assures that record documentation is concise, timely, and appropriate ➢ Conducts or reviews annual performance evaluations of resource staff ➢ Reviews staff and resource family compliance issues ➢ Reviews and evaluates effectiveness/satisfaction data and implements necessary changes to improve program quality and achieve established outcomes ➢ Implements Saint Francis Ministries policies and follows directives as required. Follows and adheres to all pertinent Saint Francis Ministries Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms ➢ Is knowledgeable of and follows all safety procedures ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels ➢ Ensures clients' rights are protected
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year ➢ Other duties as assigned
Job Specific Core Competencies (As observed by supervisor/evaluator)	➢ Job Knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies (As observed by supervisor/evaluator)	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationships others/teamwork ➢ Housekeeping and safety ➢ Appearance

JOB DESCRIPTION

Job Title: Director-Kinship	Last Revision: March 2019
Program: Nebraska	Reports To: Assistant Vice President of Services Classification: Exempt

MISSION STATEMENT

Saint Francis, providing healing and hope to children and families

BASIC PURPOSE OF THE JOB

The Director-Kinship is responsible for administering and managing the service delivery and contract outcome in the Kinship department.

JOB REQUIREMENTS

Minimum Education and Licensure/Certifications	➢ Master's degree in Social Work or related degree.
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	➢ Demonstrates competence and continues training in age-specific competencies for infant through adult clients
Minimum Work Experience	➢ 4 years of child welfare direct service experience.
Required Skills, Knowledge, and Abilities	➢ Mandated Reporter ➢ Receives training in trauma informed practice and incorporates knowledge in day to day practice ➢ Demonstrates effective written and verbal communication skills ➢ Able to relate, communicate and work with multiple and diverse internal and external constituents, including staff, clients, DHHS, community agencies and the court systems ➢ Demonstrates strong leadership skills in the below areas: • Developing Direct Reports: The extent to which one is able to guide direct reports through their careers and help prepare for leadership positions through providing challenging tasks and development plans. • Innovation Management: Teaches intelligent risk-taking, encouraging direct reports to look at new ways to solve problems, and when to implement new ideas. • Motivating Others: The ability to create a climate in which people want to do their very best and can motivate many kinds of direct reports. Empowers others through pushing tasks and decisions downwards. • Strategic Agility: The ability to look at internal and external trends and adjust your role in a strategic plan. Able to anticipate future consequences and trends accurately and is future oriented. • Building Effective Teams: The ability to assemble and lead strong, high-functioning teams to solve organizational issues of all sizes. Shares successes with the team and organization and fosters an open dialogue. • Managing Vision and Purpose: The ability to communicate and reinforce the mission and vision of the organization in a compelling way so direct reports feel a sense of purpose in the work they do. ➢ Team player that supports corporate decisions and SFCS' vision, mission and ministry ➢ Ability to build, manage, direct, oversee and coordinate multiple and complex functions, projects and relationships ➢ Able to work flexible schedule including on-call ➢ Demonstrates effective leadership and interpersonal skills ➢ Knowledge of family counseling techniques, both individual and group ➢ Understanding of child and adolescent development and family systems ➢ Understanding of family-centered practice, child welfare, the state system, and behavioral health care delivery systems ➢ Understanding of budget development and implementation

	➢ Understanding of management information systems ➢ Ability to travel throughout the State ➢ Handles multiple priorities ➢ Independent discretion/decision making within the scope and responsibility of the position ➢ Manages emotions and can make decisions under pressure ➢ Manages stress appropriately ➢ Works alone effectively ➢ Works in close proximity to others and/or in a distracting environment ➢ Works with others effectively/teamwork ➢ Understands and Practices Universal Precaution
Essential Functions	➢ Provides direct supervision and support to the Kinship Supervisors, including completion of annual performance evaluations. ➢ Develops and oversees the completion of performance expectations. Conducts corrective counseling, provides guidance and recommends termination when necessary. ➢ Fills in for Supervisor when absent. ➢ Hires staff in coordination with Human Resources and Supervisor. ➢ Assists with maintaining the physical office environment. ➢ Monitors and evaluates the Kinship Program statewide, ensuring the quality and effectiveness of program, while assuring that outcomes are achieved. ➢ Manages program within budget, monitoring results monthly to assure fiscal goals are accomplished. ➢ Liaison with DHHS, the courts, and communities across the state, assessing community needs and assuring positive relationships. ➢ Assures that record documentation and management information data is complete and accurate. ➢ Reviews and evaluates effectiveness/satisfaction of data and implements necessary changes to improve program quality and achieve established outcomes. ➢ Advises Assistant Vice President of critical trends, problems or events in Kinship ➢ Participates in strategic planning process with Leadership team to develop program growth ➢ Assures program compliance with all licensing and accreditation standards and all federal, state, and local rules, statutes and regulation and terms of DHHS contract ➢ Ensures clients' rights are protected. ➢ Is knowledgeable of and follows all safety procedures
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year ➢ Other duties as assigned
Job Specific Core Competencies *(As observed by supervisor/evaluator)*	➢ Job knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance

JOB DESCRIPTION	
Job Title: Security Administrator	Last Revision: March 2019
Program: Nebraska	Reports To: Chief Information Officer Classification: Exempt

MISSION STATEMENT
Saint Francis, providing healing and hope to children and families.

BASIC PURPOSE OF THE JOB
The Security Administrator will act as t h liaison between Saint Francis and DHHS.

JOB REQUIREMENTS	
Minimum Education and Licensure/ Certifications	➢ Bachelor's in IT or related field
Minimum Job Requirements	➢ Must be 21 years of age ➢ Must pass a drug screen, Nebraska Child Abuse and Neglect Registry Clearance, any background checks deemed to be necessary. ➢ Lifting requirements 50 lbs. ➢ Must have a valid NE driver's license, acceptable driving and reliable transportation.
Client Population Served	N/A
Minimum Work Experience	➢ 5 years working in IT field with information security
Required Skills, Knowledge, and Abilities	➢ Mandated reporter ➢ Ability to work flexible schedule ➢ Understanding of budget development and implementation ➢ Ability to travel ➢ Consistently exercises discretion and independent judgment in performance of duties in conformance with applicable policies, procedures, statutes, rules and regulations ➢ Handles multiple priorities ➢ Able to relate, communicate and work with multiple and diverse constituencies, within and external to Saint Francis ➢ Ability to build, manage, direct, oversee and coordinate multiple and complex function, projects and relationships ➢ Manages stress appropriately ➢ Works alone effectively ➢ Works in close proximity to others and/or in a distracting environment ➢ Works with others effectively/teamwork ➢ Understands and practices Universal Precautions

Essential Functions	➢ Directs oversight of network configuration. ➢ Bi-annual evaluation of network security weaknesses. ➢ Software and Hardware maintenance. ➢ User training on security and network interface. ➢ Allocating data science and IT resources. ➢ Notifying DHHS when an employee is hired or leaves employment. ➢ Providing documentation for DHHS for user accounts. ➢ Conducting background checks for all new employees. ➢ Notifying DHHS immediately in the event of a security incident involving muses of the state's case management system or loss of client information. ➢ Ensuring security awareness and acceptable use training is conducted and document for all staff on initial hire and annually thereafter, providing documentation for DHHS upon request with in 3 days. ➢ Coordinates relationships with staff, providers, consumers and the program. ➢ Develops, implements, and ensures compliance with Saint Francis policies and follows directives as required. Follows and adheres to all pertinent Saint Francis Standard Operating Procedures (SOP's), rules, personnel policies and procedures; related accreditation and licensure standards; and federal, state and local rules, statutes, regulations, and contractual terms. ➢ Is knowledgeable of and follows all safety procedures. ➢ Reports unusual incidents through appropriate Risk Management, clinical and safety channels. ➢ Ensures clients' rights are protected.
Non-Essential Functions	➢ Prefer a minimum of 40 hours in-service education per year. ➢ Other duties as assigned.
Job Specific Core Competencies *(As observed by supervisor/ evaluator)*	➢ Job knowledge (as defined in the essential job functions) ➢ Judgment ➢ Quality of work (accuracy) ➢ Quantity of work (productivity)
Organizational Core Competencies *(As observed by supervisor/ evaluator)*	➢ Initiative ➢ Versatility ➢ Attendance/Punctuality ➢ Effectiveness in working relationship with others/teamwork ➢ Housekeeping and safety ➢ Appearance ➢ Leadership

Saint Francis
MINISTRIES

Attachment S
Catalogue of Services
By Zip Code

Saint Francis Ministries • 509 E. Elm Street • Salina Kansas 67401
785-825-0541 • Toll Free: 800-423-1342

Saint Francis
MINISTRIES

In Home Service Provider	
Service Provider	Zip Code
Heartland Family Service	68105 68111
Lutheran Family Services of Nebraska, Inc.	68102 68111
Boys Town	68010
KVC	68137
Children's Square	68106
Apex Foster Care	68114
Christian Hertiage	68104
Omni Inventive Care	68117
Paradigm	68127
Nebraska Children's Home Society	68137
Child Saving Institute	68132
Capstone Behavioral Health	68105
Community Options	68105
Jewish Family Services	68154
Bethany in Omaha (Christian Services)	68137
Women's Center for Advancement	68131
Heartland Ministry Center	68110
Juan Diego Center (Catholic Charities)	68107
Omaha Home for Boys	68104
YES: Youth Emergency Services	68131
Project Harmony (child advocacy center)	68137

Saint Francis
MINISTRIES

Attachment R
Resumes

Saint Francis Ministries • 509 E. Elm Street • Salina Kansas 67401
785-825-0541 • Toll Free: 800-423-1342

THE VERY REV. ROBERT NELSON SMITH
robert.smith@saintfrancisministries.org

VOCATIONAL OVERVIEW

Saint Francis Ministries (Saint Francis Community Services, Inc.) **2014 to present**
Dean, President & CEO
Salina, Kansas

Illinois Valley Community Hospital **2009 to 2014**
Chief Operating Officer
**formerly Vice President, Physician Services and Quality*
Peru, Illinois

LaSalle County, Illinois, Episcopal Ministry **2011 to 2014**
Associate Rector
Peru, Illinois

ThedaCare, Inc. **2006 to 2009**
LEAN ThedaCare Improvement System Facilitator &
Director of Growth and Support Services, ThedaCare Physicians
Appleton, Wisconsin

Community Health Network **2003 to 2006**
Vice President, Physician Services
Berlin, Wisconsin

St. Mary's Good Samaritan, Inc. **1996 to 2003**
A member of SSM Health Care
Centralia and Mt. Vernon, Illinois

- Director of Professional Services (2000 to 2003)
  St. Mary's Good Samaritan Physicians
- Director of Corporate Communications (1996 to 2003)

Congressman Glenn Poshard **1991 to 1996**
LBJ Scholar, Legislative Assistant and Campaign Staff
Washington, DC

ORDAINED MINISTRY EXPERIENCE

Saint Francis Ministries (Saint Francis Community Services, Inc) **2014 to present**
Dean, President & CEO
Salina, Kansas

As Dean and President/CEO of Saint Francis Ministries, with corporate offices in Salina, Kansas, I lead the largest social welfare ministry founded in the Episcopal tradition which provides services to more than 31,000 children and families in Arkansas, Kansas, Oklahoma, Nebraska, Mississippi, Texas, El Salvador, Honduras, and other international efforts. I provide overall strategic direction, financial viability and corporate vision. valuates effects of external forces on Saint Francis and affiliate corporate entities with operational budgets in excess of $140 million. Ensure attainment of strategic goals and objectives occur through recruitment, selection, development, motivation, evaluation and retention of over 1,200 qualified staff. Keep board and senior staff informed about current trends, issues, opportunities, threats and activities related to the child welfare arena and marketplace. Encourage the integration of Saint Francis within the community(s) served by overseeing an effective communication and public relations program. Work with appropriate legislators, regulators, and representatives of child welfare sector, industry, civil, legislative, Church leaders to develop legislative initiatives and social policy statements which will improve child welfare services and behavior health programs.

LaSalle County Episcopal Ministry **2011 to 2014**
Associate Rector
Diocese of Chicago

As the Associate Rector, I provided sacramental, liturgical and pastoral leadership and support to four Episcopal churches that form the LaSalle County (Illinois) Episcopal Ministry. This ministry included regular Sunday celebration of the Mass, sacramental services, pastoral visitations, coordination and support of Latin American mission partnerships, teaching and other components of parish community development.

NOT-FOR-PROFIT HEALTH CARE LEADERSHIP EXPERIENCE

Illinois Valley Community Hospital **2009 to 2014**
Chief Operating Officer

As Chief Operating Officer, I was directly responsible for department operational budgets in excess of $125 million and worked to promote the development of processes and systems that result in improved patient care, patient safety and access to services. I recommended and executed service line and business unit strategies, chaired the hospital's ethics committee, served ex officio as a non-voting member of the Board-of-Directors, recruit physicians and have operational responsibilities for the system's IVCH Medical Group (which includes primary care, rural health clinics, orthopedics, ENT, OBGYN, retail health, urgent care, mental health services and a community clinic designed to meet the increasing needs of uninsured and underinsured patients), Occupational Health, Physical and Aquatic Rehabilitation, Anesthesia, Information Technology, Pastoral Care, Patient Access, Marketing and Public Relations, Continuous Improvement, Organizational Effectiveness, Quality, Utilization Review, Risk, Health Information Management and Patient Advocacy functions.

ThedaCare, Inc. **2006 to 2009**
LEAN Facilitator &
Director of Growth and Support Services
ThedaCare Physicians

As a ThedaCare Improvement System LEAN Facilitator, I led, taught and coached continuous process improvement based upon the Toyota Production System to individuals and teams in order to achieve ThedaCare's core purpose to deliver health care services with measurably better value (quality/cost).

As Director of Growth and Support Services for ThedaCare Physicians I was responsible for the analysis and recommendation of new business initiatives and ensuring the operational support functions of billing, coding, information technology (including the EPIC electronic medical record platform) and ThedaCare-On-Call nurse direct system were efficient and effective. ThedaCare Physicians employees 140+ physicians, 50+ advanced practice nurses and operates 22 medical sites in Wisconsin.

Community Health Network **2003 to 2006**
Vice President, Physician Services

As Vice President, Physician Services for Community Health Network, I developed key physician driven clinical service specialties designed to demonstrate superior clinical, financial and service performance results. This was accomplished through service growth initiatives (service lines included: primary care, urology, cardiology, orthopedics, general surgery, nephrology, obstetrics, gynecology, pulmonology and pediatrics), physician relationship improvement efforts and leading Community Health Network's Medical Group administrative function

ST. MARY'S GOOD SAMARITAN, INC. **1996 to 2003**
DIRECTOR OF CORPORATE COMMUNICATIONS &
DIRECTOR OF PROFESSIONAL SERVICES
A MEMBER OF SSM HEALTH CARE

With St. Mary's Good Samaritan, I was successful in leading the engagement of state and federal public policy makers; integrating leadership and operations of the system's employed medical group(s); creating, implementing and managing organizational development plans, edited the organization's annual Lincoln Award for Performance Excellence application based on Malcolm Baldrige National Quality Award criteria (SMGSI won the Lincoln Award's highest level of recognition in 2003) and demonstrated expertise in the development of professional communication strategies.

CONGRESSIONAL EXPERIENCE

CONGRESSMAN GLENN POSHARD **1991 TO 1996**
LEGISLATIVE ASSISTANT

My primary role as the legislative assistant was to brief the Congressman on legislative and regulatory issues impacting the 19th Congressional District of Illinois. In addition, I was responsible for coordinating constituent services particular to areas of expertise. These areas included transportation, infrastructure development and environmental legislation and regulatory impact.
Prior to joining the Congressman's professional staff I served his office as a Lyndon Baines Johnson Congressional Scholar and worked extensively on local and Congressional primary and general election campaigns.

EDUCATIONAL ACHIEVEMENTS

Doctor of Ministry — Virginia Theological Seminary
Alexandria, Virginia
anticipated graduation 2021

Master of Arts, Ministry
Cum Laude — Nashotah House Theological Seminary
Nashotah, Wisconsin
2009

Master of Arts, Business — Webster University
St. Louis, Missouri,
2003

Bachelor of Arts — Eastern Illinois University
Charleston, Illinois, 1994

REFERENCES

Mr. David Schaffer
Cell: 312.330.0300
Home Address: 1407 N. Sandburg Terrace, Chicago IL 60610-1507
Bus. Address: Miller, Canfield, Paddock and Stone, P.L.C., 225 W. Washington St., Ste. 2600, Chicago IL 60606

The Rt. Rev. Jeffrey D. Lee
Bus. Phone: 312.751.4200
Bus Address: Episcopal Diocese of Chicago, 65 East Huron, Chicago IL 60611

Ms. Mischel Miller
Cell: 620.272.4950
Home Address: 3209 SW Arrowhead Rd., Topeka KS 66614

Thomas W. Blythe

PROFESSIONAL EXPERIENCE

Saint Francis Ministries. Salina, Kansas
President/Chief Operating Officer — September 2017 to Present

Saint Francis Ministries (Saint Francis Community Services, Inc.) is a non-profit child welfare agency with operations in 7 states and Central America. Approximately 1,200 employees administer services in Foster Care, Adoption, Family Reintegration and Family Preservation to over 31,000 youth. A 42 bed inpatient Psychiatric Residential Treatment Center provides intensive inpatient treatment for youth.

- Oversees strategic development.
- Responsible for operational areas including Adoption, Family Reintegration, Foster Care, Foster Care Homes, Preservation, Residential programs and International Ministries.
- Responsible for Human Resources, Strategic Planning, Organizational Excellence, Training and Performance Improvement/Quality.
- Coordinates organization culture initiative.
- Works with departments to utilize Six Sigma to redesign processes to improve efficiency and reduce cost.

Vice President Human Resources — November 2015 to September 2017

- Redesigned and implemented organization compensation program.
- Coordinated with Director Compensation to reduce benefit expense without eliminating or altering benefit plan offerings.
- Worked with Human Resources Director to review and update Human Resources policy.
- Created the Organizational Effectiveness department to help drive Organizational behavior within the organization.

St. Mary's Good Samaritan, Inc. Centralia, Illinois
System Vice President Human Resources — October 2007 to October 2015.

St. Mary's Good Samaritan, Inc. is comprised of two acute care hospitals and a physician organization. A Joint Operating Agreement signed in 1996 formed a single organization consisting of approximately 330 beds, 1,900 employees and annual gross patient revenues of $400 million. Serving nearly 300,000 people in a nine-county area, St. Mary's Good Samaritan is the first two-time recipient of the Illinois Performance Excellence Gold Award for "Achievement of Excellence" and as a member of SSM Health Care, is part of the first health care organization to win the Malcolm Baldrige National Quality Award.

- Responsible for Human Resources across two hospital campuses.
- Developed recommendation for system wide standardized approach for employee safety and worker's compensation claims management.
- Project Team Lead of system wide initiative to standardize payroll practices and implement Employee Self Service technology across SSM as part of overall 3-year HR process standardization initiative.
- Coordinate staff transition planning in preparation for move to new Hospital in fall 2012.
- Collaborate with senior leadership to improve middle management's skills.
- Strategic Business Partner to senior management team providing support and direction regarding workforce.

Director Human Resources — April 1999 to October 2007.

- Responsible for Human Resources annual operating budget of $25 million.
- Standardized Human Resources policies, procedures, compensation and benefits between two hospitals.
- Led SSM corporate team to develop and implement peer interview program based for entire system of approximately 22,000 employees.
- Utilize CQI principles as part of the shared accountability model practiced across the organization.
- Facilitated Nursing Team on Recruitment and Retention issues.

Community Hospital of Ottawa, Ottawa, Illinois.
Senior Human Resources Coordinator — August 1996 to March 1999.

Community Hospital of Ottawa is a 124-bed not-for-profit hospital with 575 employees and annual gross patient revenues of $100,000 million.

- Reviewed pay grade structures and recommended adjustments.
- Maintained effective performance planning and review system.
- Updated personnel policies and procedures related to compensation, overtime, shift differentials, holiday and weekend premiums.
- Advised department managers regarding employment law and hospital policies.
- Maintained plan documents for health insurance, life insurance, dental insurance, long-term disability and tax-deferred annuities.

Human Resources Coordinator — May 1993 to January 1996.

- Reviewed and screened applications to determine qualifications.
- Interviewed potential applicants.
- Coordinated employee health insurance plan.
- Conducted new-employee orientation program monthly.
- Handled worker's compensation administration including accident investigation and monthly reporting.
- Assisted employees with questions concerning hospital policies, procedures and employment laws.

Illinois Hospital & Health systems, Naperville, Illinois.
Territory Representative — January 1996 to August 1996.

Illinois Compensation Trust (ICT) is a first-dollar workers' compensation program that currently serves over 100 health care organizations in Illinois.

- Administered worker's compensation benefits for twenty-seven Illinois member hospitals.

EDUCATION

Webster University, St. Louis, Missouri.
Master of Arts
March 2006. Major: Human Resources Management

Drake University, Des Moines, Iowa.
Bachelor of Science in Business Administration.
December 1991. Major: Management.

PROFESSIONAL AFFILIATIONS

American Society for Healthcare Human Resources Administration.
Central Illinois Society for Healthcare Human Resource Administration.
Society for Human Resource Management.
Jefferson County YMCA, Board Member
Jefferson County Development Corporation, Workforce Development Committee Member

PROFESSIONAL REFERENCES

Brenda Alexander
Vice President Human Resources
St. Mary's Good Samaritan, Inc.
1 Good Samaritan Way
Mt. Vernon, IL 62864 618-899-1042
brenda_alexander@smgsi.com

Tim Link, MA, MCC
Master Certified Coach
Principal - Link Resource Group, Inc.
Leadership Coaching and Organizational Consulting
Phone: (316) 634-2328

Jeff Wipperman
Senior Vice President
Truss Advantage
551 W 107th St #300, Overland Park, KS 66207
mobile: 816.536.6008

W. Dean Fuhrman | 913-269-0383 | wdfuhrman@mac.com | 2117 W. 50th Street, Westwood Hills, KS 66205

Summary profile

Began career in international multi-disciplinary accounting and consulting firms. Acquired significant knowledge base about business and people, how to manage multiple business needs and demands while also keeping the big picture in mind. Adept in all aspects of financial management with experience in multiple industries. Co-founded, developed and operated a local CPA firm, and subsequently worked for two clients in upper level management positions in financial services and real estate development/management. Currently Consultant and CFO Specialist working chiefly with clients in transition. Strong manager experienced in handling operations, financial and accounting needs, human resources and planning. A summary of work experience follows this section.

Experience

Consultant and CFO Specialist

Provides executive leadership through Tarsus CFO Services, LLC by developing unique and innovative solutions to problems in diverse industries and functional areas such as financial reporting, analysis and planning, cash flow forecasting, metric reporting, acquisitions, restructurings, divestitures, capital formation, stakeholder communications, working capital analysis and process improvement. Key projects include:

- Developed, in conjunction with management and investors, processes and plans for controlling and improving cash flow for companies in transition (growth, acquisitions, business restructurings)
- Created a blueprint for operating, tax, and financial processing and reporting for a start-up technology firm
- Coordinated hiring process for newly-form, private-equity-backed service company and then worked extensively with the CPA firm to complete the first-year audit.
- Developed financial reporting structure for multi-state, multi-entity company, including acquisition reporting, GAAP compliance, and management and investors needs
- Mobilized to triage multiple financial management issues for a company in transition after changes in the management structure
- Developed cash forecasting models to improve management insights into operating needs

Real Estate Development and Management

Hired by Union Hill, a Kansas City real estate development and management company with 21 employees, to provide accounting and management expertise in connection with growth plans. Responsible for accounting, cash flow management, internal operational and external financial reporting for 17 companies, tax and other compliance matters, risk management, human resources, and IT management (with outside IT consulting firm as technical resource). Key projects include:

- Managed bookkeeping transition from long-time bookkeeper
- Converted accounting software while recovering from an accounting server crash
- Issued Tax Increment Financing bonds for the Union Hill area

Small Business Consulting

Provided cost effective management support for small businesses. Key projects include:

- Facilitated strategic and operational planning
- Supervised accounting function and prepared accounting records and financial statements for audits of 10 investment funds, along with leading preparation of related tax returns with outside CPA firm
- Streamlined existing accounting systems for efficiency

- Assisted with all aspects of a business purchase, along with setting up accounting, operational, and marketing processes and documentation
- Advised and assisted in determining software/hardware needs and facilitated installation for small businesses
- Designed and maintained website and monthly newsletter for a small business

Investment Advisory / Brokerage

Hand picked to manage Prairie Capital Management, Inc.'s national wealth management and brokerage practice's back office operations to free up other executives to pursue firm growth strategies. Responsible for staff supervision, brokerage operations and administrative staff, improving workflow processes, and providing accounting and tax support internally and for clients. Key projects include:

- Designed workflow process improvements for investment advisory and brokerage services and internal accounting systems accommodating significant growth (over 400% growth in assets under management) while limiting staff headcount growth
- Performed supervisory compliance reviews of brokerage and investment advisory services and participated in regular regulatory examinations by SEC, FINRA, and other agencies
- Planned and prepared for annual financial statement audits and lead tax return processing with outside CPA firm for nine investment funds
- Developed staff: hired 30 new staff members and lead a staff of approximately 25
- Improved cash flow through improved billing and accounts receivable processes
- Planned for and implemented conversion of existing brokerage platform to new clearing broker

Professional Service Firms

Worked at two large international CPA firms and spent a year working as the controller for a locally owned marketing/graphic design firm. Then co-founded a local CPA firm focusing on small business's and individual's accounting, tax, and consulting needs. Key projects include:

- Created and operated two CPA firms, including acquiring and integrating two CPA firms as part of growth and profitability strategy
- Worked extensively with small business owners assisting them in their personal and business matters
- From 2001 through 2007, tax practice was focused exclusively on working with high net worth individuals in connection with other duties at Prairie Capital
- Lead privately and publicly held businesses audits, including initial public offerings
- Developed and improved staff performance; frequently assigned staff targeted for additional training or experience and worked with all staff for improved performance and taught national audit training courses for second-year staff at international CPA firm

W. Dean Fuhrman | 913-269-0383 | wdfuhrman@mac.com | 2117 W. 50th Street, Westwood Hills, KS 66205

Employment History

Years	Position	Company	Industry
2014 – Present	CFO Consultant	Tarsus CFO Services, LLC	Construction, Service, and Manufacturing
2012 - 2014	CFO	Union Hill	Real Estate Development / Management
2008 - Present	Co-Owner	Yoga Gallery, LLC	Yoga Studio / Leisure and Fitness
2008 - 2012	Owner/Consultant	Self-employed	Consulting
2001 - 2007	CFO	Prairie Capital Management, Inc.	Financial Services
2001 - 2007	Vice President	George K. Baum & Company	Financial Services
2001 - 2007	Vice President	PCM, Inc.	Financial Services
2001 – 2007	Owner/President	W. Dean Fuhrman, CPA, P. A.	Professional Services / CPA
1985 – 2000	Owner/President	Fuhrman & Tierney, P. A.	Professional Services / CPA
1983 – 1985	Supervisor	Laventhol & Horwath	Professional Services / CPA
1982 – 1983	Controller	Studio in the Woods, Inc.	Professional Services / Marketing
1977 – 1981	Supervising Senior	KPMG	Professional Services / CPA

Education / Professional Designations / Other

Bachelor of Science in Business Administration (with honors) Kansas State University

Certified Public Accountant

FINRA Brokerage Licenses Series 7 General Securities Representative, Series 24 General Securities Principal, and Series 66 Uniform Combined State Law Examination

Graduate Leadership Overland Park

Board Member, Support Kansas City, Inc. – Audit Committee Chair; Marketing/Development Committee

References

Darrell R. Tierney, President, Windward Private Wealth Management, Inc.

10955 Lowell Avenue, Suite 410, Overland Park, KS 66210 Ph. 913-381-7411

Cal Stolle, Consultant

4900 Main Street, Suite 750, Kansas City, MO 64112 Ph. 913-558-2905

Mike Duncan

4759 Quivira Drive, Shawnee, KS 66216 Ph. 913-709-6136

DIANE CARVER

Vice President Children and Family Services

WORK EXPERIENCES

Saint Francis Community Services, Inc. (2016-Present)
Vice President – Children and Family Services

- Responsible for all operational aspects of Reintegration, Foster Care and the Adoption Program and the ultimate program quality for DCF.
- Responsible for hiring and retaining competent RFC staff with the assistance of Area Directors, supervisors and HR staff.
- Serves as direct supervisor for Area Directors, Assistant VP-RFC, Care Management staff and departmental assistant. Coordinates, supervises and provides leadership and general oversight for all direct reports.
- Develops and executes operational plans and budgets. Implements and executes the operational plans within budget.
- Directly responsible for design, development and implementation of the RFC program.
- Monitors program to assure compliance with licensing and accreditation standards, established administrative, financial, clinical, and personnel policies, procedures and protocol.
- Provides leadership, guidance, and direction for program, to ensure compliance with outcomes.
- Participates in strategic planning processes with Executive Leadership Team.
- Translates the corporate vision into actionable plans.
- Works to continuously improve service delivery to ensure efficiency and effectiveness.
- Operates program/department in a manner which promotes financial viability.
- Liaison with DCF and the courts, assuring a positive working relationship to facilitate accomplishing program outcomes.
- Collaborates with local agencies to determine community needs and develop a full continuum of services for youths and families. Coordinates relationships with staff, providers, consumers, and the program.

Kansas Department for Children and Families (2012—2016)
Public Service Executive II, Prevention and Protection Services

- Provided statewide leadership, planning, implementation and administration of child welfare prevention and protection services.
- Responsibilities included program, resources and personnel management, information management, monitoring and evaluation.
- Served as member of statewide protection and prevention management team.

Kansas Social and Rehabilitation Services (2004-2012)
Public Service Executive I, II, Children and Family Services

- Provided leadership, planning, implementation and administration of Adult Protective Services and Children and Family Services (APS/CFS) programs within the region.
- Duties included direction of a large professional, paraprofessional and clerical staff in developing program goals and devising effective and efficient administrative procedures to achieve those goals in accordance with federal/state laws, rules, and regulations and polices.

Responsible for resource management regarding allocations, contracts and grants (totaling over three million dollars per year.

References

Thomas Buell
DCF Wichita Regional Director
2601 S. Oliver St.
Wichita, KS 67210
316-337-7000
Thomas.Buell@ks.gov

Pamela Beach
DCF West Regional Director
2709 Amherst
Manhattan, KS 66502
785-776-4011
Pamela.Beach@ks.gov

Amy Neuman
DCF Administrator
410 N. Haverhill Rd
El Dorado, KS 67042
316 321-4200
Amy.Neuman@ks.gov

Matthew R. Stephens Matt.Stephens@st-francis.org

EDUCATION:

Bachelors of Science in Social Work
Kansas State University, Manhattan, KS

WORK EXPERIENCE:

Vice President, System Improvement and Innovation September 2018-Present
Saint Francis Ministries, Salina KS

- Managed staff facilitate solution based employee workgroups utilizing Lean Six Sigma methodology
- Provide oversight to Performance Improvement/ Quality Assurance Department
- Coordinate Kansas Quality Award efforts

Director of Innovation Center April 2016-September 2018
Saint Francis Community Services, Salina KS

- Facilitate solution based employee workgroups utilizing Lean Six Sigma methodology
- Support Saint Francis in performance excellence initiatives
- Provide guidance to Process Improvement Specialists

Administrator December 2011-April 2016
Neuvant House of Lawrence, Lawrence KS

- Coordinated and communicated with staff, family, and community members about the addition of Neuvant House East
- Ensure facilities were operated in accordance with State of Kansas Adult Care Home Regulations
- Led a staff of 25-30 employees including hiring, training, and provided staff with usable feedback

Social Work Specialist July 2006 –December 2011
SRS, Lawrence, KS

- Formed positive relationships with individuals and agencies working in the child welfare system
- Collaborated and effectively communicated with community professionals
- Investigated and assessed child abuse/neglect allegations

AWARDS AND LICENSES:

Certified Lean Six Sigma (Green Belt)
2016
Bronze Award (Neuvant House) American Healthcare Association
2014
2012 Deficiency Free Surveys
2012
Licensed Adult Care Home Operator
Present
Child Welfare Scholar Recipient
2005-2006

ORGANIZATIONS:

Member, The Shelter Inc. Board of Directors
Treasurer, Lawrence Area Partners on Aging
Member, Jayhawk Breakfast Rotary Club
Member, Lawrence Chamber of Commerce

REFERENCES:

Kris Roy
Executive Director
The Children's Shelter
1925 Delaware Street
Lawrence KS 66049
kroy@theshelterinc.org
F: (785) 843-2085

Sherry Marshall
Executive Director
Midwest Excellence Institute
4215 Philips Farm Road, STE 101-A
Columbia, MO 65201
sherry.marshall@midwestexcellence.org
573-817-8310

Alison Kossover
Owner
Kossover Strategic Business Solutions
5331 Kenton St
Shawnee, KS 66226
alison@kossoversolutions.com
913 707 3694

Cost Proposal

original
RFP 5995 Z1

Saint Francis
Community Services®

Serving Children and Families Since 1945

Attachment C
Cost Proposal

Saint Francis
MINISTRIES

Attachment C
Cost Proposal

Saint Francis Ministries • 509 E. Elm Street • Salina Kansas 67401
785-825-0541 • Toll Free: 800-423-1342

Cost Proposal

Request for Proposal Number 5995 Z1

Firm Name: Saint Francis Community Services

	Initial Contract Period Year One	Initial Contract Period Year Two	Initial Contract Period Year Three	Initial Contract Period Year Four	Initial Contract Period Year Five	First Optional Renewal Period Year One	Second Optional Renewal Period Year One
Monthly Administrative Cost	$ 136,559	$ 313,527	$ 329,204	$ 345,664	$ 362,947	$ 381,094	$ 400,149
Monthly Program Cost							
Monthly Family Preservation	$ 341,398	$ 783,818	$ 823,009	$ 864,159	$ 907,367	$ 952,736	$ 1,000,372
Monthly On-Going Case Mgmt	$ 136,559	$ 313,527	$ 329,204	$ 345,664	$ 362,947	$ 381,094	$ 400,149
Direct Services	$ 68,280	$ 156,764	$ 164,602	$ 172,832	$ 181,473	$ 190,547	$ 200,074
Monthly Out-of-Home Care	$ 819,355	$ 1,881,163	$ 1,975,221	$ 2,073,982	$ 2,177,681	$ 2,286,566	$ 2,400,894
Total Monthly Program Cost	$ 1,365,591	$ 3,135,272	$ 3,292,035	$ 3,456,637	$ 3,629,469	$ 3,810,943	$ 4,001,490
Annual Do Not Excess Amount	$ 18,025,808	$ 41,385,589	$ 43,454,868	$ 45,627,612	$ 47,908,992	$ 50,304,442	$ 52,819,664
Startup Costs	$ 1,043,904						

Attachment One
award of Initial Funds

5995 Z1 ATTACHMENT ONE – AWARD OF INITIAL FUNDS

SUBRECIPIENT INFORMATION	
Subrecipient Name	Saint Francis Ministries, Inc., f/k/a Saint Francis Community Services, Inc.
Subrecipient DUNS Number	831126193
Parent DUNS Number	831126193
Principal Place of Performance (City/State/Country/Zip Code + 4)	Corporate Office 509 E. Elm Street Salina, KS 67401-2353
Nebraska Congressional District	2nd

FUNDING TOTALS	
Total Amount of Federal Funds Obligated	$
Total Amount of State Cash Funds Obligated	$
Total Amount of State General Funds Obligated	$
Total Amount of Federal Award Committed to Subrecipient	*Same as Total Subaward below*
TOTAL SUBAWARD	0

Federal Agency Name	Catalog of Federal Domestic Assistance (CFDA) Name	CFDA Number	Federal Award Date	Federal Award Identifier Number (FAIN)	Amount of Federal Funds Obligated
Administration for Children and Families	Title IV-E Foster Care	93.658	October 1, 2018	G-1901NEFOST	$
			Click here to enter a date		$

ADDENDUM FIVE - REVISED SCHEDULE OF EVENTS

Date: May 30, 2019

To: All Bidders

From: Annette Walton / Nancy Storant, Buyer
AS Materiel Purchasing

RE: Addendum for RFP Number 5995 Z1 opened April 4, 2019 at 2:00 p.m. Central

---

Schedule of Events

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

1.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	June 4, 2019 ~~May 30, 2019~~ ~~May 15, 2019~~
2.	Subaward finalization period	June 4, 2019 ~~May 30, 2019~~ ~~May 14, 2019~~ Through June 30, 2019 ~~June 14, 2019~~
3.	Award of subaward	July 1, 2019
4.	Subrecipient start date	January 1, 2020

This addendum will become part of the proposal and should be acknowledged with the RFP.

ADDENDUM FOUR- REVISED SCHEDULE OF EVENTS

Date: May 16, 2019

To: All Bidders

From: Annette Walton / Nancy Storant, Buyer
AS Materiel Purchasing

RE: Addendum for RFP Number 5995 Z1 opened April 4, 2019 at 2:00 p.m. Central

---

Schedule of Events

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

1.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	May 30, 2019 ~~May 15, 2019~~
2.	Subaward finalization period	May 30, 2019 ~~May 14, 2019~~ Through June 30, 2019 ~~June 14, 2019~~
3.	Award of subaward	July 1, 2019
4.	Subrecipient start date	January 1, 2020

This addendum will become part of the proposal and should be acknowledged with the RFP.

ADDENDUM THREE, QUESTIONS and ANSWERS 2ND ROUND

Date: February 27, 2019

To: All Bidders

From: Annette Walton / Nancy Storant, Buyers
AS Materiel, State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5995 Z1 to be opened April 4, 2019 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the RFP. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.	V.A.4. and V.A.5.	25	Is there an expectation that all licensed foster homes are Resource Family Homes?	Yes. The goal for DHHS is o have all licensed foster homes provide visitation and mentoring to caretakers in order to speed the reunification process.
2.	V.A.4., V.A.5., and Glossary of Terms	25, vi-xii	There is no definition for "licensed foster home" or "foster home" in the Glossary of Terms section. Please provide a clear differentiation between "licensed foster home" and "resource family home."	Foster home - General term used for out-of-home care placement in a family setting. This could include Relative Foster Home, Kinship foster Home or Licensed Foster Home licensed through an Agency Supported Foster Care contractor. Licensed Foster Home, or Licensed Foster Care Home – The term used for a foster home that has met State requirements for licensure as a Licensed Foster Care Home. The Resource Family Home is required o be a Licensed Foster Care Home and the bidder should propose a model that would fit the requirements of the RFP. (Resource Family Service, which includes the

				delivery of foster care services, respite care, family support and visitation services to children and families residing in the state of Nebraska. The objectives of the Resource family are focused on 1). Delivering high quality foster care and wraparound services for families whose children have been removed from the home of the caretaker; 2) Implement evidence-based models of foster care to the Child Welfare service array in order to meet the requirements of the Families First Prevention Service Act, and; 3) Integrating a family-focused and family driven approach that builds protective factors in families. The roles and responsibilities of the Resource Family is to provide care for children removed from their caretaker; mentoring for caretakers whose children have been placed in the Resource Family home; visitation between the caretaker and the child; engagement with and support of the caretaker; provide transportation for child to and from appointments, school, and school activities, and; maintain level of normalcy for the child to the extent possible.
3.	V.A.9.d.	32	Is the expectation that the North Carolina Family Assessment Scale be completed for every youth receiving case management, irrespective of their legal (court vs. non-court) or placement (in-home vs out-of-home) status? If yes, then is this required to be completed by the caseworker or can this be completed by a service	Yes. The North Carolina Family Assessment should be completed internally for every family receiving case management services. The North Carolina Family Assessment is required to be completed by the case worker.

			provider?	
4.	V.C.5.j. and V.C.5.k.	36	Currently relative placements and kinship placements are considered “out of home” as there is a removal from the parent. Going forward, under FFPSA: 1. Will there be times when a child is placed with a relative, but not considered a removal? If yes, then: a. Will this placement be paid? If yes, then will the Nebraska Caregivers Responsibilities (NCR) tool determine the rate? If not the NCR, then what will determine the rate? b. Will these relatives be considered resource parents? c. Will the placement need to be provisionally licensed? 2. Will there be times when a child is placed with a non-relative (fictive kin), but not considered a removal? If yes, then: a. Will this placement be paid? If yes, will the Nebraska Caregivers Responsibilities (NCR) tool determine the rate? If not the NCR, then what will determine the rate? b. Will these fictive kin be considered resource parents? c. Will the placement need to be provisionally licensed?	1. Yes. 1a. No. Informal living arrangements can be identified and utilized by the family. This is an informal support and does not receive foster care payments. 1b. No. 1c. No. 2. Yes. Removals are completed by law enforcement or the courts. Families can be engaged in informal living arrangements on their own. 2a. No. These are supportive services identified by the family to assist them in times of crisis. 2b. No. 2c. No.
5.	V.D.9.	38	How many youth are currently being served through the Interstate Compact on the Placement of Children (ICPC) in the ESA?	43 youth are currently being served through ICPC in the ESA.

6.	V.H.8.a.	43	The RFP calls for monthly financial statements prepared using the accrual method according to GAAP. In our monthly reconciliations, we have found that it works well to produce financial statements using paid claims only for expenses (partially cash method). If the year-end financials are prepared using the accrual method, would the State be open to negotiating the best method to produce the monthly financial statements?	DHHS requires the accrual method for monthly financials due to timeliness of information.
7.	VI.A.2.i, Attachment Six (REQ # CO-3), and Question 90 of Addendum 2	57, Attach. Six Pg 2, and Addendum 2 pg 16	We currently have over 300 staff working on the case management subaward, is a resume required for each of them? If no, then please identify the minimum project personnel that bidders are required to include resumes for.	No. Please send resumes for CEO, COO, CFO, Director of CQI, and Case management directors.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal response.

ADDENDUM TWO
QUESTIONS and ANSWERS AND REVISED SCHEDULE OF EVENTS

Date: February 13, 2019

To: All Bidders

From: Annette Walton/Nancy Storant, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5995 Z1to be opened April 4, 2019, at 2:00 P.M. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.	V. C. 2	34-35	Will the subrecipient be required to complete the Structured Decision Making (SDM) Safety Assessment, Family Strengths and Needs Assessment, and the Risk Assessment? For subrecipients not currently utilizing this model at the time of award, will a grace period be given for training and implementation?	Yes. No, implementation and training should be addressed in the transition plan. The Subrecipient must be ready to start Jan 1, 2020.
2.	V. A. 9. D	32	Is the subrecipient required to complete the North Carolina Family Assessment Scale (NCFAS) in addition to the SDM Family Strengths and Needs Assessment?	Yes.
3.	V. C.	33	Scope of Practice lists Family Preservation as separate from On-going Case Management, but the RFP does not list a separate description of requirements. Are the requirements listed in Section C, Project Requirements the same for Family Preservation Services?	Family Preservation, for the purposes of the RFP, are stand-alone services requested from the Subrecipient to meet the needs of a family during the investigation process. This does not include case management services. No, the requirements are not the same.
4.	V. D. 1	36	What is meant by a "catalogue of in-home	The Subrecipient should provide a listing, with descriptions of all in-home services that will be made

			services available in each zip code of the Eastern Services Area"?	available in the zip codes of Eastern Service Area (ESA).
5.	V. E. 10. b. I	40	Where can staffing rations for this RFP be found?	Please see Statute 68-1207 at https://nebraskalegislature.gov/laws/statutes.php?statute=68-1207 Reference can also be found in Attachment Two Eastern Service Area Operations Manual of the RFP, page 23.
6.	IV. A	25	Are residential placements case managed by the subrecipients, and are they paid by the subrecipients? If so, what are the rates and number of youth placed in each facility?	Yes. Any residential placements that are not funded by Nebraska Medicaid would be paid by the Subrecipient. Currently there are three levels of residential placement that are not paid by Medicaid: Group Home A (GHA), Group Home B (GHB), and Emergency Shelter Care (ESC). The rates for each are: GHA = $116.00/day GHB = $89.50/day ESC =$146.00/day Placement as of 01/14/2019: GHA - 1 GHB - 23 ESC - 3
7.	Attachment 2, 3. Caseload Ratio Requirements	23	What is the expected ratio for Case Managers and Supervisors?	The current staffing ratio for DHHS Case Managers to Supervisors ranges from 6:1 to 7:1.
8.	Attachment 3	1	Can DHHS provide a breakdown of the current percentage of placements in Essential, Enhanced, and Intensive levels of foster care?	Approximately; Essential – 53% Enhanced – 35% Intensive – 12%
9.	Attachment 3	1	Is a list of licensed foster homes with the number of beds available for the Eastern Service Area?	Yes. It will be made available to the Subrecipient after award of the contract. There are approximately 837 licensed foster home beds in the Eastern Service Area.
10.	Attachment 3	1	What percentage of children are being placed in the current subrecipient's sponsored foster homes compared to subcontractors' foster homes?	Approximately 25% of children are placed in homes sponsored by the current Suprecipient. Approximately 75% of children placed out of the home are placed in homes sponsored by subcontractors of the Subrecipient.
11.	Attachment 3	1	Is the number of local residential placements in the Eastern Service Area available, and if so, does it detail bed capacity?	Please see the following link for details on residential placements in the Eastern Service Area Roster of Licensed Residential Child-Caring Agencies: http://dhhs.ne.gov/publichealth/documents/ResidentialAndChildCaringRoster.pdf Yes.
12.	1. C. Schedule of Events	2	The subaward will be awarded July 1st but the start date is	Yes.

			not until January 1, 2020- is the subrecipient able to hire staff during the period between the award and the start date, and will the subrecipient be reimbursed for those costs?	 Yes. All costs allowed by the contract will be reimbursed.
13.	V. E. 2	38	Is the subrecipient required to transport clients both within the state **and** out-of-state?	Yes.
14.	V. H. 8. a	43	What are the new foster care reimbursement rates?	See Attachment Five Foster Care Reimbursement Rate Committee Eighth Meeting Transcript.
15.	IV. A	25	Is the subrecipient responsible for purchasing equipment to communicate with the State of Nebraska to submit invoices?	Yes.
16.	V. H. 8. A	43	What are the requirements for the monthly financial statements?	DHHS requires financial statements including a balance sheet, income statement, and statement of cash flows in a format to be agreed upon during subaward negotiations. The financial statements will be prepared using the accrual basis of accounting and using Generally Accepted Accounting Principles (GAAP).
17.	Attachment 3	1	Does the number of recipients for In-Home services in Attachment 3, Column G, represent children or families?	The number represents the number of children.
18.	Introduction	V	The ESA represents 40% of the child welfare population of Nebraska. What percentage of the 40% are referred to Alternative Response? Is it possible to have children from the same family involved in both this contract and Alternative Response? If/when that happens, how will services with the family, especially the parents, be coordinated?	As of June 2018, 7% of children in open cases in ESA were involved in Alternative Response. DHHS handles all Alternative Response cases. The only way for children to be served in AR and by the Subrecipient at the same time would be if a family was in the process of adopting children or fostering children and had an open case with the Subrecipient and an intake came in on the parents and their biological children. If this were to happen, the CFS AR Worker would coordinate with the Sub-recipient worker to speak with the non-biological children in the home. The CFS AR worker would address any services the family needed in relation to the reason for the AR Intake and allow the Subrecipient worker to continue to address the services and needs of the family related to their case. Coordination will take place between the family, AR worker and the Subrecipient.

19.	Introduction	V	"The CFS investigative worker and the subrecipient's newly assigned case management worker will meet with the family together either at the home or at the first court hearing, to transfer case management responsibilities" Will CFS meet with the family prior the first court hearing to complete family find activities as well as engage the caregivers?	Yes.
20.	Introduction	V	Subrecipient Key Roles and Responsibilities does not list Independent Living activities; however, they are listed elsewhere in the proposal. On page 45 it states that the bidder is not responsible for payment for "Case management and extended services for a young adult who has entered into a voluntary services and support agreement under the Bridge to Independence Program, except those requirements under said program that should be performed prior to the time the young adult reaches 19 years of age and is discharged from Resource Family care". Please provide explanation around the Bridge to Independence Program and which children/what services the bidder will be expected to serve?	Information regarding the Bridge to Independence Program can be found on the DHHS website: http://dhhs.ne.gov/children_family_services/BridgeToIndependence/Pages/Home.aspx The Subrecipient will be responsible for ensuring state laws and Bridge to Independence program requirements are met in regards to the youth that have not yet reached the age of 19 years and are involved with ongoing case management services.
21.	Section 1-C	2	The opening is April 4, 2019 at 2:00 p.m. CST. By what date must the proposals be submitted in order to make sure they are included in the proposal opening?	The response must be submitted at any time prior to April 4, 2019 at 2:00 pm CT. Any response received after this date/time will not be evaluated.
22.	Section 1-C	2	Does the bidder need to present at the Proposal Opening?	No.
23.	Section II-	11	With what frequency does the State pay the subrecipient? When payments are delayed for breach or another reason, how long may the State withhold payments from the subrecipient?	Monthly. For noncompliance with law or the terms of this subaward, the state may impose additional conditions pursuant to 45 CFR 75.207, may take other actions including withholding of payments pursuant to 45 CFR 75.371, or may take any other action available to it under the terms of this subaward or under law

			Do late payments from the state accrue interest?	Interest on any payment must be pursuant to and consistent with the Nebraska Prompt Payment Act, Neb. Rev. Stat. §§ 81-2407 et seq.
24.	Section	13	Must the $1,000,000 bond be secured for proposal or upon award?	The performance bond must be obtained prior to contract execution.
25.	Section V-A-4 and 5	32	Is the expectation that only the bidder will recruit, retain and presumptively license “Resource Family Homes”? What licensing designation would this be under the LCPA for each home? Can you please provide more detail around caregiver and organization expectations for the roles and responsibilities of these families? V.A. 4 and 5 state that the bidder will recruit and retain resource families. Could you provide baseline data as to current number of resource families in the Eastern Services Area? what is the pay structure for resource families vs. traditional foster or treatment foster families?	No, Subrecipient can recruit, retain, and license homes or subcontract to recruit, retain and license Resource Family Homes. The license designation would be a licensed Foster Care Home by the Division of Public Health. Resource Family Service, which includes the delivery of foster care services, respite care, family support and visitation services to children and families residing in the state of Nebraska. The objectives of the Resource family are focused on 1). Delivering high quality foster care and wraparound services for families whose children have been removed from the home of the caretaker; 2) Implement evidence-based models of foster care to the Child Welfare service array in order to meet the requirements of the Families First Prevention Service Act, and; 3) Integrating a family-focused and family driven approach that builds protective factors in families. The roles and responsibilities of the Resource Family is to provide care for children removed from their caretaker; mentoring for caretakers whose children have been placed in the Resource Family home; visitation between the caretaker and the child; engagement with and support of the caretaker; provide transportation for child to and from appointments, school, and school activities, and; maintain level of normalcy for the child to the extent possible. Resource Family is not currently part of the service array in Nebraska. DHHS is seeking a bidder to propose a model that will meet the requirements of this RFP. There is no baseline data for the current number Resource Families in the Eastern Service Area. At this time there is no pay structure for the Resource Family service to compare to traditional foster care. Nebraska Medicaid currently does not have a pay structure for treatment foster care.
26.	Section V-A-9-a	32	Is DHHS using the criteria from the Feds to identify	Yes.

			programs as Well Supported, Supported and Promising practices? Can programs found on the California Evidence Based Clearinghouse for Child Welfare practice be used? What Well Supported services are available in the existing service array? What Supported services are available in the existing service array? What Promising Practices are available in the existing service array?	Yes. Information on Nebraska Evidence-Based Practices can be found on the DHHS website at: http://dhhs.ne.gov/children_family_services/Documents/Nebraska%20Evidenced%20Based%20Practices.pdf
27.	Section V-A-9-g	32	Does having two beds available for every child include all homes licensed by DHHS and treatment foster care agencies? What is the expected time frame for this goal? How many foster homes are licensed in the ESA service agency? Is the expectation for approximately 5400 homes based on the June 2018 DHHS census?	No. The required time frame to have two beds for every child in care is by Operational Start Date. (Please see glossary for Operational Start Date) There are 651 licensed foster homes in the ESA as of 01/29/2019 It is required that the Subrecipient have two *beds* in licensed foster homes for every child in care in the Service Area.
28.	Section V-A-9-g	32	Do DHHS foster home licensing requirements differentiate between relative/kinship foster homes and non-relative/kinship foster homes?	Currently in regulations there are items that are able to be waived for a relative foster home in order to license that home. All other homes, including kinship foster homes, must go through all licensing requirements (http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-395/Chapter-03.pdf).
29.	Section V-B-2 & 4	33	What is the reimbursement for services DHHS utilizes from the subrecipient's service array during the Initial Assessment for youth who are not referred for on-going case management?	Under current protocol, during the IA, if safety services, placement services or any paid intervention is needed to ensure family safety, the family is referred to the Subrecipient for service coordination and delivery. The Subrecipient utilizes their current provider panel/service array to meet the needs of the family on a Utilization Management service delivery model. The IA worker remains primary case manager until time of transfer, but all services are arranged and paid for via the Subrecipient. These services are billed to the DHHS under a separate rate than the case management rate.
30.	Section V-B-8-c	33	Does DHHS approve emergency placement changes?	No.

			Can the subrecipient make these emergency placements if immediate notification is made to DHHS and the court following the placement change?	Yes.
31.	Section V-B-10-a	33	Is the subrecipient responsible for collecting needed verifications for IV-E eligibility? Is the subrecipient responsible for determining IV-E eligibility?	Yes. No, the Subrecipient would not be responsible for determining IV-E eligibility, as that responsibility remains with our DHHS staff.
32.	Section V-C-1	33	Will subrecipient be permitted to participate in and utilize DHHS's CQI process including PPI (Provider Performance Improvement)?	Yes.
33.	Section V-C-2-b	34	Can the subrecipient attend trainings offered through DHHS? Will subrecipient be permitted to participate in DHHS's pre-service training (initial caseworker training) program? Will DHHS provide the subrecipient training on DHHS tools, such as the SDM tool? Will DHHS provide training on NFOCUS? What kind of training is available re: The Indian Child Welfare Act and effective implementation of services with tribe members?	Yes. Yes. Yes. Yes. New worker training includes dedicated time to train and educate about the Indian Child Welfare Act (ICWA), including federal and state laws and regulations. The ICWA Case Management Guide developed by *Center for Children Families and the Law* and DHHS is utilized for much of the ICWA training, which is provided in the classroom setting and via online learning for approximately seven hours. References to the ICWA are made throughout the training, as applicable, and specific N-FOCUS training related to completing Cultural Plans is also included. Additionally, DHHS is available for technical assistance in connecting and working with the Tribes.
34.	Section V-C-5-d	36	The bidder is expected to "Identify and consider all relatives and kin first." Typically this is part of the	There are family finding efforts by DHHS prior to the first court hearing. This question should be taken in full context of V-C-5 – "The Subrecipient must exhaust all other options prior to placing a child outside the family home.

			initial meeting with the family. Since the bidder is not introduced until the first court hearing, does this mean that no family find activities occur before the "hand off"? Please define the specific family find responsibilities between DCFS and the bidder as well as timeframes to engage these potential resources.	When placements outside the family home must occur, the Subrecipient shall: Identify and consider all relatives and kin first, as possible placement options including placement with any known sibling." DHHS will make every effort to locate relatives during the investigation stage in the event the child needs to be removed from the caretaker's home. If no relatives are located prior to the transfer of the case to the Subrecipient, the Subrecipient will be responsible for family finding services in order to place the child with family or find permanency within the federal time frames.
35.	Section V-C-5-l	36	Is the "provisional license" designation available for foster parents or only for relative or kinship homes?	Available for all current regulations state for Provisional License: DHHS may issue a time limited, nonrenewable provisional license to an applicant who is unable to comply with all licensure requirements and standards, has a documented plan to comply and is capable of compliance within the time period stated in the license as approved by the licensing agent and licensing agency.
36.	Section V-D-1	36	Please describe exactly what DCFS would expect in a "Catalogue of In-Home Services". What is the purpose of this document for the proposal? Is there a current catalogue and if so, could you please provide an example?	The Subrecipient should provide a listing, with descriptions of all in-home services that will be made available in the zip codes of ESA. The purpose of the catalogue is to: 1) to determine if the Subrecipient has appropriate services for the population in the Eastern Service Area; 2) verify any evidence-based models in accordance with FFPSA and in order to claim IV-E funding for in home services; 3) develop coding for tracking purposes. No, a future service catalogue will adhere to requirements of FFPSA. Please see Attachment 8 FFPSA INFORMATION
37.	Section V-D-3-b	36	"Culturally humble" is repeated throughout. What is the working definition that DHHS is using for this phrase? In order to hire appropriate bi-lingual staff, what languages are most prevalent in the ESA?	**Cultural humility** is the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of **cultural** identity that are most important to the [person]." Families are viewed as collaborators in the process and teach us about their own uniqueness. Those who practice cultural humility view their families as capable and work to understand their worldview and any oppression or discrimination that they may have experienced as well. Spanish, Somali, Karen, Dinka, Vietnamese
38.	Section V-D-4-a	37	"The subrecipient must ensure that a sufficient capacity of trained resource families are available to foster and adopt	Yes, this will include all provider agencies the Subrecipient subcontracts with in order to meet this requirement.

			children in the Eastern Service Area”. Does this include all provider agencies?	
39.	Section V-D-9	38	What types of cases are included in these courtesy supervisions? ICPC cases? Other DHHS youth in Nebraska? Are there other types? Presumably these would be children from other areas of Nebraska rather than ICPC. Would the payment structure be the same? Would the bidder be responsible for setting up a contract for payment with DCFS in those areas or does “courtesy” mean without reimbursement?	This includes ICPC cases and other state wards who may originate from other Service Areas in the state of Nebraska but have been placed in the Eastern Service Area. The payment structure would be the same. The Subrecipient will be reimbursed for services rendered for courtesy.
40.	Section V-E-2-c	38	What types of youth and/or circumstances require secure transportation?	The most common circumstance is when a youth, who has been arrested and held by Law Enforcement, and *not* supervised by State Probation, must be transferred to a secure facility or detention facility
41.	Section V-E-3	38	It states that the subrecipient shall complete a Social Security Administration Access Agreement. Will this allow for the subrecipient to receive data exchanges from SSA?	In the administration of the foster care program, it is sometimes necessary for the Subrecipient to have access to information obtained from the Social Security Administration. The successful Subrecipient will need to cooperate with DHHS to execute all necessary agreements and establish required safety protocols to receive this information.
42.	Section V-E-5-b-vi	39	Is drug testing required at the time of employment only? What is the minimum panel required for drug testing?	Drug testing would be required as part of the hiring process and any other time as requested by DHHS. The minimum panel required is a five-panel drug screen. CFSS candidates are tested for Amphetamines, Cocaine, Marijuana, Opiates, Phencyclidine (PCP).
43.	Section V-E-8-c	40	Is it permissible to submit a proposal that includes an already-identified second-tier subrecipient? What are the specific requirements related to the competitive bid process for the second tier subrecipients? Can these be waived?	Yes, as long as the Second-Tier Subrecipient was retained via the process described in Section V.E.8.c. The Subrecipient must follow procurement standards within 45 CFR 75.326 et sec for procurement under this subaward. No.
V.C.2.a.i 44.	Section V-E-8-c	40	Can the bidder submit as a lead agency with an identified subcontractor organization to complete specific portions of the proposal rather than bid to	Please see response to question 43. The Subrecipient cannot subcontract for case management under this subaward.

			an unidentified second tier subrecipient post award?	
45.	Section V-H-1-a	41	Are there established Foster Home Maintenance rates? If so, what is the methodology and is there a rate listing available? Are rates broken down by age group? What, if any, is the current process to seek reimbursement for Title IV-E eligible costs? Do Child Placing Agencies or Residential Facilities participate in a Random Moment Time Study to allocate case management accordingly for Title IV-E reimbursement?	Yes. Please see Attachment Five. The methodology is in Attachment Five of the RFP. Yes rates are broken down by age groups and level of care. As the Title IV-E Agency, DHHS collects supportive documentation for foster care maintenance costs. Part of this collection process is having the provider enter maintenance expenses in the NFOCUS computer system for tracking purposes. The claim information is then used by the DHHS finance and accounting office to request IV-E reimbursement, as allowed under title IV-E guidelines. DHHS is seeking to also claim administrative costs associated with foster care, so it will be important for the Subrecipient to have methodology developed for such costs, to assist in accessing IV-E funding. No.
46.	Section V-H-3-a	42	What costs would be considered Direct vs. Indirect?	The Subrecipient must follow 45 CFR 75.413 regulations to determine Direct Costs and 45 CFR 75.414 to determine Indirect Costs. The determination of Direct and Indirect Costs depends on what the Subrecipient allocates to Direct and Indirect Costs.
47.	Section V-H-3-b	42	Are there any cost restrictions (i.e. Cap on Administrative costs as a percentage of total direct program costs, Caps on Fringe Benefits and Payroll Taxes percentage of Salary and Wages, etc.)?	No, however every proposal will be reviewed for reasonableness. If a bidder has an Indirect Cost Rate Agreement with the federal partner, that rate must be used. If the bidder does not currently or has never had an approved negotiated an Indirect Cost Rate Agreement with the federal partner, the reasonableness standard must be used.
48.	Section V-H-3-c	42	Can the subrecipient have access to NFOCUS data for the ESA after it has been entered? This would allow the subrecipient to create dashboards, PQI reports, etc.	Yes.
49.	Section V-H-9-a	44	Do purchases in excess of $25,000 pertain only to the funds expended in relation to this contract or to the subrecipient's operations in aggregate? Are the number of purchases that exceed $25,000 capped on an annual basis or during	Purchases in excess of $25,000 pertain only to this subaward. No, this section does not require a cap, just approval from DHHS.

			the life of the contract?	
50.	Section V-H-10-a	44	Are bonuses that are awarded to the entire organization considered to be part of the "normal employee benefit package" thus not requiring DHHS approval?	All incentive compensation must follow 45 CFR 75.430 in addition to the requirements of this subaward.
51.	Section V-I-4-h-ii	45	Does DHHS require bidders to have an active and on-going Child-placing Agency license or an application for a license at the time of the proposal (April 4, 2019)? How much time does DHHS recommend for a bidder's application for a license to be processed and awarded before the readiness review? Please describe the relationship, as it is currently or envisioned, between the bidder as a licensed LCPA and provider foster care/TFC agencies. If the bidder must be an LCPA and expected to directly recruit and retain resource families, they will be competing with their provider network or be in the position of applicants of transfers from provider agencies. What is the structure that DCFS envisions?	The license must be obtained prior to the operational start date. At least 90 days. When the Subrecipient becomes a licensed child placing agency, the Subrecipient would determine which homes they would be recruiting, training, and retaining, and which child placing agencies they would be contracting with.
52.	Section V-K-2	46	What is the state authorized connection and encryption methodology for accessing information from the state case management system?	External access to the N-FOCUS application is available to approved individuals through Citrix XenApp and NetScaler. Citrix is an encrypted web application requiring multi-factor authentication.
53.	Section V-L-1-b	48	Is retainage forfeited on an annual basis if performance targets are not met, or can retainage be collected at the end of the 5-year period if performance targets are met for the entire contract period?	No. Please see Section V.L.1.c.
54.	Section V-L-1	48	What is the penalty for exceeding case load ratios of 1:12/1:17? Are there mandated Supervisor to Caseworker ratios? What are the current	Per Statute 68-1207, the Subrecipient must maintain a caseload of 12-17 families per caseworker. Failure to do so may result in DHHS taking action set forth in section II.J. or any other remedy available by law. No. Current ratio of Supervisor to Caseworker is 1:7.

			Supervisor to Caseworker ratios?	
55.	Section V-L-2-b-i through v	48-49	Regarding the performance measures tied to retainage items i. through v.: What are the results of the incumbent for each of the performance measures for the past two years?	The use of performance measures is a new process. The performance measures have not been used in prior contracts.
56.	Section V-L-3-a-i through xix.	49-52	Regarding the federal targets listed in 3-a- i. through xix.: What are the results of the incumbent for each of the federal targets for the past two years? Since the CFSR measures are based on rolling calendar year, can you confirm that the first performance period that the subrecipient will be accountable begins on January 1, 2020?	Please see Attachment Nine. Yes, the period the Subrecipient will be accountable will begin on Jan 1, 2020.
57.	Section V-N-1	54	Is it possible to negotiate the $300,000 cap for start- up costs? Can you give an example of costs that would not be considered reimbursable?	No. Any costs outside of transition planning, staff recruitment, and service contract procurement.
58.	Section V-N-1	54	Will capacity building costs be included in proposal cost scoring calculation?	No.
59.	Section V-N-1	54	Any non-incumbent sub-recipient must recruit, hire, and train a workforce to be ready to perform on January 1, 2020. This represents a significant expense. Can a non-incumbent sub-recipient budget for this cost recovery over the course of the first two years?	No.
60.	Section VI-A	55	If the bidder's corporate offices are in another state, with an existing Board of Directors, can an Advisory Board be developed to advise on NE matters only, specific to this contract? Or must the corporate Board of Directors include 51% of NE residents?	Neb Rev Stat. 43-4204 requires the Subrecipient must have a board of directors of which at least 51% of the membership is comprised of Nebraska residents who are not employed by the Subrecipient or by a subcontractor of the Subrecipient.
61.	Section VI-A	55	Do proposed Board of Directors members need to be identified in the proposal?	No.

62.	Section VI-A-2-j	57	Do proposed sub-contracted licensed child placing agencies (LCPA's) need to be identified in the proposal?	Yes.
63.	Section VII-A	59	Can a management fee be included in the cost proposal?	No.
64.	Section VII-A	59	Does a budget narrative need to be submitted?	No.
65.	Section VII-A	59	Can you provide or direct us to information about the incumbent's annual expenditures for the last five years? Including information on costs for residential placements, treatment foster care, agency foster care, relative/kin placements, Medicaid services and family preservation/reunification services paid for by the incumbent. Does DHHS expect that the subrecipient will have flexible funding for concrete services that are needed for family preservation and reunification? If yes, what is the annual expenditure of the incumbent?	Due to time constraints DHHS will only be able to provide expenditure data from July 2016 to December 2018. Please see Attachment Ten – PromiseShip Variable Expenses – July 2016 to December 2018. Yes, as long as the costs are included in the "do not exceed" amount. Please see Attachment Ten – PromiseShip Variable Expenses – July 2016 to December 2018.
66.	Section VII-A	59	What are the rate listings for community based services? What are the rate listings for residential placement services? What are the rate listings for foster care homes maintained by DHHS? What are the rate listings for foster care homes maintained by foster care agencies?	Please see Attachment Eleven CB Rates. Please see question #6. Please see Attachment Five. The rates for foster care homes maintained by DHHS only pay the Out of Home Maintenance rate, not the ASFC rate. Please see Attachment Five.
67.	Operations Manual	6	Could the subrecipient have dedicated space within an office to serve as temporary housing or have access to an apartment, condo, home for supervision if placement isn't found for youth within the 3-hour required timeframe?	No. the Subrecipient would need to work with Project Harmony to use the triage center in these situations. Project Harmony is a non-profit organization that works with DHHS in abuse/neglect investigations. https://projectharmony.com/
68.	Operations Manual	8	Is a separate CPA prepared audit, specific to Nebraska	If a Single Audit is required pursuant to 45 CFR 75.501, said audit would suffice to meet the

			operations required for this program or is an audit of the subrecipient total financial operations acceptable?	requirements of the RFP. DHHS may, however, require agreed-upon procedures engagements as a result of Subrecipient's performance or compliance with the other terms and conditions, regardless of whether a Single Audit is performed.
69.	Operations Manual	9	Can you share the SDM tool?	Yes. Please see Attachment Twelve SDM Documents.
70.	Operations Manual	11	Can you identify what policies and procedures that DHHS utilizes for successful implementation of Every Student Succeeds Act?	Currently, DHHS does not have any policies and procedures related to the Every Student Succeeds Act.
71.	Operations Manual	12	Does "agency-based foster care" mean DHHS licensed families or privately licensed families, or both?	Agency-Based Foster Care means foster homes that are supported by an agency that holds and maintains a Child Placing Agency License. This does not include licensed homes supported by DHHS.
72.	Operations Manual	12	Can the subrecipients place children in a LCPA's home without prior notification to or approval from the LCPA?	Yes.
73.	Operations Manual	16	Do DHHS attorneys represent the ubrecipient during court hearings? Are there situations when the subrecipient will need to be represented by separate paid counsel for DHHS business?	DHHS attorneys only represent DHHS in court hearings. Yes.
74.	Operations Manual	20	Does the subrecipient have access to NRAE funds to pay for adoption attorneys?	No. The Subrecipient would not be able to use Non-recurring Adoption Expense (NRAE) funds for adoption attorneys because the adoption subsidy is paid through DHHS. DHHS finalizes all adoption paperwork prior to the adoption.
75.	Operations Manual	23	Is it allowable to use the SAFE format for home studies rather than DHHS format, if prior approval is received?	Yes, the Subrecipient may use the Structured Analysis Family Evaluation (SAFE) format for home studies rather than the DHHS format, if prior approval is received.
76.	Operations Manual	23	Can the subrecipient develop its own training for foster parents in addition to the required TIPS-MAPP?	Yes, the subrecipient can develop its own training for foster parents in addition to the required Trauma Informed Partnering for Safety and Permanence-Model Approach to Partnership in Parenting (TIPS-MAPP).
77.	Operations Manual	23	How many initial training hours are required for DHHS foster parents? How many on-going training hours are required for DHHS foster parents?	Current regulations state for the Initial license- not less than 21 clock hours of Department approved pre-service training. Licensed foster parents are required to complete 12 clock hours of on-going training per year.
78.	Operations Manual	24	At the time of case closure, is the entire physical file returned to DHHS? If yes, is the subrecipient required to keep a duplicative file?	Yes. The Subrecipient is not required to maintain a duplicative copy of the case file at time of case closing. All hard copy documents are to be scanned into document imaging before the hard case file is returned to DHHS at time of case closure. All procedures used for copying and retaining case files

				must be in compliance with HIPPA regulations.
79	Operations Manual	26	For those who are transporting youth, must they have a Nebraska driver's license?	No. Anyone transporting youth must have a valid driver's license and must adhere to licensing standards for operating a motor vehicle in the State of Nebraska.
80.	Operations Manual	26	What type of defensive driving course is required?	Any defensive driving course provided by Nebraska Safety Council or similar.
81.	Operations Manual	26	Can staff transport in personal cars and/or company cars? Can the subrecipient use dedicated drivers or contract with a transportation company?	Yes, personal vehicles or company vehicles can be used for transportation. Insurance requirements apply for both. The Subrecipient must use a transportation provider if a youth needs to be transported securely. Yes.
82.	Attachment 5		Are the rates from 2014 still current? How do they compare to other states?	Yes; There is the Foster Care Rate Committee which was developed through the Nebraska Children's Commission who developed the rates which were partially implemented in 2014. The rates paid by Nebraska are higher than other surrounding states
83.	Attachment 5		Where are the definitions for "essential, enhanced, and intensive"?	Yes. Please see Attachment Thirteen – Nebraska Caregiver responsibility (NCR).
84.	Attachment 6, req IST-1	3	Can applicants have access as a test user to NFOCUS during the bidding process to determine capability as well as potential interface with current internal information systems?	A test system is not available to access N-FOCUS during the bidding process.
85.	Attachment 6, req PLC-1	7	Please clarify if the expectation is that the bidder, as an LCPA, is to develop the pool of resource families or engage with the provider community to ensure capacity?	As a Licensed Child Placing Agency (LCPA), the Subrecipient can either recruit, submit for licensure and retain, qualified homes as Resource Family homes, or subcontract with local LCPAs to recruit, submit for licensure, and retain. Please also see response to Question 25.
86.	Attachment 6, req PLC 2	7	If the bidder is required to recruit and retain resource families, are these families licensed as DCFS families or under the bidder's LCPA license? If they are under the bidder's LCPA license, are children outside of the Eastern Services Area allowed to be placed in these homes if requested?	The LCPA and Foster Care Home License are two different licenses issued by DHHS, Division of Public Health. A LCPA will submit licensing documentation to DHHS and DHHS will issue the license for the foster care home. The foster care home will be designated as being supported by the LCPA. Payments for the foster care home will be made by the Subrecipient to the foster care home. Since DHHS is licensing the homes, request is not needed to place children who originate from outside the ESA into homes licensed by the Subrecipient in the ESA.
87.	Attachment 6, req. T&T-2	9-10	To best develop an implementation plan, can you please provide a list of	The Subrecipient must follow all applicable regulations in 45 CFR 75.316 et seq to transition any property from the incumbent to the Subrecipient.

			equipment that might be transitioned by the current subrecipient as well as roster of current staff positions.	
88.	V.A.9.d.	32	Please clarify what is meant by the statement: "100% of children served live at home safely..."	The Subrecipient must develop a continuum of services that will ensure that all children served will live at home safe from harm, danger, or risk of further abuse or neglect.
89.	Attachment Six (REQ # YTH-2)	Attach. Six-pg 13	There is no mention of the National Youth in Transition Data (NYTD) survey requirement anywhere within the RFP Sections I-VII. What are the expectations of the successful subrecipient for fulfilling the NYTD requirement?	The Subrecipient will be responsible to report data for the National Youth in Transition Database. The Subrecipient will make efforts to locate youth and ensure survey completion on youth required to be report to the National Youth in Transition Database. Please see Section 14 in the ESA Operations Manual, Attachment Two pg. 47.
90.	VI.A.2.i. and Attachment Six (REQ # CO-3)	RFP-pg 57 and Attach. Six-pg 2	The statement is: "The bidder should provide resumes for all personnel proposed by the bidder to work on the project." Are we to assume that we need to include resumes for each individual that will be working on the contract, if known, to include all front line staff, administrative support, etc? If not, what positions does DHHS want the proposer to identify in the proposal?	Yes, to the extent that the personnel are known at the time of the proposal submission.
91.	Attachment Six	1	Are bidders expected to provide detailed responses to each of the Business Requirements directly within Attachment Six?	Yes.
92.	Attachment Six	1	Are bidders expected to provide detailed responses to each of the Business Requirements as part of the "bidder's proposed solution" that is contained in a separate section of the full bidder's response, and include Attachment Six as a reference document?	No. Please see response to question 91.
93.	VI. and Attachment Six	RFP-pg 55 and Attach. Six-pg 1	Is Attachment Six the format for responding to all requirements in Sections V? If not, what is the preferred format to adequately "identify the subdivisions of 'Project Description and Scope of Work' clearly in their proposals"?	Yes.
94.	II.J.	11	This section refers to the Title IV-E State plan. Will the State	Yes.

			post a copy of the Title IV-E State plan?	
95.	II.L.2.	12	The last sentence in the first paragraph of this subsection refers to "the State's use of the Licensed Software. . ." To what does this refer, and how is this related to this RFP?	This is a boilerplate term. Not all terms are applicable to a specific service. If it does not apply, please disregard or note in the comments above the term.
96.	II.L.3.	12	This subsection states that "the subrecipient shall indemnify and hold harmless the indemnified parties. . ." Please identify the indemnified parties referred to in this subsection.	Please refer to section II.L.1. in the RFP.
97.	II.N.	13	Please explain the necessity for requiring a performance bond in this subaward. Will the State consider waiving the requirement of a performance bond?	The necessity for requiring a performance bond is, in the event of a breach of contract, and case management in the ESA needs to be transferred to DHHS, the performance bond will partially cover these costs. DHHS will not waive the requirement of a performance bond.
98.	II.S.	14	Please clarify the role of the Long Term Care Ombudsman with regard to this subaward.	Please see response to question 95.
99.	II.U.1.a.	16	The first row in the table contained in this subsection includes dates that fall before the subaward start date. Will the State consider deleting the first row?	No. There is a difference between the subaward start date and the Operational Start Date (please see glossary for Operational Start Date). The Subrecipient will be able to incur costs between the subaward start date and the Operational Start Date.
100.	III.A.	17	The fifth paragraph in this subsection states that all personnel assigned by subrecipient to this subaward shall be employees of the subrecipient, a Second Tier subrecipient, or a subcontractor. Please clarify whether individual independent contractors (non-employees) working with subrecipient are permitted to be assigned to this subaward by subrecipient.	Yes, independent contractors are permitted to be assigned to this subaward by the Subrecipient. An example of this , an independent contractor hired to complete an assessment or evaluation could be assigned to this subaward. Please see bidding requirements in Section V.E.8.c.
101.	III.A.	17	The last paragraph in this subsection states that "subrecipient shall include a similar provision, for the protection of the State, in the subaward with any subcontractor engaged to perform work on this subrecipient." Please clarify which provision is required to be included.	The provision required is one that shall insure that the terms and conditions contained in any subaward or subcontract with a Second Tier Subrecipient or subcontractor does not conflict with the terms and conditions of this subaward.
102.	IV.E.	26	Please clarify the payment	Yes, payment is rendered by DHHS monthly in

			structure for this subaward. Specifically, will payment be rendered by the State monthly, in advance as required by 45 CFR §305 (b)(1)?	advance.
103.	V.A.9.g.	32	Please provide the number of licensed foster home beds currently available for the Eastern Service Area.	See question 9.
104.	V.A.9.g.	32	There is often a difference between licensed beds and "useable" beds. Can you provide the average number of licensed foster home beds that are on hold each month?	Average of ESA Agency Supported Homes on Hold: 77. Average of ESA Available Beds on Hold: 138. Average of ESA Licensed Beds on Hold: 184. (Time frame for data 8/27/18 through 01/28/19).
105.	V.A.9.g.	32	For beds on hold, what is the actual average amount of time it takes, from start to finish, for the Out of Home Assessment process to reach completion and for homes determined to be safe to be off hold?	The average amount of time, from start to finish, to complete the Out of Home Assessment process is 30 days. This includes the investigative process and the review of results of the investigation.
106.	V.C.5.c.	36	This section states that subrecipients "Provide a report to DHHS using the DHHS' preferred format that summarizes the decision to place the child outside the home OR CURRENT PLACEMENT and provides a justification for this decision including demonstrating that all other options were exhausted prior to placing a child outside the home OR CURRENT PLACEMENT." Does this mean that any time a placement change occurs, this justification will be documented in a specified format?	Yes.
107.	V.D.8.k.	38	According to this section, rates are equal to or lower than rates paid to other providers contracted by DHHS. Does this allow for services within the subrecipient's service array that are not within the DHHS service array? If so, what is the expectation for rate setting?	Yes. The Subrecipient will submit rate methodology of services to DHHS prior to implementation. If similar or comparable services exist at the same time, DHHS will negotiate rate setting with the Subrecipient. The rate setting must be documented and supported by verifiable data.
108.	V.E.8.i and V.D.8.g.	40,38	This section states the "subrecipient must receive prior written approval from DHHS before subrecipient,	

			subcontractor or Second Tier subrecipients engage in the practice of assessing or collecting client fees or co-pays for services." Is this expected for each provider or by individual situation? How does this apply to utilizing sliding scale fee providers and required co-pays for items such as the WCA BIP program? Also how does DHHS see this aligning with utilization of the most appropriate funding source such as outlined in section V.D.8.g?	The sliding scale fee or required copays would be an exception to the language above requiring prior written approvals for fees or co-pays. The same rule would apply to all fees and co-pays. Each situation will be reviewed individually. The two would not affect each other. In both instances, all available and existing community resources available must be exhausted first before charging the subaward.
109.	V.H.4.a.	43	States that "subrecipients and Second Tier subrecipients shall pay foster families using the rate methodology and same foster care maintenance rate paid to foster families by DHHS." However, the rate methodology recommended by the Nebraska Children's Commission is different than the rate structure utilized by DHHS (pre-assessment rates). Which methodology will be utilized?	DHHS did not accept all recommendations which were made by the Children's Commission in 2014. DHHS does not currently utilize a pre-assessment rate. The foster care payment and the administrative rates which were recommended in 2014, are the rates that DHHS accepted and currently utilize. The Subrecipient must utilize these rates.
110.	V.H.13	44	The list of expenses the "subrecipient is not responsible for payment" does not include the Douglas County Youth Center (DCYC) services. Who is responsible for the cost of detention for ESA youth referred to and served by the Douglas County Youth Center (DCYC)?	The Subrecipient is responsible for the cost of detention for youth referred to and served by DCYC.
111.	V.A.8.d.	32	This section states that the subrecipient will "ensure 100% of families are applying for and accepting services through public assistance programs..." Since participation in these programs is entirely voluntary on the part of families, would the Department consider amending this section to read "ensures that 100% of families are informed of and encouraged to apply for services available through public assistance programs"?	No, it is the responsibility of the case manager to assist families in applying for services through the public assistance programs to ensure maximization of federal funds whenever possible.
112.	V.L.1.	48	Per 45 CFR §75.305, payment to a subrecipient	No. The designated period for any of the performance measures contained in Section V.L2.

			cannot be withheld unless certain conditions are met. Non-performance is one of those conditions. However, the non-performance has to be established prior to the withholding of payment. With this in mind, would DHHS consider amending this section to eliminate retainage in the first year of the subaward?	(b) I – v, along with the target for each measure, the appropriate baseline, methodology, and the percent of the Subrecipient's subcontracted expenditures that are required to be performance based will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution. DHHS will be using both state and federal funds in this subaward. All conditions placed on usage of these funds in this subaward apply regardless of whether state or federal funds are being used. As DHHS claims federal funds off the activities conducted in this subaward, retainage, however, will only be taken out of state funds.
113.	V.L.1.	48	Would DHHS consider eliminating retainage and negotiating an incentive plan with the subrecipient that is tied to cost efficiencies achieved by the subrecipient? For example, an incentive program that describes how the subrecipient would receive and invest any funds within the "not to exceed" funding cap not required to pay for allowable, reasonable and necessary costs incurred in the operating year?	No.
114.	Attachment Six (REQ # FIN-2)	3	What other time tracking methods would be acceptable to DHHS as related to maximization of Title IV-E funding? For example, if Title IV-E is the only material Federal funding source, would Title IV-E eligible caseload as a percentage of total caseload be an acceptable tracking method?	Any other time-tracking method that is approved by Administration of Children and Families that will allow DHHS to confirm time spent on eligible IV-E cases. DHHS currently uses the Random Moment Time Study for DHHS administrative expenses to be claimed to title IV-E for reimbursement. Any other method to claim Administrative costs should be listed in the Subrecipient's cost allocation plan and if they plan to use another method than what is already approved by our federal partners, their method would have to be approved by the Administration for Children and Families (ACF) Only the ACF can approve alternative methods of tracking and billing for these costs.
115.	V.L.2.b.ii	48-49	How is this performance metric different from the V.L.3.a.iii performance metric?	V.L.2.b.ii measures the time of successful case closure for children not involved with court, while V.L.3.a.iii measure the rate of a non-court involved children removed from home.
116.	V.L.2.b.ii	48-49	A) For the 2.b.ii. performance metric, "Average Time to Successful Case Closure for Non-court Involved Children," are we to assume the term "rolling 12 month average" is defined as the following: for each monthly metric we calculate the value using the previous twelve months data? Please give an example. B) Is the definition provided	A) and B) Yes, this is a rolling 12 months.

			here for the term "rolling 12 month average" the same definition used in each of the measures using the rolling 12 month average language?	
117.	V.L.2.b.iii	49	A) For the 2.b.iii. performance metric, "Rate of Removal of Non-court Involved Children (in-home)," please confirm if we would calculate each month's metric by looking at the previous 12 months removals. Is that correct? If not, please provide us the details. Please give an example. B) For the 2.b.iii. performance metric, "Rate of Removal of Non-court Involved Children (in-home)," are we to assume the term "rolling 12 month average" is defined as the following: for each monthly metric we calculate the value using the previous twelve months data? Please give an example. C) If we were calculating this monthly metric as defined, the denominator would be the count of in-home non-court children and the numerator would be the number of in-home non-court children that were removed and the child status changes from "non-court involved" to "ward." Is that the correct approach? Please give an example.	A) Yes this is correct. B) Yes this is correct. C) The denominator should be the count of non-court case that closed during the last twelve months.
118.	V.L.2.b.v	49	A) For the 2.b.iii performance metric, "Median Months to Reunification for Court Involved Children in foster care "Are we to assume that the term "reunification" is defined as the date the youth goes home to live with their parent(s) irrespective of whether the case was closed? If not, please the definition. B) What is the date range we should be using to calculate this metric? For example, should we use a rolling 12 months or something different? If different, please give an example. C) If we were calculating this metric using our data, we	Yes, parent or caretaker from whom the child was removed. Yes. This is a CFSR Round 2 Federal measure which includes a Trial Home Visit accommodation. This metric will be measured and reported by to the

			would start by counting the number of days the child was in care and divide by 30, then round up or down to the nearest whole number to get the number of months in care for the child, and then calculate the median of the population of children. Is that the correct approach? Please give an example.	Subrecipient by DHHS. This will be calculated by looking at all children who were discharged from foster care, in foster care for 8 days or longer, to the date of reunification
119.	V.L.2.b.v	49	A) For this metric, "Rate of Court Involved Children in Foster Care for 24 Months or More who Achieve Permanency," we read this performance metric to be the same as the federal CFSR Round 3 definition of "Permanency in 12 Months for Youth in Care 24 Months or More." Is that correct? If not, please give an example. B) If we were calculating this metric, we would use the first of a month as a point in time for youth who were in care for 24 months or more and then determine which of those on that date achieved permanency in 12 months or less. Is that correct? If not, please give an example.	A) Yes, this is the CFSR Round 3 Permanency in 12 for Children in Care 24 months or more. B) Yes.
120.	V.L.3.a.iii	49	How is the 3.a.iii performance metric different from the 2.b.ii performance metric?	See question 115. *The measure is not tied to Federal Data Indicators, the appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
121.	V.L.3.a.ix	50	A) Is this performance metric a monthly metric? B) Are we to assume that the denominator includes all court involved youth in an out-of-home placement to include congregate care (i.e., group home) and treatment placements? C) Does the removal date play a role in calculating this metric? If so, how?	A) Yes. B) Yes. C) No. *This measure is not tied to Federal Data Indicators, the appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
122.	V.L.3.a.x	50	A) Is this performance metric a monthly metric? B) Are we to assume that the denominator includes all	A) Yes. B) Yes.

			children that are wards and living in an out-of-home placement including congregate care placement, such as group homes and treatment placements? C) Does the removal date play a role in calculating this metric? If so, how?	C) No. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
123.	V.L.3.a.xi	50	A) How do we count youth who are still in the 12th grade but "age out"? B) Would this youth fall in the denominator or numerator (or both)? C) Is this measure specific to only wards or does this reference non-court involved youth as well?	A) The youth would have to complete 12th grade to be included in the numerator. B) A youth that has not completed 12th grade would be in the denominator. C) Non-court youth are excluded. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
124.	V.L.3.a.xi	50	A) Is this a quarterly or annual metric? B) If it is in the best interest of the child to move schools, how is that incorporated into the measure? C) How are natural transitions accounted for? (For example: a youth who was in middle school when entered out-of-home care and is still in care, but who starts to attend the assigned high school for his/her district in the new school year.) D) Is the age the current age or age at removal? E) Is this a monthly or quarterly metric? F) What is the date range for the numerator/denominator? G) Is the youth only counted for the metric when she/he gets removed?	A) Quarterly. B) This section does not reference moving schools. C) Natural transitions in school are not accounted for in the calculation of this measure. D) Age at removal. E) Quarterly. F) Three month rolling. G) Yes. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution..*
125.	V.L.3.a.xiii	51	A) Should the numerator read "….changed placements two or more times"? B) Should the numerator read	A) & B) Section V.L.3.z.xiii will be replaced and superseded with: Numerator Number of children in care for six to 12 continuous months during the designated 12 month period who have changed placements two or more times during their first 6 months in care."

			"…changed placements two or more times during their first six months in care"? C) What is considered a placement change for purposes of this measure?	C) The federal definition of placement change which generally includes an out of home placement with a different address, excluding locked facilities *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
126.	V.L.3.a.xiv	51	A) Assume that a youth is care for exactly 12 months. Will that youth be counted in the metric in 3.a.iii or 3.a.iv or both? B) Should the numerator read "…changed placements two or more times during their first 12 months in care since their removal date"? C) What is considered a placement change for purposes of this measure? D) Is the youth population for this metric the same definition of the population for the federal CFSR Placement Stability measure in Round 2?	A) Question cannot be answered due to conflicting reference points. B) No. C) The federal definition of placement change which generally includes an out of home placement with a different address, excluding locked facilities. D) No. The Federal measure stratifies the data in two different ways: by years in care and number of placements. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
127.	V.L.3.a.xv	51	Will youth in continuous care for 18+ months reported in the 3.a.xiv measure also fall in and be reported for this measure?	Yes. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
128.	V.L.3.a.xvi	51	A) What counts as a case manager change? For example, do we count when a case manager goes on extended leave (e.g., medical leave)? B) Should the numerator read "…change case manager two or more times their first six months in care"?	Any time a new case assignment is made, to include vacancies or extended medical leave, counts as a case manager change. No. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
129.	V.L.3.a.xvii	51	A) Should the numerator read "…changed case manager three or more times during their first 12 months in care	No.

			since their removal date"? B) Will youth in continuous care for 12+ months with three or more case manager changes reported in the 3.a.xvi measure also fall in and be reported for this measure? C) What counts as a case manager change? For example, do we count when a case manager goes on extended leave (e.g., medical leave)?	Youth with > 12 months continuous care will only be included in xvii. Please see question 128 A. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
130.	V.L.3.a.xviii	51	A) Should the numerator read "…changed case manager three or more times since their removal date"? B) Will youth in care for 18 months with three or more case manager changes measured in 3.a.xvii also follow in this measure? C) What counts as a case manager change? For example, do we count when a case manager goes on extended leave (e.g., medical leave)?	No. Yes. Please see question 128 A. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
131.	V.L.3.a.xix	52	Is the data in the denominator for cases that opened as non-court and were continuously in non-court and subsequently closed as a non-court case? That is, does the denominator exclude non-court youth who transfer to court-involved status?	No. This measure will include in the denominator youth that go to court following a non-court episode. *This measure is not tied to Federal Data Indicators. The appropriate baseline and target will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.*
132.			If a subrecipient is in fact selected through this process, will DHHS be held to the same outcome and performance expectations set forth for the potential subrecipient?	DHHS will continue to meet the statutes and regulatory requirements to provide the best services to children and families.
133.			How was the outcome from the consultation with the Stephen Group incorporated into this RFP?	This question is outside of the scope of this RFP. Please provide a response that best meets the requirements of the RFP.

ACTIVITY		DATE/TIME
1.	State responds to written questions through RFP "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	February 13, 2019 ~~TBD~~ ~~February 6, 2019~~
2.	Last day to submit written questions 2nd round	February 20, 2019
3.	State responds to 2nd round questions through RFP "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	February 27, 2019
4.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	April 4, 2019 2:00 PM Central Time
5.	Review for conformance to RFP requirements	April 5, 2019
6.	Evaluation period	April 8, 2019 Through April 22,2019
7.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
8.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	May 15, 2019
9.	Subaward finalization period	May 14, 2019 Through June 14, 2019
10.	Award of subaward	July 1, 2019
11.	Subrecipient start date	January 1, 2020

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal response.

ADDENDUM ONE - REVISED SCHEDULE OF EVENTS

Date: February 6, 2019

To: All Bidders

From: Annette Walton / Nancy Storant, Buyers
AS Materiel Purchasing

RE: Addendum for RFP Number 5995 Z1 to be opened April 4, 2019 at 2:00 p.m. Central

---

Schedule of Events

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

ACTIVITY		DATE/TIME
1.	State responds to written questions through RFP "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	TBD ~~February 6, 2019~~
2.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	April 4, 2019 2:00 PM Central Time
3.	Review for conformance to RFP requirements	April 5, 2019
4.	Evaluation period	April 8, 2019 Through April 22,2019
5.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
6.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	May 15, 2019
7.	Subaward finalization period	May 14, 2019 Through June 14, 2019
8.	Award of subaward	July 1, 2019
9.	Subrecipient start date	January 1, 2020

This addendum will become part of the proposal and should be acknowledged with the RFP.

State of Nebraska State Purchasing Bureau
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508
Phone: (402) 471-6500

SOLICITATION NUMBER	RELEASE DATE
RFP 5995 Z1	January 9, 2019
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
April 4, 2019 2:00 P.M. Central Time	Annette Walton / Nancy Storant

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska (State), Department of Administrative Services (DAS), Materiel Division, State Purchasing Bureau (SPB), is issuing this Request for Proposal (RFP) Number 5995 Z1 for the purpose of selecting a qualified bidder to provide Full Service Case Management for Child Welfare Services. A more detailed description can be found in Section V. The resulting subaward may not be an exclusive subaward as the State reserves the right to subaward for the same or similar services from other sources now or in the future. Under federal law, the resulting contract awarded will also be a "subaward," and the Contractor will also be a "subrecipient," as defined by 45 CFR § 75.2.

The term of the subaward will be five (5) years commencing upon execution of the subaward by the State and the bidder (Parties). The subaward includes the option to renew for two (2) additional one (1) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this subaward beyond the termination date when mutually agreeable to the Parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.04, State contracts in effect as of January 1, 2014, and contracts entered into thereafter, must be posted to a public website. The resulting contract, the RFP, and the successful bidder's proposal or response will be posted to a public website managed by DAS, which can be found at http://statecontracts.nebraska.gov.

In addition and in furtherance of the State's public records Statute (Neb. Rev. Stat. § 84-712 et seq.), all proposals or responses received regarding this RFP will be posted to the State Purchasing Bureau public website.

These postings will include the entire proposal or response. Bidders must request that proprietary information be excluded from the posting. The bidder must identify the proprietary information, mark the proprietary information according to state law, and submit the proprietary information in a separate container or envelope marked conspicuously in black ink with the words "PROPRIETARY INFORMATION". The bidder must submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992) THE BIDDER MAY NOT ASSERT THAT THE ENTIRE PROPOSAL IS PROPRIETARY. COST PROPOSALS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA. The State will then determine, in its discretion, if the interests served by nondisclosure outweighs any public purpose served by disclosure. (See Neb. Rev. Stat. § 84-712.05(3)) The bidder will be notified of the agency's decision. Absent a State determination that information is proprietary, the State will consider all information a public record subject to release regardless of any assertion that the information is proprietary.

If the agency determines it is required to release proprietary information, the bidder will be informed. It will be the bidder's responsibility to defend the bidder's asserted interest in non-disclosure.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, proposal, or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a proposal or response to this RFP, specifically waives any copyright or other protection the contract, proposal, or response to the RFP may have; and, acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a proposal or response to this RFP, and award of a contract. Failure to agree to the reservation and waiver will result in the proposal or response to the RFP being found non-responsive and rejected.

Any entity awarded a contract or submitting a proposal or response to the RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and

attorney fees and expenses, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or the proposals and responses to the RFP, awards, and other documents.

TABLE OF CONTENTS

TABLE OF CONTENTS iii

GLOSSARY OF TERMS vi

I. PROCUREMENT PROCEDURE 1

- A. GENERAL INFORMATION 1
- B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS 1
- C. SCHEDULE OF EVENTS 2
- D. WRITTEN QUESTIONS AND ANSWERS 3
- E. PRICES 3
- F. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory) 3
- G. ETHICS IN PUBLIC CONTRACTING 3
- H. DEVIATIONS FROM THE REQUEST FOR PROPOSAL 4
- I. SUBMISSION OF PROPOSALS 4
- J. BID PREPARATION COSTS 4
- K. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL 4
- L. BID CORRECTIONS 4
- M. LATE PROPOSALS 5
- N. PROPOSAL OPENING 5
- O. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS 5
- P. EVALUATION COMMITTEE 5
- Q. EVALUATION OF PROPOSALS 5
- R. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS 6
- S. BEST AND FINAL OFFER 6
- T. REFERENCE AND CREDIT CHECKS 6
- U. AWARD 6

II. TERMS AND CONDITIONS 8

- A. GENERAL 8
- B. NOTIFICATION 9
- C. NOTICE (POC) 9
- D. GOVERNING LAW (Statutory) 9
- E. BEGINNING OF WORK 9
- F. CHANGE ORDERS 10
- G. NOTICE OF POTENTIAL CONTRACTOR BREACH 10
- H. BREACH 10
- I. NON-WAIVER OF BREACH 11
- J. REMEDIES FOR NONCOMPLIANCE 11
- K. SEVERABILITY 11
- L. INDEMNIFICATION 12
- M. ATTORNEY'S FEES 13
- N. PERFORMANCE BOND 13
- O. ASSIGNMENT, SALE, OR MERGER 13
- P. FORCE MAJEURE 14
- Q. CONFIDENTIALITY 14
- R. OFFICE OF PUBLIC COUNSEL (Statutory) 14
- S. LONG-TERM CARE OMBUDSMAN (Statutory) 14
- T. EARLY TERMINATION 15
- U. CONTRACT AND GRANT CLOSEOUT 15

III. CONTRACTOR DUTIES 17

- A. INDEPENDENT CONTRACTOR / OBLIGATIONS 17
- B. EMPLOYEE WORK ELIGIBILITY STATUS 18
- C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory) 18
- D. COOPERATION WITH OTHER CONTRACTORS 19

E. PERMITS, REGULATIONS, LAWS 19
F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES 19
G. INSURANCE REQUIREMENTS 20
H. ANTITRUST 22
I. CONFLICT OF INTEREST 22
J. STATE PROPERTY 23
K. SITE RULES AND REGULATIONS 23
L. ADVERTISING 23
M. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory) 23
N. DISASTER RECOVERY/BACK UP PLAN 24
O. DRUG POLICY 24

IV. PAYMENT 25

A. COSTS 25
B. TAXES (Statutory) 25
C. INVOICES 25
D. INSPECTION AND APPROVAL 25
E. PAYMENT 26
F. LATE PAYMENT (Statutory) 26
G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS 26
H. ACCESS TO RECORDS 26
I. AUDIT REQUIREMENTS 27
J. FEDERAL FINANCIAL ASSISTANCE 28
K. SMOKE FREE PROVISIONS 28
L. HUMAN TRAFFICKING PROVISIONS 28
M. LOBBYING 29
N. MANDATORY DISCLOSURES 29
O. PUBLICATIONS 30
P. DEBARMENT, SUSPENSION OR DECLARED INELIGIBLE 30
Q. RESEARCH 30
R. SUBRECIPIENTS OR CONTRACTORS UNDER THIS SUBAWARD 30

V. PROJECT DESCRIPTION AND SCOPE OF WORK 32

A. PROJECT OVERVIEW 32
B. PROJECT ENVIRONMENT 32
C. PROGRAM REQUIREMENTS FOR ON-GOING CASE MANAGEMENT 33
D. PROGRAM REQUIREMENTS FOR SERVICE DELIVERY 36
E. ADMINISTRATIVE REQUIREMENTS 38
F. TRANSITION AND IMPLEMENTATION 41
G. READINESS REVIEW 41
H. FINANCIAL REQUIREMENTS 41
I. FEDERAL AND STATE LEGAL AND POLICY REQUIREMENTS 44
J. COST RECONCILIATON PROCEDURE 46
K. INFORMATION SYSTEM REQUIREMENTS 46
L. RETAINAGE AND PERFORMANCE MEASUREMENTS 48
M. REPORTING REQUIREMENTS (DELIVERABLES) 52
N. CAPACITY BUILDING COMPONENT 54

VI. PROPOSAL INSTRUCTIONS 55

A. PROPOSAL SUBMISSION 55

VII. COST PROPOSAL REQUIREMENTS 59

A. COST PROPOSAL 59
B. PRICES 59

Form A Bidder Contact Sheet 60

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM 61

INTRODUCTION

The Department of Health and Human Services (DHHS), Division of Children and Family Services (CFS) is dedicated to providing child welfare services in the least intrusive and least restrictive manner possible. Services offered are based on family voice and choice and designed to give families and children the opportunity to safely preserve their family whenever possible, engage with both formal and informal community resources, strengthen parents' protective capacity in order to keep children safe from harm, meet the needs of children and families as identified through the assessment process, be culturally humble, and include parents, siblings, and extended family.

The CFS continuum of services includes prevention activities and coordination, child protective services that focus on the safety, health and wellbeing of the child, parental and sibling engagement, family voice and choice in service provision, respite, resource families and independent living, adoption, domestic violence, safety, mental health, substance abuse and treatment services, as well as educational initiatives. These services are provided by CFS personnel or through contracted vendors.

CFS seeks a single external entity to provide full service case management, including the development and purchase of the full array of services to meet the needs of children and families in the Eastern Service Area of Nebraska. This service area is composed of the two counties, Douglas and Sarpy, with a combined population of 675,950 people. Douglas County is the most populous and urban county in the State of Nebraska. The Eastern Service Area has 40 percent of child welfare cases in the State of Nebraska, including a variety of families from different socio-economic and cultural backgrounds.

The Subrecipient selected to provide services to the Eastern Service Area will receive assignments based on the following process:

- Calls of reported child abuse and neglect come into the statewide reporting hotline and are screened by hotline staff. Some calls may not be accepted based on statutory requirements. Some families may be referred to the Alternate Response program. Alternative Response is a program that helps families with less severe reports of child abuse and/or neglect, connect with the supports and services they need in order to enhance the parent's ability to keep their children safe and healthy. The Alternative Response program is not a part of this RFP.

- If the report is opened for investigation, information is gathered to complete a safety assessment (within 24 hours of contact) and a risk assessment (within 30 days). The decision points of the safety and risk assessments determine if further CFS involvement is needed. If there is not a safety issue but the family has other unmet needs, CFS will refer the case to available community programs.

- If a case is opened for ongoing CFS involvement, either through court or non-court services, a referral will be made to the Subrecipient for the provision of ongoing services and case management.

- This referral will be made through a written formal document as well as a meeting to discuss the case to ensure a streamlined information exchange.

- The CFS investigative worker and the subrecipient's newly assigned case management worker will meet with the family together either at the home or at the first court hearing, to transfer case management responsibilities.

Summary of Key Roles and Responsibilities in Eastern Service Region under the subaward:

Role of CFS	Subrecipient	Courts
Abuse Hotline	Family Preservation	Assign Custody
Investigations	On-going case management	Hold review hearings
Legal Services	Service coordination	Case/custody closure
N-Focus SAQWIS System	Recruit Resource Families	
License Residential Providers	Foster Care	
	Adoptions	

Through this subaward, a Subrecipient must deliver high quality case management and child protection services, including provision of Well-Supported, Supported, and Promising Practice evidence-based models that strengthen families and build protective factors in families, in compliance with the federal Families First Preservation Services Act (FFPSA), part of the Bipartisan Budget Act of 2018 (H.R. 1892). When family preservation is not possible, the Subrecipient will ensure the recruitment and retention of culturally humble resource families to care for the child(ren), ensure the delivery of trauma-informed services, and engage and support the biological parents in the reunification process. If permanency is not attained for the child in a timely manner, then the Subrecipient will provide an array of culturally humble adoptive parents willing to provide a forever family to the child who support the engagement of the child in cultural activities and maintain sibling connections whenever possible.

GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

After Receipt of Order (ARO): After Receipt of Order.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Agreement: A contract or subaward, as defined herein, or both, as context provides.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Award: All purchases, leases, subawards, or contracts which are based on competitive proposals will be awarded according to the provisions in the RFP. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer (BAFO): In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: The offer submitted by a vendor in a response to a written solicitation.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the vendor will not withdraw the bid.

Bidder: A vendor who submits an offer bid in response to a written solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Change Order: Document that provides amendments to an executed purchase order or subaward.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade

secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Continuous Quality Improvement Culture: Behaviors and beliefs of Subrecipient personnel that constantly and consistently promote quality improvement in work and service delivered to clients.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement. See Subaward.

Contract Administration: The management of the contract / subaward which includes and is not limited to; contract / subaward signing, contract / subaward amendments and any necessary legal actions.

Contract Award: Occurs upon execution of the State document titled "Service Contract Award" by the proper authority.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Subrecipient. Contract management also encompasses contract monitoring which includes, but is not limited to, both on and offsite document and practice review focused on outcomes and objectives specified in the contract document.

Contract / Subaward Period: The duration of the contract / subaward.

Contractor: Any individual or entity having a contract to furnish commodities or services. See also Subrecipient.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the subaward.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Subrecipient.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or subaward.

Discharge: The formal act of ending a service or case.

Eastern Service Area: The geographic area of Douglas and Sarpy counties in Nebraska, designated for case management services.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals (offers made in response to written solicitations).

Evidence-Based: Well-researched interventions with clinical experience and ethics, and client preferences and culture to guide and inform the delivery of treatments and services as referenced in the Families First Prevention Services Act (FFPSA). Evidence-based models, as indicated in the FFPSA include Well-supported, Supported, and Promising Practice models.

Extension: Continuance of a subaward for a specified duration upon the agreement of the parties beyond the original Subaward Period. Not to be confused with "Renewal Period".

Federal Funding Agency: The United States Department of Health and Human Services (HHS).

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the vendor.

Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Independent Living Services: Services which prepare youth ages 14 to 19 for making the transition from adolescence to adulthood. Independent Living Services will include services who are expecting to be a parent, and parenting a child.
Installation Date: The date when the procedures described in "Installation by Subrecipient", and "Installation by State", as found in the RFP, or subaward, are completed.

Interested Party: A person, acting in their personal capacity, or an entity entering into a subaward or other agreement creating a legal interest therein.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Subrecipient to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Maltreatment: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or, an act or failure to act which presents an imminent risk of serious harm.

Mandatory/Must: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Mandatory/ Must and Shall/Will/Must.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Non-Federal Entity: As defined by 45 CFR § 75.2, a state, local government, Indian tribe, institution of higher education (IHE), or nonprofit organization that carries out a Federal award as a recipient or subrecipient.

Nonprofit Organization: As defined by 45 CFR § 75.2, any corporation, trust, association, cooperative, or other organization, not including Institutions of Higher Education, that: (1) Is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; (2) Is not organized primarily for profit; and (3) Uses net proceeds to maintain, improve, or expand the operations of the organization.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Operational Start Date: Date the Subrecipient starts managing referred child welfare case under this agreement.

Outsourcing: The subawarding out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Subrecipient fulfills any and all obligations under the subaward.

Permanency: When a child: is returned to his/her parent; legally adopted; legal guardianship has been established; or has

been placed in another permanent living situation.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Point of Contact (POC): The person designated to receive communications and to communicate.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the subaward for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the subaward.

Promising Practice: a practice shall be considered to be a promising practice if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measure of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that:

1. Was rated by an independent systematic review for the quality of the study design and execution and determined to be well designed and well executed; and
2. Utilized some form of control (such as an untreated group, a placebo group, or a wait list study. (Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.)

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serves no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to a RFP or resultant subaward, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provisionally Licensed – A time-limited, non-renewable license issued to an applicant who is unable to comply with all licensure requirements and standards, and is capable of compliance within the time period stated on the license.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Quality Assurance: A program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met.

Quality Assurance Review: A critical evaluation of a project, service, or facility to ensure that all standards of quality are met.

Quality Improvement Process: A system involving the measurement, analysis, and actions taken to improve quality in services, treatment, or care.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Subrecipient.

Release Date: The date of public release of the written solicitation to seek offers.

Renewal Period: Optional subaward periods subsequent to the original Subaward Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Information (RFI): A general invitation to vendors requesting information for a potential future solicitation. The RFI is typically used as a research and information gathering tool for preparation of a solicitation.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Resource Family: A family, subawarded through an accredited agency that has a child placing licensing license, who provides placement and permanency for children, support and education for parents, as well as supervised visitation for families whose children have been removed from the parental home due to abuse and/or neglect.

Resource Family Home: The residence in which a Resource Family lives and provides services as a Resource Family. (see Resource Family).

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Second Tier Subaward: an award provided by Subrecipient to another subrecipient for the subrecipient to carry out part of a Federal award received by the pass-through entity.

Second Tier Subrecipient: A non-Federal entity that receives a subaward from the Subrecipient to carry out part of a Federal program.

Secure Transportation: Providing for the safe, secure, and humane treatment of youth during transport to a secure facility or psychiatric facility. Transportation Secure shall include the use of the least restrictive mechanical restraint available that allows for the safety and security of the youth, while preserving the dignity of the youth transported.

Service Area: geographic area designated by the Division of Children and Family Services for case management services. The Division of Children and Family Services has five service areas in Nebraska; Eastern, Central, Northern, Southeast, and Western.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Commodity: When an item is available from only one source due to the unique nature of the requirement, its supplier, or market conditions.

Sole Source – Services: A service of such a unique nature that the vendor selected is clearly and justifiably the only practical source to provide the service. Determination that the vendor selected is justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a subaward.

State Business Days: Days of the week considered as working days by the State of Nebraska, not including weekends or State holidays.

Statutory: These clauses are controlled by state law and are not subject to negotiation.

Subaward: As defined in 45 CFR § 75.2, an award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a Federal award received by the pass-through entity. See Contract.

Subcontractor: Individual or entity with whom the Subrecipient enters a subaward to perform a portion of the work awarded to the Subrecipient. See also Second Tier Subrecipient.

Subrecipient: The non-Federal entity (as defined by 45 CFR § 75.2) that receives a Subaward from a pass-through entity to carry out part of a Federal program. See Contractor.

Substantiated: An investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by state law or policy.

Supported Practice: a practice shall be considered to be a supported practice if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one (1) study that:

1. Was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed;
2. Was a rigorous random controlled trial (or; if not available, a study using a rigorous quasi-experimental research design);
3. Was carried out in a usual care practice setting; and
4. The study described established that the practice has a sustained effect (when compared to a control group) for at least six (6) months beyond the end of the treatment.(Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.)

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Subrecipient as functioning or being capable of functioning, as an entity.

Termination: Occurs when either Party, pursuant to a power created by agreement or law, puts an end to the subaward prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third Party: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and subcontractors, Second Tier Recipients, or agents, and their employees. It shall not include any entity or person who is an interested Party to the subaward or agreement.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product or service.

Utilization Management: The use of techniques that allow the Subrecipient to manage the cost of services by assessing its appropriateness before it is provided using evidence-based criteria or guidelines.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to the Subrecipient by State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, subaward, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Subrecipient regarding any such report. The vendor performance report will become a part of the permanent record for the Subrecipient. The State may require vendor to cure. Two such reports may be cause for immediate termination.

Well-Supported Practice: A practice shall be considered to be a well-supported practice if the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two (2) studies that;

1. Were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed
2. Were rigorous random controlled trials (or, if not available, studies using a rigorous quasi-experimental research design);
3. Were carried out in a usual care or practice setting; and
4. At least one of the studies described established that the practice has a sustained effect (when compared to a control group) for at least one (1) year beyond the of treatment. (Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.)

Will: See Shall/Will/Must.

Work Day: See Business Day.

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

The RFP is designed to solicit proposals from qualified bidders who will be responsible for providing Full Service Case Management for Child Welfare Services at a competitive and reasonable cost.

Proposals shall conform to all instructions, conditions, and requirements included in the RFP. Prospective bidders are expected to carefully examine all documents, schedules, and requirements in this RFP, and respond to each requirement in the format prescribed. Proposals may be found non-responsive if they do not conform to the RFP.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this RFP reside with the State Purchasing Bureau. The point of contact (POC) for the procurement is as follows:

Name: Annette Walton / Nancy Storant Buyer(s)
Agency: State Purchasing Bureau
Address: 1526 K Street, Suite 130
Lincoln, NE 68508
Telephone: 402-471-6500

E-Mail: as.materielpurchasing@nebraska.gov

From the date the RFP is issued until the Intent to Award is issued, communication from the bidder is limited to the POC listed above. After the Intent to Award is issued, the bidder may communicate with individuals the State has designated as responsible for negotiating the subaward on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this RFP. The POC will issue any clarifications or opinions regarding this RFP in writing. Only the buyer can modify the RFP, answer questions, render opinions, and only the SPB or awarding agency can award a subaward. Bidders shall not have any communication with, or attempt to communicate or influence any evaluator involved in this RFP.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts, subawards or obligations;
2. Contact required by the schedule of events or an event scheduled later by the RFP POC; and
3. Contact required for negotiation and execution of the final subaward.

The State reserves the right to reject a bidder's proposal, withdraw an Intent to Award, or terminate a subaward if the State determines there has been a violation of these procurement procedures.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

ACTIVITY		DATE/TIME
1.	Release RFP	January 9, 2019
2.	Last day to submit written questions	January 23, 2019
3.	State responds to written questions through RFP “Addendum” and/or “Amendment” to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	February 6, 2019
4.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	April 4, 2019 2:00 PM Central Time
5.	Review for conformance to RFP requirements	April 5, 2019
6.	Evaluation period	April 8, 2019 Through April 22,2019
7.	“Oral Interviews/Presentations and/or Demonstrations” (if required)	TBD
8.	Post “Intent to Award” to Internet at: http://das.nebraska.gov/materiel/purchasing.html	May 15, 2019
9.	Subaward finalization period	May 14, 2019 Through June 14, 2019
10.	Award of subaward	July 1, 2019
11.	Subrecipient start date	January 1, 2020

D. WRITTEN QUESTIONS AND ANSWERS

Questions regarding the meaning or interpretation of any RFP provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5995 Z1; Full Service Case Management for Child Welfare Services Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Bidders should present, as questions, any assumptions upon which the bidder's proposal is or might be developed. Proposals will be evaluated without consideration of any known or unknown assumptions of a bidder. The subaward will not incorporate any known or unknown assumptions of a bidder.

It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov, but may be delivered by hand or by U.S. Mail. It is recommended that bidders submit questions using the following format.

RFP Section Reference	RFP Page Number	Question

Written answers will be posted at http://das.nebraska.gov/materiel/purchasing.html per the Schedule of Events.

E. PRICES

Prices submitted on the cost proposal form shall remain fixed for the first two (2) years of the contract. Any annual request for an increase in the annual Not To Exceed amount, subsequent to the first two (2) years of the subaward shall not exceed five percent (5%) of the previous annual Not to Exceed amount. Increases will not be cumulative across the remaining periods of the subaward. Requests for an increase must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current subaward year. Documentation will be required by the State to support the increase in the annual Not To Exceed amount. Documentation must show an increase in external cost outside of the control of the Subrecipient.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the subaward by the parties. Per federal law, no profit may be made from this subaward. See 45 CFR § 75.400.

F. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory)

Subrecipient must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The Subreceipient who is the recipient of an Intent to Award may be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html. This must be accomplished prior to execution of the subaward.

G. ETHICS IN PUBLIC CONTRACTING

The State reserves the right to reject bids, withdraw an intent to award or award, or terminate a subaward if a bidder commits or has committed ethical violations, which include, but are not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilize the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from receiving a subaward with any state or federal entity:
4. Submitting a proposal on behalf of another Party or entity; and
5. Collude with any person or entity to influence the bidding process, submit sham proposals, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the bid, or prejudice the State.

The bidder shall include this clause in any subcontract or Second Tier Subaward entered into for the exclusive purpose of performing this subaward.

Bidder shall have an affirmative duty to report any violations of this clause by the bidder throughout the bidding process, and throughout the term of this subaward for the awarded Subreceipient and their subcontractors / Second Tier Subreceipients.

H. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

The requirements contained in the RFP become a part of the terms and conditions of the subaward resulting from this RFP. Any deviations from the RFP in Sections II through VI must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the subaward. Any specifically defined deviations must not be in conflict with the basic nature of the RFP, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

I. SUBMISSION OF PROPOSALS

Bidders should submit one proposal marked on the first page: "ORIGINAL". If multiple proposals are submitted, the State will retain one copy marked "ORIGINAL" and destroy the other copies. The Bidder is solely responsible for any variance between the copies submitted. Proposal responses should include the completed Form A, "Bidder Contact Sheet". Proposals must reference the RFP number and be sent to the specified address. Please note that the address label should appear as specified in Section I B. on the face of each container or bidder's bid response packet. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The RFP number should be included in all correspondence.

Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming.

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP.

The State shall not incur any liability for any costs incurred by bidders in replying to this RFP, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this RFP.

The Technical and Cost Proposals should be packaged separately (loose-leaf binders are preferred) on standard 8 ½" by 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text. The Technical Proposal should not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts Second Tier Subrecipients and so forth, shall be considered in the Technical Proposal so that the bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions.

J. BID PREPARATION COSTS

The State shall not incur any liability for any costs incurred by bidders in replying to this RFP, including any activity related to bidding on this RFP.

K. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL

Violation of the terms and conditions contained in this RFP or any resultant Subrecipient, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award;
3. Withdrawal of the Award;
4. Termination of the resulting subaward;
5. Legal action; and
6. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

L. BID CORRECTIONS

A bidder may correct a mistake in a bid prior to the time of opening by giving written notice to the State of intent to withdraw the bid for modification or to withdraw the bid completely. Changes in a bid after opening are acceptable only if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

M. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Late proposals will be returned unopened, if requested by the bidder and at bidder's expense. The State is not responsible for proposals that are late or lost regardless of cause or fault.

N. PROPOSAL OPENING

The opening of proposals will be public and the bidders will be announced. Proposals **WILL NOT** be available for viewing by those present at the proposal opening. Vendors may contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website. Once proposals are opened, they become the property of the State of Nebraska and will not be returned.

O. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS

The proposals will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Proposals not meeting the requirements may be rejected as non-responsive. The requirements are:

1. Original Request for Proposal for Contractual Services form signed using an indelible method;
2. Clarity and responsiveness of the proposal;
3. Completed Corporate Overview;
4. Completed Sections II through VI;
5. Completed Technical Approach;
6. Completed State Cost Proposal Template; and,
7. Completed Attachment 1: Award of Initial Funds.

P. EVALUATION COMMITTEE

Proposals are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions.

Q. EVALUATION OF PROPOSALS

All proposals that are responsive to the RFP will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
  - **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the RFP;
  - **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
  - **c.** whether the bidder can perform the subaward within the specified time frame;
  - **d.** the quality of bidder performance on prior subawards;
  - **e.** such other information that may be secured and that has a bearing on the decision to award the subaward;

2. Technical Approach; and,
3. Cost Proposal.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any subaward entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a proposal in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this subaward, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria will be released with the RFP.

R. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The State may determine after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel, identified in their proposal, may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their proposals.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the proposals received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

S. BEST AND FINAL OFFER

If best and final offers (BAFO) are requested by the State and submitted by the bidder, they will be evaluated (using the stated BAFO criteria), scored, and ranked by the Evaluation Committee. The State reserves the right to conduct more than one Best and Final Offer. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

T. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a proposal in response to this RFP, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a proposal, withdraw an intent to award, or rescind the award of a subaward.

U. AWARD

The State reserves the right to evaluate proposals and award subawards in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the proposals, or at any point in the RFP process, the State of Nebraska may take one or more of the following actions:

1. Amend the RFP;
2. Extend the time of or establish a new proposal opening time;
3. Waive deviations or errors in the State's RFP process and in bidder proposals that are not material, do not compromise the RFP process or a bidder's proposal, and do not improve a bidder's competitive position;

4. Accept or reject a portion of or all of a proposal;
5. Accept or reject all proposals;
6. Withdraw the RFP;
7. Elect to rebid the RFP;
8. Award single lines or multiple lines to one or more bidders; or,
9. Award one or more all-inclusive subawards.

The RFP does not commit the State to award a subaward. Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Any protests must be filed by a bidder within ten (10) business days after the intent to award decision is posted to the Internet.

II. TERMS AND CONDITIONS

Bidders should complete Sections II through VI as part of their proposal. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the RFP, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this RFP. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this RFP.

The bidders should submit with their proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the subaward. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The subaward resulting from this RFP shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the RFP;
3. Questions and Answers;
4. Subrecipient's proposal (RFP and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the subaward.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Subrecipient's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Subrecipient and State shall identify the subaward manager who shall serve as the point of contact for the executed subaward.

Communications regarding the executed subaward shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth below, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

C. NOTICE (POC)

The State reserves the right to appoint a Buyer's Representative to manage [or assist the Buyer in managing the subaward on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the Subreceipient will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the Subrecipient.

D. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this subaward, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this subaward will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this subaward on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final subaward, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final subaward are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid subaward has been fully executed by the State and the successful Subrecipient. The Subreceipient will be notified in writing when work may begin.

F. CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State and the Subrecipient, upon the written agreement, may make changes to the contract within the general scope of the RFP. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the subaward shall not be deemed a change. The Subrecipient may not claim forfeiture of the subaward by reasons of such changes.

The Subrecipient shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Subreceipient shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Subrecipient's proposal, were foreseeable, or result from difficulties with or failure of the Subrecipient's proposal or performance.

No change shall be implemented by the Subrecipient until approved by the State, and the subaward is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the subaward and law.

G. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If Subrecipient breaches the subaward or anticipates breaching the subaward, the Subrecipient shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the subaward. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

H. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the subaward in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of subaward does not waive the right to immediately terminate the subaward for the same or different subaward breach which may occur at a different time. In case of default of the Subrecipient, the State may subaward the service from other sources and hold the Subrecipient responsible for any excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Subrecipient shall retain all available statutory remedies and protections.

I. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

J. REMEDIES FOR NONCOMPLIANCE

Acknowledge (Initial)	NOTES/COMMENTS:

DHHS may, if Subrecipient fails to comply with federal statutes, regulations, Title IV-E state plan, or with the terms of the Subaward:

1. Impose any of the Specific Conditions listed in 45 CFR § 75.207;
2. Temporarily withhold any payments pending the correction of the deficiency by Subrecipient;
3. Disallow all or part of the cost of the activity or action not in compliance;
4. Wholly or partly suspend or terminate Subaward (see also Termination, below, and Breach, above);
5. Recommend suspension or debarment proceedings be initiated by the Federal Funding Agency; and
6. Take any other remedies that may be legally available.

If DHHS imposes items 3, 4, or 6, above, DHHS may withhold future payments, or seek repayment to recoup costs paid by DHHS, or both.

Failures to comply include, but are not limited to, Subrecipient's inability to meet or exceed the federal standards contained in FFPSA. If this, or any other failure bySubrecipient to comply with any federal statute, regulation, Title IV-E state plan, or term of this Subaward, is a proximate cause of any reduction in federal funds to DHHS, DHHS may disallow costs under this Subaward in an amount up to DHHS' reduction in federal funding.
Nothing in this section shall limit any other legal remedies available to DHHS.

K. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the subaward is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the subaward did not contain the provision held to be invalid or illegal.

L. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Subrecipient agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Subrecipient, its employees, subcontractors, consultants, representatives, and agents, resulting from this subaward, except to the extent such Subrecipient liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Subrecipient agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Subrecipient or its employees, subcontractors, Second Tier Subrecipients, consultants, representatives, and agents; provided, however, the State gives the Subrecipient r prompt notice in writing of the claim. The Subrecipient may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Subrecipient has indemnified the State, the Subrecipient shall, at the Subrecipient's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Subrecipient, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Subrecipient shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, and, Second Tier subrecipients and their employees provided by the Subrecipient.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Subrecipient may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

M. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the subaward, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.

N. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the subaward to include any renewal and/or extension periods. The amount of the bond must be an established dollar amount $1,000,000. The bond will guarantee that the Subrecipient will faithfully perform all requirements, terms and conditions of the subaward. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the subaward.

O. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Either Party may assign the subaward upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Subrecipient retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Subrecipient's business. Subrecipient agrees to cooperate with the State in executing amendments to the subaward to allow for the transaction. If a third party or entity is involved in the transaction, the Subrecipient will remain responsible for performance of the subaward until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this subaward and perform all obligations of the subaward.

P. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the subaward due to a natural or manmade event outside the control and not the fault of the affected Party (“Force Majeure Event”). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party’s own employees will not be considered a Force Majeure Event.

Q. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

R. OFFICE OF PUBLIC COUNSEL (Statutory)

If it provides, under the terms of this subaward and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Subrecipient shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this subaward.

S. LONG-TERM CARE OMBUDSMAN (Statutory)

Subrecipient must comply with the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this subaward.

T. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The subaward may be terminated as follows:

1. The State and the Subrecipient, by mutual written agreement, may terminate the subaward at any time however, the two parties must agree, in writing, upon the termination conditions, including the effective date and, in case of partial termination, the portion to be terminated.

2. The State, in its sole discretion, may terminate the subaward for any reason upon thirty (30) calendar day's written notice to the Subrecipient. Such termination shall not relieve the Subrecipient of warranty or other service obligations incurred under the terms of the subaward. In the event of termination the Subrecipient shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the subaward immediately for the following reasons:

- **a.** if directed to do so by statute;
- **b.** Subrecipient has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
- **c.** a trustee or receiver of the Subrecipient or of any substantial part of the Subrecipient 's assets has been appointed by a court;
- **d.** fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the subaward by its Subrecipient, its employees, officers, directors, or shareholders;
- **e.** an involuntary proceeding has been commenced by any Party against the Subrecipient under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Subrecipient has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Subrecipient has been decreed or adjudged a debtor;
- **f.** a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
- **g.** Subrecipient intentionally discloses confidential information;
- **h.** Subrecipient has or announces it will discontinue support of the deliverable; and,
- **i.** In the event funding is no longer available.

4. The Subrecipient may terminate the subaward upon sending written notification to DHHS setting forth the reasons for such termination, the effective date, and, in the case of partial termination, the portion to be terminated. However, if DHHS determines in the case of partial termination that the reduced or modified portion of the Subaward will not accomplish the purposes for which the Federal award was made, DHHS may terminate the Subaward in its entirety. In either case, the effective date shall be as provided by the Subrecipient and may be no less than 180 (one-hundred and eighty) days.

5. All notices of termination must be consistent with 45 CFR § 75.372 and shall provide a notice period and effective date as set forth in this Subaward.

U. CONTRACT AND GRANT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. The following closeout procedures apply to this subaward at the end of each federal fiscal year, except for (a), which shall apply at the end of the federal fiscal year and the end of the subaward term, and (e), which shall apply at the end of the subaward term only:

a. The Subrecipient shall finalize and pay all costs for services provided under this subaward as follows:

Term	Deadline to Finalize and Pay Obligations
Initial subaward Start date through September 30, 2019	November 15, 2019
October 1, 2019 through September 30, 2020	November 15, 2020
October 1, 2020 through September 30, 2021	November 15, 2021
October 1, 2021 through September 30, 2022	November 15, 2022
October 1, 2022 through September 30, 2023	November 15, 2023
October 1, 2023 through September 30, 2024	November 15, 2024
October 1, 2024 through September 30, 2025	November 15, 2025
October 1, 2025 through September 30, 2026	November 15, 2026

These deadlines apply to all costs whether paid with state or federal funds, or both. Costs that are not finalized and paid by these deadlines shall not be reimbursed by DHHS, except that DHHS may authorize an extension, in writing, of the above deadlines. If DHHS has previously paid for an incurred cost that has not been finalized and paid by Subrecipient by the applicable deadline, DHHS may withhold additional payments to recoup that cost.

b. Consistent with the terms of the federal award, and after all reports are received, DHHS shall make any necessary adjustments upward or downward in the federal share of costs.

c. DHHS shall make prompt payments, as consistent with the terms set forth herein, for all costs allowable under the terms of this Subaward.

d. Subrecipient shall immediately return to DHHS any unobligated balance of cash advanced or shall manage such balance in accordance with DHHS instructions.

e. Within 30 days, except as otherwise stated herein, Subrecipient shall assist and cooperate in the orderly transition and transfer of subaward activities and operations with the objective of preventing disruption of services. This includes but is not limited to:

i. Transfer all completed or partially completed deliverables to the State;

ii. Transfer ownership and title to all completed or partially completed deliverables to the State;

iii. Return to the State all information and data, unless the Subrecipient is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Subrecipient's routine back up procedures;

iv. Cooperate with any successor Subrecipient, person or entity in the assumption of any or all of the obligations of this subaward;

v. Cooperate with any successor Subrecipient, person or entity with the transfer of information or data related to this subaward

vi. Return or vacate any state owned real or personal property; and

vii. Return all data in a mutually acceptable format and manner.

2. *Post-Closeout Adjustments and Continuing Responsibilities*. The closeout of the subaward does not affect any of the following:

a. The right of DHHS to disallow costs and recover funds on the basis of a later audit or other review. DHHS shall make any cost disallowance determination and notify Subrecipient within the record retention period.

b. The obligation of Contractor to return any funds due as a result of later refunds, corrections, or other transactions including final indirect cost rate adjustments.

c. Audit requirements in 45 CFR § 75 Subpart F.

d. As applicable, property management and disposition requirements in Subpart D—Post Federal Award Requirements in 45 CFR §§ 75.317 through 75.323.

e. Records retention requirements contained herein.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that the Subrecipient is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Subrecipient is solely responsible for fulfilling the subaward. The Subrecipient or the Subrecipient's representative shall be the sole point of subaward regarding all contractual matters.

The Subrecipient shall secure, at its own expense, all personnel required to perform the services under the subaward. The personnel the Subrecipient uses to fulfill the subaward shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Subrecipient's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Subrecipient to the subaward shall be employees of the Subrecipient, a Second Tier Subrecipient or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Subrecipient, Second Tier Subrecipient, or a subcontractor to fulfill the terms of the subaward shall remain under the sole direction and control of the Subrecipient, Second Tier Subrecipient, or the subcontractor respectively.

With respect to its employees, the Subrecipient agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Subrecipient 's employees, including all insurance required by state law;
3. Damages incurred by Subrecipient 's employees within the scope of their duties under the subaward;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;
5. Determining the hours to be worked and the duties to be performed by the Subrecipient s employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Subrecipient , its officers, agents, or subcontractors or subcontractor's employees)

If the Subrecipient intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Subrecipient shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Subrecipient to reassign or remove from the project any Subrecipient or subcontractor employee.

Subrecipient shall insure that the terms and conditions contained in any subaward or contract with a Second Tier Subrecipient or subcontractor does not conflict with the terms and conditions of this subaward.

The Subrecipient shall include a similar provision, for the protection of the State, in the subaward with any subcontractor engaged to perform work on this Subrecipient .

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Subrecipient is an individual or sole proprietorship, the following applies:

1. The Subrecipient must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

The completed United States Attestation Form should be submitted with the RFP response.

2. If the Subrecipient indicates on such attestation form that he or she is a qualified alien, the Subrecipient agrees to provide the US Citizenship and Immigration Services documentation required to verify the Subrecipient‘s lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Subrecipient understands and agrees that lawful presence in the United States is required and the Subrecipient may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Subrecipient shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Subrecipients of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Subrecipient guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of subaward. The Subrecipient shall insert a similar provision in all subcontracts for services to be covered by any subaward / contract resulting from this RFP.

The Subrecipient shall comply with all civil rights and nondiscrimination law in the provision of the services under this Subaward. This includes, but is not limited to:

1. The Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq.;

2. Federal regulations governing programs and services provided under grants from the U.S. Department of Health and Human Services (HHS) at: 45 CFR § 75.300; 45 CFR §§ 80 et seq. (nondiscrimination under programs receiving or benefitting from assistance through HHS); 45 CFR §§ 84 et seq. (nondiscrimination on the basis of handicap in HHS programs or activities receiving federal financial assistance); 45 CFR §§ 86 et seq. (nondiscrimination on the basis of sex in education programs and activities receiving or benefitting from federal financial assistance); 45 CFR §§ 87 et seq. (Equal Treatment for Faith-Based Organizations); and 45 CFR §§ 91 et seq. (nondiscrimination on the basis of age in HHS programs or activities receiving federal financial assistance).

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Subrecipient may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Subrecipient shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Subrecipient is not required to compromise Subrecipient's intellectual property or proprietary information unless expressly required to do so by this subaward.

E. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The subaward price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Subrecipient shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the subaward. The Subrecipient must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. *Data.* DHHS shall own all rights in data resulting from this Subaward. The Federal Funding Agency reserves the right to obtain, reproduce, publish, or otherwise use the data produced under this subaward, and to authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes.

2. *Copyright.* As consistent with federal law, Subrecipient may copyright any of the copyrightable material and may patent any of the patentable products produced in conjunction with the Scope of Work under subaward without written consent from DHHS. DHHS and any Federal Funding Agency hereby reserve a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the copyrightable material for federal or state government purposes.

3. *Patent.* All patent rights under this subaward shall be as set forth in the clause contained in 37 C.F.R. § 401.14, and consistent with all other applicable federal law.

G. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Subrecipient shall not commence work on the subaward until the insurance is in place. If Subrecipient subcontracts or subawards any portion of the contract the Subrecipient must, throughout the term of the contract / subaward, either:

1. Provide equivalent insurance for each subcontractor / Second Tier Subrecipient and provide a COI verifying the coverage for the subcontractor / Second Tier Subrecipient;

2. Require each subcontractor / Second Tier Subrecipient to have equivalent insurance and provide written notice to the State that the Subrecipient has verified that each subcontractor / Second Tier Subrecipient has the required coverage; or,

3. Provide the State with copies of each subcontractor's / Second Tier Subrecipient's Certificate of Insurance evidencing the required coverage.

The Subrecipient shall not allow any subcontractor / Second Tier Subrecipient to commence work until the subcontractor / second tier subrecipient has equivalent insurance. The failure of the State to require a COI, or the failure of the Subrecipient to provide a COI or require subcontractor / Second Tier Subrecipient insurance shall not limit, relieve, or decrease the liability of the Subrecipient hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the subaward or within three (3)years of termination or expiration of the subaward, the Contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and three (3)years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Subrecipient elects to increase the mandatory deductible amount, the Subrecipient shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this subaward, the State may recover up to the liability limits of the insurance policies required herein.

1. WORKERS' COMPENSATION INSURANCE

The Subrecipient shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the Subrecipient's employees to be engaged in work on the project under this subaward and, in case any such work is sublet, the Subrecipient shall require the subcontractor / Second Tier Subrecipient similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's / Second Tier Subrecipient's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Subrecipient shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Subrecipient and any subcontractor / Second Tier Subrecipient performing work covered by this subaward from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Subrecipientor by any subcontractor / Second Tier Subrecipient, or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory**. **The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$5,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

3. EVIDENCE OF COVERAGE

The Subrecipient shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Health and Human Services
Attn: DHHS Service Area Administrator
301 Centennial Mall South
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Subrecipient shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Subrecipient .

H. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

I. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist a relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this RFP or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or an appearance of conflict of interest.

The bidder certifies that it will not knowingly employ any individual known by bidder to have a conflict of interest.

The Parties shall not knowingly, for a period of two years after execution of the subaward, recruit or employ any employee or agent of the other Party who has worked on the RFP or project, or who had any influence on decisions affecting the RFP or project.

J. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient shall be responsible for the proper care and custody of any State-owned property which is furnished for the Subrecipient's use during the performance of the contract. The Subrecipient shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

K. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient shall use its best efforts to ensure that its employees, agents, and subcontractors comply with site rules and regulations while on State premises. If the Subrecipient must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Subrecipient .

L. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

M. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

Subrecipient shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the subaward are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Subrecipient 's performance, the State may create an amendment to the subaward to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

N. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

O. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Subrecipient certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Subrecipient agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

IV. PAYMENT

A. COSTS

Under this subaward, DHHS shall only pay for actual and allowable costs (as defined in this section) incurred during the term of this subaward.

To be allowable, all costs must be:

1. Necessary for the performance of the subaward activities;
2. Reasonable, as provided in 45 CFR § 75.404;
3. Allocable to the federal award, as provided in 45 CFR § 75.405;
4. Consistent with all other requirements of the Cost Principles in 45 CFR §§ 75 Subpart E; and,
5. Consistent with all other law, regulation, policy, or other requirements applicable to the state or federal funds involved.

To be actual, all costs must be finalized and spent by the appropriate dates set forth in Section II.U. Contract and Grant Closeout, and as otherwise set forth herein. This may include, but is not limited to, restrictions on funds including in federal appropriations bills for the federal funds used in this subaward.

Any requirements applicable to the federal funds shall also be applied to the state funds involved in this subaward.

Per federal law, no profit may be made from this subaward. See 45 CFR § 75.400.

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Subrecipient 's equipment which may be installed in a state-owned facility is the responsibility of the Subrecipient.

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Invoices for payments must be submitted by the Subrecipient to the agency requesting the services with sufficient detail to support payment. Subrecipient’s invoice shall include the agency’s name, address, contact phone number, date of invoice, and date of service. Invoices should be sent to DHHS Children and Family Services 301 Centennial Mall S. Lincoln, NE 68509. The terms and conditions included in the Subrecipient’s invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the subaward.

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the subaward shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Subrecipient, Second Tier Subrecipient, or subcontractor duties under the subaward are being performed, and to inspect, monitor

or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Subrecipient monthly when the terms and conditions of the subaward and specifications have been satisfactorily completed on the part of the Subrecipient as solely determined by the State. (Neb. Rev. Stat. §73-506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Subrecipient to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Subrecipient prior to the Effective Date of the subaward, and the Subrecipient hereby waives any claim or cause of action for any such services.

Payments may be withheld as set forth in 45 CFR § 75.305(a)(6), as amended from time to time, as otherwise provided herein, or according to other applicable law.

F. LATE PAYMENT (Statutory)

The Subrecipient may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State's obligation to pay amounts due on the subaward for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the subaward with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Subrecipient written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Subrecipient shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date for noncancelable obligations properly incurred by Subrecipient prior to termination, and costs incurred on, or prior to, the termination date.

H. ACCESS TO RECORDS

Acknowledge (Initial)	NOTES/COMMENTS:

Subrecipient shall provide access for DHHS, or its authorized representative, to any documents, papers, or other records pertinent to Subaward, in order to make audits, examinations, excerpts, and transcripts. The Subrecipient shall provide the same access to the Federal Funding Agency, the Inspectors General, the Comptroller General of the United States, or any of their authorized representatives. These rights also includes timely and reasonable access to Subrecipient's personnel for the purpose of interview and discussion related to such documents, papers

or other records. These rights are not limited to the retention periods included herein but continue as long as the records are retained by Subrecipient.

Subrecipient shall comply with all federal retention requirements as amended from time to time and shall maintain all financial records, supporting documents, statistical records, and all other records pertinent to Subaward, for three (3) years from the date of submission of the final financial report, as provided in Section V.M. .Reporting Requirements.

In addition to the foregoing retention periods, all records must be retained as specified in 45 CFR §§ 75.361 (a) through (f), as applicable. This includes, but is not limited to: if any litigation, claim, or audit is started before the expiration of the three (3) year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken.

Records that fall under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and all associated rules and regulations, including but not limited to the policies and procedures identified in 45 CFR § 164.316, shall be maintained for six (6) years from the date of their creation or date when the policy or procedures were last in effect.

I. AUDIT REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Subrecipient shall comply with all applicable federal audit requirements, including but not limited to those in 45 CFR § 75 Subpart F; an audit required by these regulations must be prepared and issued by an independent auditor in accordance with generally accepted government auditing standards. A copy of the audit is to be made electronically available or sent to: Nebraska Department of Health and Human Services, Financial Services, and P.O. Box 95026, Lincoln, NE 68509-5026.

Subrecipient shall comply with 45 CFR §§ 75.508 through 75.512, including but not limited to: (a) procure or otherwise arrange for the audit required by this part in accordance with § 75.509, and ensure it is properly performed and submitted when due in accordance with § 75.512; (b) prepare appropriate financial statements, including the schedule of expenditures of Federal awards in accordance with § 75.510; (c) promptly follow up and take corrective action on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan in accordance with § 75.511; (d) provide the auditor with access to personnel, accounts, books, records, supporting documentation, and other information as needed for the auditor to perform the audit required by law.

In addition to, and in no way in limitation of any obligation in this Subaward, Subrecipient shall be liable for audit exceptions, and shall return to DHHS all payments made under this Subaward for which an exception has been taken or that has been disallowed because of such an exception, upon demand from DHHS.

The Subrecipient shall maintain its accounting records in accordance with generally accepted accounting principles. DHHS reserves the right to require Subrecipient to submit required financial reports on the accrual basis of accounting. If Subrecipient’s records are not normally kept on the accrual basis, Subrecipient is not required to convert its accounting system but shall develop and submit in a timely manner such accrual information through an analysis of the documentation on hand (such as accounts payable).

J. FEDERAL FINANCIAL ASSISTANCE

Acknowledge (Initial)	NOTES/COMMENTS:

The Subrecipient shall comply with all applicable provisions of 45 C.F.R. §§ 87.1-87.2. The Subrecipient certifies that it shall not use direct federal financial assistance to engage in inherently religious activities, such as worship, religious instruction, and/or proselytization.

K. SMOKE FREE PROVISIONS

Acknowledge (Initial)	NOTES/COMMENTS:

SMOKE FREE. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds in Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The Subrecipient certifies that the Subrecipient will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

L. HUMAN TRAFFICKING PROVISIONS

Acknowledge (Initial)	NOTES/COMMENTS:

The Subrecipient shall comply with and be subject to the requirements of the Trafficking Victims Protection Act of 2000, 22 USC §§ 7101 et seq.

The Subrecipient, its employees, any subcontractors or Second Tier Subrecipients under this award, and Second Tier Subrecipients' or subcontractors' employees may not:

1. Engage in severe forms of trafficking in persons during the period of time that the award is in effect;
2. Procure a commercial sex act during the period of time that the award is in effect; or
3. Use forced labor in the performance of the subaward.

M. LOBBYING

Acknowledge (Initial)	NOTES/COMMENTS:

1. No federal or state funds paid under this Subaward shall be paid for any lobbying costs as set forth herein.
2. Lobbying Prohibited by 31 U.S.C. § 1352 and 45 CFR §§ 93 et seq, and Required Disclosures.
   a. Subrecipient certifies that no federal or state appropriated funds shall be paid, by or on behalf of Subrecipient, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this award for: (a) the awarding of any federal agreement; (b) the making of any federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any federal agreement, grant, loan, or cooperative agreement.
   b. If any funds, other than federal appropriated funds, have been paid or will be paid to any person for influencing or attempting to influence: an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with Subaward, Subrecipient shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. Lobbying Activities Prohibited under Federal Appropriations Bills.
   a. No funds under Subaward shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any state or local government itself.
   b. No funds under this Subaward shall be used to pay the salary or expenses of any grant or subaward recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive legislative relationships or participation by an agency or officer of an State, local or tribal government in policymaking and administrative processes within the executive branch of that government.
   c. The prohibitions in the two sections immediately above shall include any activity to advocate or promote any proposed, pending or future federal, state or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale of marketing, including but not limited to the advocacy or promotion of gun control.

4. Lobbying Costs Unallowable Under the Cost Principles. In addition to the above, no funds shall be paid for executive lobbying costs as set forth in 45 CFR § 75.450(b). If Subrecipient is a nonprofit organization or an Institute of Higher Education, other costs of lobbying are also unallowable as set forth in 45 CFR § 75.450(c).

N. MANDATORY DISCLOSURES

Acknowledge (Initial)	NOTES/COMMENTS:

The Subrecipient must disclose to the State, in a timely manner and in writing, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting this subaward in accordance with 2 CFR

§200.113. Failure to make required disclosures can result in any of the remedies described in §200.338 Remedies for noncompliance, including suspension or debarment. (See also 2 CFR part 180 and 31 U.S.C. 3321).

O. PUBLICATIONS

Acknowledge (Initial)	NOTES/COMMENTS:

Subrecipient must acknowledge federal and DHHS funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with federal and DHHS funds. Subrecipient is required to state: (1) the percentage and dollar amounts of the total program or project costs financed with federal and DHHS funds; and (2) the percentage and dollar amount of the total costs financed by nongovernmental sources.

P. DEBARMENT, SUSPENSION OR DECLARED INELIGIBLE

Acknowledge (Initial)	NOTES/COMMENTS:

The Subrecipient certifies that neither it nor its principals are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any state or federal department or agency. The Subrecipient certifies that it is registered with the System of Award Management (SAM) (https://www.sam.gov), in good standing, and that the entity will maintain annual certification in accordance with Federal Acquisition Regulations. Failure to comply with this section, including maintaining an active registration and/or good standing with SAM, may result in withholding of payments or immediate termination of the subaward.

Q. RESEARCH

Acknowledge (Initial)	NOTES/COMMENTS:

The Subrecipient shall not engage in research utilizing the information obtained through the performance of Subaward without the express written consent of DHHS. The term "research" shall mean the investigation, analysis, or review of information, other than aggregate statistical information, which is used for purposes unconnected with this Subaward.

R. SUBRECIPIENTS OR CONTRACTORS UNDER THIS SUBAWARD

Acknowledge (Initial)	NOTES/COMMENTS:

In contracting or subawarding any portions of this subaward, Subrecipient shall follow 45 CFR §§ 75.327 through 75.335. If Subrecipient enters into a subaward (as defined by 45 CFR § 75.2) with any non-federal entity (also as defined by 45 CFR § 75.2) out any portion of this subaward, Subrecipient shall monitor the subaward as necessary

to ensure that the subaward is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward; that subaward performance goals are achieved. As applicable, Subrecipient shall follow the requirements for pass-through entities, including but not limited to 45 CFR § 75.352.

Subrecipient shall maintain copies of all procurement subawards and documentation of its compliance with the provisions cited above.

Subrecipient shall ensure that all subcontractors and Second Tier Subrecipients comply with all requirements of this subaward and applicable federal, state, county and municipal laws, ordinances, rules, and regulations.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this RFP.

A. PROJECT OVERVIEW

The State of Nebraska, DHHS is issuing this RFP to solicit proposals from qualified bidders to provide Full Service Case Management, which includes the delivery of on-going case management and a continuum of services to children and families residing in Douglas and Sarpy counties (herein referred to as the Eastern Service Area). The objectives for the subaward are:

1. Delivering high quality case management to effectively serve child protection cases;

2. Results and accountability with managing and delivering prevention services that are Well-Supported, Evidenced-Based services in the Subrecipient's service continuum that integrate a strengthening families approach to build protective factors in families in accordance with the time periods stated in FFPSA;

3. Minimizing time in care and promoting reunification and/or adoption in 12 months or less;

4. Recruiting licensed Resource Family homes;

5. Retaining Resource Families for foster and adoptive placements;

6. Utilizing practice models that maximize Federal IV-E funds, and;

7. Identifying how the State benefits by utilizing a Subrecipient to provide case management services in these two counties.

8. The Subrecipient will develop an on-going case management model that:

   a. Effectively engages 100% of families referred for service;
   b. Operates in a culture of continuous quality improvement, as evidenced by data based decision-making and utilization of performance indicators and trend data;
   c. Trains all staff to be trauma-informed, culturally humble, and to build on strengths-based and utilizes family voice and choice in planning and service provision; and,
   d. Ensures 100% of families are applying for and accepting services available through public assistance programs such as Supplemental Nutrition Assistance Program (SNAP), Medicaid, Low Income Home Energy Assistance Program (LIHEAP), child care, and services available from non-profit and community organizations prior to the utilization of State General Funding for payment of services.

9. The Subrecipient will develop a continuum of services that will ensure:

   a. Service expenditures are Well-Supported evidenced-based service in their service continuum in accordance with the time periods specified in the FFPSA;
   b. Delivery to 100% of children and families during the time that DHHS is completing the Initial Assessment;
   c. Delivery to 100% of children and families during the time the Subrecipient is delivering on-going case management, which prevents out-of-home placements and that supports reunification and permanency;
   d. 100% of children served live at home safely, achieve permanency within timeframe of federal measures, and experience improved health and well-being as indicated using the North Carolina Family Assessment Scale;
   e. Utilize appropriate funding sources, such as private pay from the family, private insurance provided by the family, Medicaid, or Behavioral Health Regions for treatment services for 100% eligible individuals;
   f. At least 50% of all prevention service expenditures will meet the criteria of Well-Supported as outlined in the FFSPA; and,
   g. A network of recruited and retained licensed foster homes, such that there is a ratio of two beds in licensed foster homes for every child in care in the Service Area.

B. PROJECT ENVIRONMENT

1. Attachment Three - Service Area Monthly Summary Reports document – Eastern Service Area data includes the number of children and families served in Douglas and Sarpy counties by placement type.

2. DHHS will utilize the Subrecipient's service array to prevent children from being placed out of the family home during the time that DHHS is conducting the Initial Assessment of safety and risk.

3. DHHS is responsible for the care of state wards served under the terms of this subaward. Such ultimate authority cannot be delegated to other parties. DHHS reserves all rights and responsibilities.

4. DHHS may make referrals for service delivery during the time DHHS is conducting the Initial Assessment.

5. DHHS will be the final authority on all decisions related to case management.

6. DHHS reserves sole authority for:

- **a.** Staffing and operating the Child Abuse/Neglect Hotline system for community reporting of suspected child abuse/neglect;
- **b.** Conducting all Initial Assessments of safety and risk;
- **c.** Conducting Out-of-Home Assessments on accepted reports of child abuse/neglect allegations in out-of-home settings (including foster homes, daycare, group homes, and other facilities); and,
- **d.** Licensing of foster homes, child care providers, group homes, and other facilities.

7. DHHS is the sole authority for:

- **a.** Accepting all relinquishments of parental rights;
- **b.** Consenting to adoptions; and,
- **c.** Entering into guardianship and adoption subsidies.

8. DHHS reserves the right to:

- **a.** Review and approve case plans and court reports prior to the Subrecipient submitting them to the courts and legal parties;
- **b.** Provide legal support for legal staffing and to request early hearing or other motions;
- **c.** Approve all requests for placement changes;
- **d.** Approve all requests for case management transfers from the Eastern Service Area to another Service Area;
- **e.** Approve all requests for courtesy supervision to be delivered in the Eastern Service Area; and,
- **f.** Delegate authority to Subrecipient, where allowable by law, or rescind its delegated authority previously given to Subrecipient, at the discretion of DHHS.

9. DHHS will update the Eastern Service Area Operations Manual (Attachment Two) that outlines processes and responsibilities to ensure that the day-to-day operations in the Eastern Service Area are seamless throughout the life of the resulting subaward. The current Eastern Service Area Operations Manual is available for reference as Attachment Two.

10. Title IV-E foster care funds are an important funding source for states to provide foster care maintenance payments for eligible children.

- **a.** DHHS seeks to make accurate and timely reimbursement claims for Title IV-E foster care maintenance payments.
- **b.** When the state subawards to a child placing agency to perform administrative functions of the state, the state may claim federal financial participation through Title IV-E at the rate of fifty percent (50%) for administrative expenditures necessary for the proper and efficient administration of the foster care program, in accordance with the Families First Prevention Services Act.
- **c.** DHHS goal is to maximize the amount of Title IV-E funds claimed in this subaward.

11. This Subaward will involve both state and federal funds. Information about the federal funding for Federal Fiscal Year 2019, as required by 45 CFR § 75.352, is contained on Attachment One Award of Additional Funds. DHHS shall provide Subrecipient further funding information for future Federal Fiscal Years.

C. PROGRAM REQUIREMENTS FOR ON-GOING CASE MANAGEMENT

1. The Subrecipient must operate within a culture of continuous quality improvement, with a focus on ensuring that children are safe, achieving timely permanency, and experience improved health and enhanced well-being through the Subrecipients work with the family to meet the children's needs and prevent recurrence of maltreatment. The Subrecipient must operate a continuous quality improvement program.

2. The Subrecipient shall develop, deliver and manage a model of on-going case management which:

a. Recruits and retains a qualified workforce to respond to and serve the diverse needs of abused or neglected and at-risk families.

i. The role and function of on-going case management staff and the supervision of on-going case management staff must not be subcontracted by the Subrecipient. On-going case management must be performed by direct employees of the Subrecipient.
ii. Staff delivering ongoing case management and supervising ongoing case management must have at least a Bachelor's Degree from an accredited university or college in social work, psychology, counseling, human development, education, criminal justice or other related area. Another Bachelor's Degree combined with four years of case management or human services experience is also acceptable.
iii. The Subrecipient must maintain written verification of the employee's college education.
iv. The Subrecipient must hire a diverse workforce that reflects the population being served.
v. The Subrecipient must organizationally understand, recognize and respond to the effects of all types of trauma experienced by the case management workforce.

b. Trains staff on the knowledge, skills and abilities required to conduct and supervise case management.

i. The Subrecipient shall ensure staff receive initial training in a manner that consistent with Neb. Rev. Stat. § 68-1214, and maximizes IV-E training funds for the State. This training must be approved by DHHS.
ii. After initial training, all case managers shall successfully complete the DHHS formal assessment process to demonstrate competency prior to assuming responsibilities as a case manager. The formal assessment process shall include a written and oral evaluation of the case manager's knowledge and competency in case management and support services. The Subrecipient shall maintain record of each case manager's competency assessment.
iii. The Subrecipient shall provide 24 hours of annual professional development training for staff and document training attended in the staff's training record.
iv. The Subrecipient shall provide a monthly training calendar to DHHS.
v. The Subrecipient shall use best practice guidelines, approved by DHHS, to train staff in, to include but not limited to, Trauma Informed Care and Motivational Interviewing.

c. Uses the DHHS-approved assessment model (currently DHHS uses the Structured Decision Making® (SDM) assessment model) to include, but not limited to, the Implementation of Safety Organized Practice model within the Eastern Service Area.
http://dhhs.ne.gov/children_family_services/Pages/Safety-Organized-Practice.aspx

i. The Subrecipient must conduct quality assurance reviews to ensure quality and timeliness of all assessments completed.
ii. The Subrecipient must develop a training plan and it must be approved by DHHS prior to implementation.

d. Coordinates, collaborates and communicates information sharing between individuals and agencies serving the child and family. At a minimum, this includes:

i. Child;
ii. Parents (custodial and non-custodial);
iii. Safety plan participants;
iv. The child's family members;
v. Resource Family parents or other temporary placement providers;
vi. Medical and dental providers;
vii. School representatives;
viii. Behavioral health providers;
ix. Law enforcement; and,
x. Legal parties in the court.

e. Creates a case plan during the course of service that:

i. Utilizes family voice and family choice.

- **a)** Based on the assessment approved by DHHS (currently, Family Strength and Needs Assessment (FSNA)), the child/family selects the strategies and action steps to achieve outcomes;
- **b)** Addressing the services and supports associated with the identified needs of the child and family;
- **c)** Monitoring progress with and updating strategies and outcomes;
- **d)** Reviewing and updating goals throughout the life of the case;
- **e)** Using the DHHS-approved case plan and court report template. Information will be provided to the awarded Subrecipient; and,
- **f)** Submitting the case plan and court report to DHHS for approval at least three (3) business days prior to the date the report is due to the court.

f. Creates a court report for court-involved cases. The court report shall:

- **i.** Utilize family voice and choice;
- **ii.** Articulate safety or harm statement clearly;
- **iii.** Include Structured Decision Making assessments;
- **iv.** Outline visitation plan if child does not live with either parents or siblings;
- **v.** Address Child Support;
- **vi.** Outline reasonable or active efforts;
- **vii.** Address areas of well-being to include educational, physical/developmental, emotional, mental/behavioral, as well as cultural considerations;
- **viii.** Provide a summary and recommendations to the court; and,
- **ix.** Be submitted along with the case plan at least three (3) state business days prior to the date the report is due to the court.

g. Links children and families with informal and formal services and supports that:

- **i.** Are the least restrictive community-based services, in the intensity required, designed to meet the child and family's needs.
- **ii.** Develop and strengthen connections for children and their families with caring individuals who will support the child throughout life.
- **iii.** Identify the community resources available to meet the needs of the family preventatively and in times of crisis prior to discharge from the child welfare system.

h. Ensures that youth transitioning to adulthood are provided appropriate Independent Living services. The Subrecipient shall develop and implement a system to record and report on the following:

- **i.** Number of youth in the Subrecipient's program that are receiving Independent Living services;
- **ii.** Number of youth referred to a subcontractor / Second Tire Subrecipient for Independent Living services;
- **iii.** Number of youth eligible for Independent Living services but who are not receiving Independent Living services and the reasons for not providing services;
- **iv.** Independent Living services that each eligible youth is receiving each month;
- **v.** Monthly summary of any community planning the Subrecipient participates in to prepare youth to become self- sufficient.
- **vi.** Awarded Subrecipient must submit the system plan and report template within thirty (30) days after award of Subaward.

3. Referrals for on-going case management will be made by DHHS. This is a no reject, no eject subaward. The Subrecipient must:

- **a.** Accept and serve all children and families as of the date of the referral or court order, whichever is first;
- **b.** Serve children and families unconditionally regardless of diagnosis, history, presenting problems, family composition or behaviors;
- **c.** Provide case management to families with children between the ages of 0 and 19 who are either court involved or referred from DHHS for voluntary in-home services;
- **d.** Maintain the capacity 24 hours a day, every day of the year to receive and serve children and families referred by DHHS, and;
- **e.** Collaborate with DHHS to ensure families experience a seamless transition from the Initial Assessment Unit to On-going Case Management.

4. On-going Case Management must utilize best practice guidelines that include the DHHS-approved safety assessment model (currently DHHS uses the SDM) and the DHHS approved collaborative practice approach (Safety Organized Practice). The Subrecipient must ensure that the array of services and supports are available and accessible to children and families in the Eastern Service Area. The services and supports must have sufficient capacity to:

   a. Assess the strengths and needs of children and families;
   b. Address the needs of children and families in order to create and sustain a safe home environment;
   c. Enable children to safely remain with their parents; and,
   d. Safely reunify children as expeditiously as possible.

5. The Subrecipient must exhaust all other options prior to placing a child outside the family home. When placements outside the family home must occur, the Subrecipient shall:

   a. Document why safety planning in home is not an option;
   b. Document why placement with the other parent is not appropriate;
   c. Provide a report to DHHS using the DHHS' preferred format that summarizes the decision to place the child outside the home or current placement and provides a justification for this decision including demonstrating that all other options were exhausted prior to placing a child outside the home or current placement;
   d. Identify and consider all relatives and kin first, as possible placement options including placement with any known sibling;
   e. Ensure appropriately safe parental visitations occur on a regular and consistent basis if the child is not living with a parent;
   f. Ensure appropriately safe relative and kin foster parents complete all activities required for licensing;
   g. Place siblings together when it is safe to do so. Document safety concerns if siblings are not placed together;
   h. Ensure sibling visitations occur on a regular and consistent basis when siblings are not placed together;
   i. Ensure the continuity of family relationships and preserve connections for the child that includes but is not limited to connections with his or her parents, neighborhood, community, faith, extended family, Tribe, school, and friends;
   j. Ensure that the out-of-home placement is the least restrictive placement and most family-like setting;
   k. Ensure that placements are in DHHS provisionally licensed foster homes or licensed foster homes or licensed facilities;
   l. Ensure provisionally licensed homes receive full licensure within six (6) months of placement.
   m. Ensure that the child continues to be educated in their school of origin or the school that will support the goal of improving the child's achievement. The Subrecipient shall consult with DHHS if the child will not be attending his/her school of origin or a school that does not support the improvement of the child's achievement in school; and,
   n. Ensure that the child has the most normal and developmentally appropriate experiences that are generally afforded to children not involved with the child welfare system.

D. PROGRAM REQUIREMENTS FOR SERVICE DELIVERY

1. The bidder shall develop and submit with their bid a catalogue of in-home services available in each zip code of the Eastern Service Area. This catalogue shall be updated by the Subrecipient and provided to DHHS every quarter.

2. Services will be accessed by DHHS to support child safety through vigorous safety planning with the identified safety plan participants and promote family preservation activities, which will prevent children from being removed from the family home.
3. The service array must include Well-Supported, Supported, and evidenced-based in-home and out-of-home services and supports that integrate a strengthening families approach to build protective factors and maintain compliance with FFPSA. The Subrecipient must manage and or deliver an array of services that:

   a. Is trauma-informed, trauma-capable;
   b. Is culturally humble and linguistically appropriate;
   c. Utilizes Well-Supported, Supported or promising practices to prevent children from entering foster care;

d. At least 50% of all service expenditures related to children and families designated to be at "imminent risk of removal" will be Well-Supported evidenced-based practices as approved by the Administration of Children and Families by the end of the first year of the subaward;
e. Effectively engage those receiving the services;
f. Is delivered in the family home, neighborhood and community where the child and family reside whenever possible;
g. Utilizes data to demonstrate effectiveness;
h. Supports cross-agency collaboration with two-generational or whole family approaches; and,
i. Is consistent with any orders issued by the court.

4. The Subrecipient must ensure that a sufficient capacity of trained resource families are available to foster and adopt children in the Eastern Service Area, to include developing and implementing specific strategies to recruit resource families for historically difficult to place children (teenagers and children with medical and behavioral challenges).

a. The Subrecipient is required to expand the availability of trained foster and adoptive families in the Eastern Service Area during the terms of the subaward, as measured by a ratio of placements to children. The baseline and performance targets will be established and mutually approved prior to subaward execution. DHHS will provide reimbursement rates for Resource Family care to the Subrecipient. Please see Attachment Three: Service Area Monthly Summary Report.

5. The Subrecipient must deliver the services and supports to help youth successfully transition into adulthood.

6. The Subrecipient must ensure that the array of service and supports can be individualized to meet the unique needs of *children* being referred in both court and non-court cases. The unique needs of the child population being referred include, but is not limited to:

a. Children ages birth to five (5);
b. Infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from pre-natal drug exposure, or a Fetal Alcohol Spectrum Disorder;
c. Children who have a developmental disability or who demonstrate behaviors consistent with children who have a developmental disability, including Autism Spectrum Disorder (ASD);
d. Children who have been exposed to domestic violence;
e. Children who have extensive histories of trauma;
f. Children who have limited connections with supportive adults;
g. Youth that intersect with both the child welfare and juvenile justice systems;
h. Youth who are pregnant or parenting foster youth;
i. Youth identified as survivors of sex trafficking; and,
j. Youth who are near the age of majority and preparing to transition to adulthood.

7. The Subrecipient must ensure that the array of service and supports can be individualized to meet the unique needs of the *parents* being referred. The unique needs of this population include, but are not limited to:

a. Parents who have extensive histories of trauma;
b. Parents experiencing stress, particularly caused by poverty;
c. Parents who have mental health and substance use disorders or co-occurring disorders;
d. Parents who have been impacted by domestic violence;
e. Young parents with very limited parenting knowledge and skills;
f. Parents who may be resistant to engaging with traditional service delivery models; and,
g. Parents who are currently incarcerated or reside in institutional settings.

8. The Subrecipient must effectively manage a service array within a culture of continuous quality improvement to ensure that:

a. A single point of contact for referrals to be made at all times;
b. Sufficient service capacity is available to service the children and families being referred;
c. Services are geographically accessible to the children and families being served;
d. Services are delivered with appropriate frequency, intensity and duration;
e. Collaboration occurs with community-based and other child-serving agencies, including Medicaid Managed Care Organizations, the Regional Behavioral Health Authorities, public and private schools, public health clinics, community advocates and other interested parties, to ensure that

families are able to access and engage in the services and supports they need during and after formal child welfare system involvement. The Subrecipient shall report to DHHS any Medicaid Managed Care Organization that it believes is non-compliant with case management duties, network adequacy, or ensuring appropriate care delivery to the state Medicaid Program and CFS;

f. Eligible families are assisted with accessing the services and supports offered through DHHS's Division of Children and Family Services Economic Assistance Programs such as SNAP; LIHEAP; Temporary Assistance for Needy Families (TANF) and Emergency Assistance;

g. All available and existing community resources available to the child and family must be exhausted before Subrecipient charges the costs of any activity to this Subaward;

h. An application is made through ACCESSNebraska for both public assistance and Medicaid prior to discharge of a child or family.

i. A complete and accurate application is made to Social Security and the DHHS Division of Developmental Disabilities for children or adults who are disabled;

j. Providers of services will provide information through written documentation or oral testimony for court proceedings, as requested;

k. Service array and rates associated with the service array are equal to or lower than rates paid to other providers contracted by DHHS, Current rates will be provided to awarded Subrecipient; and,

l. State and federal funds will only be expended on items within the scope of the subaward, including, but not limited to case management and services.

9. Subrecipient must provide courtesy supervision of cases that transfer from other service areas outside of the Eastern Service Area, to ensure safety and monitoring of safety plans.

E. ADMINISTRATIVE REQUIREMENTS

1. The Subrecipient shall collaborate with DHHS to ensure families experience a seamless and well-coordinated transition from the Initial Assessment unit to on-going case management.

2. The Subrecipient must provide all in-state and out-of-state transportation related to the Subrecipient's primary business of serving children and families. Please see Attachment Seven, Estimated Mileage FY 2018.

a. The Subrecipient must ensure that it complies with all applicable Public Service Commission regulations and requirements to the extent they apply to the Subrecipient's activities in the performance of this subaward. Nebraska Public Service Commission website: http://www.psc.nebraska.gov/.

b. The Subrecipient must make a reasonable effort to maintain consistency in the individual driver(s) providing transportation and/or a transportation escort for the child.

c. The Subrecipient must provide secure transportation when necessary.

3. The Subrecipient shall complete a Social Security Administration Access Agreement.

4. Grievance Process

a. The Subrecipient must develop and distribute written guidance to families and Resource Family care families on how to lodge grievances about the Subrecipient and any actions related to the performance of the subaward.

b. The grievance process must conform to Neb. Rev. Stat. § 81-603 in that the process shall ensure that families are not dissuaded from utilizing the complaint process for fear of reprisal from the Subrecipient, Second Tier Subrecipients, or foster parents.

c. The Subrecipient must respond to grievances within ten (10) State business days related to the performance of this subaward.

d. The Subrecipient must maintain a file of all grievances and responses thereto related to the performance of this subaward.

5. Background Checks for Agents, Employees, Interns, Volunteers, Second Tier Subrecipients or Subcontractors:

a. The Subrecipient must complete and maintain the initial background checks before any agents, employees, interns, volunteers, Second Tier Subrecipients or subcontractors have direct unsupervised contact with any child or family, and every two years thereafter.

b. The Subrecipient must ensure, at a minimum, the following background checks have been completed on all agents, employees, interns, volunteers, Second Tier Subrecipients and subcontractors:

i. Nebraska Sex Offender Registry maintained by the Nebraska State Patrol;
ii. Nebraska Child Abuse and Neglect Central Registry;
iii. Nebraska Adult Abuse and Neglect Central Registry;
iv. Nebraska Department Motor Vehicles Check for License Point Status;
v. Criminal Background Check; and,
vi. Drug Test for staff providing case management, and staff providing transportation to children and families under this subaward.

c. The Subrecipient must ensure, at a minimum, the following background checks have been completed on all agents, employees, interns, volunteers, Second Tier Subrecipients and subcontractors who have been employed or resided in Nebraska for less than five (5) years if it is foreseeable that the individual may have contact with children and families in the performance of this subaward. If an individual's prior state of residence does not maintain a Sex Offender Registry, Child Abuse and Neglect Central Register, an Adult Abuse and Neglect Central Registry, or a similar registry, the Subrecipient shall complete criminal background checks in the cities, counties and states of previous residence. The Subrecipient must perform the following in the individual's prior states of employment or residence:

i. Criminal history check for each state in which the individual resided or worked;
ii. Sexual Offender Registry;
iii. Child and Adult Abuse and Neglect Central Register/try; and,
iv. State repository of driving records.

d. The Subrecipient must ensure, at a minimum:

i. When a background check results in any non-traffic record being identified, the Subrecipient shall not allow the individual to have direct unsupervised contact with any child and will develop a process to review and determine if it wants to request DHHS approval for an agent, employee, intern, volunteer, Second Tier Subrecipients or subcontractor to have direct unsupervised contact with a child or family referred by DHHS. Requests for an exception shall be made in writing to DHHS and include but not limited to, the name and background information, along with supporting documentation from the Subrecipient as to why Subrecipient believes that such person does not pose a threat to children or families. DHHS shall have ten (10) state business days to respond to such a request. Failure to respond shall not constitute approval by DHHS. All documentation related to the process is maintained in the Subrecipient's staff personnel records.
ii. All required background checks for each employee must be completed before any direct contact with children and their families, and every two (2) years from the date of hire; and,
iii. All background check documentation must be maintained in staff personnel records. This includes documentation requested and received from states other than Nebraska.

e. The Subrecipient shall be responsible for transporting children and families, and shall ensure that children and family members are transported safely and in accordance with Nebraska law, and will:

i. Ensure each employee who has the responsibility to transport children has successfully completed a defensive driving course as sanctioned by the Nebraska Safety Council or similar agency within thirty (30) business days of his or her first day of employment with the Subrecipient.
ii. Adhere to 474 NAC 5-018.06D1 Driver Standards.
iii. Provide transportation as outlined in the Provider Service Referral provided by DHHS or a Visitation Plan approved by the court.; and,
iv. Provide and use child safety restraints in accordance with Nebraska law.

6. The Subrecipient shall cooperate with performance reviews that focus on the quality of the day to day operations and financial performance of the Subrecipient.

7. Performance-Based Contracting:

a. The Subrecipient is required to enter into performance-based contracts with child welfare service providers to incentivize improved performance outcomes, including those in V.L. Retainage and Performance Measurements

b. The percent of the Subrecipient's subcontracted expenditures that are required to be performance-based will be mutually agreed upon prior to execution of subaward.

8. Subcontractors and Second Tier Subrecipients:

a. The Subrecipient must appropriately determine whether the relationship between it and any entity is appropriately a contract with a subcontractor or a subaward with a Second Tier Subrecipient, as consistent with 45 CFR § 75.351.
b. In subcontracting any portions of Subaward, Subrecipient shall follow 45 CFR §§ 75.327 through 75.335, as applicable.
c. If subawarding out any portion of Subaward to a Second Tier Subrecipient, Subrecipient must also implement a competitive application process for any Second Tier Subrecipient. Subrecipient shall monitor the subaward as necessary to ensure that the subaward is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward, as well as that subaward performance goals are achieved. As applicable, Subrecipient shall follow the requirements for pass-through entities, including but not limited to 45 CFR § 75.352.
d. The Subrecipient must ensure that information retained by any subcontractor or Second Tier Subrecipient meets state and federal legal requirements, and will be available to DHHS upon request. This includes, but is not limited to, financial information and source documentation of subcontractors or Second Tier Subrecipients for Title IV-E reimbursement and audit purposes, as well as copies of all subaward agreements and documentation, and procurement contracts and documentation of its compliance with 45 CFR §§ 75.327 through 75.335.
e. Subrecipient must not allow a subcontractor or Second Tier Subrecipient to further subcontract for services, other than foster family care, under this subaward.
f. The Subrecipient must ensure that subcontractors or Second Tier Subrecipients meet all background check requirements.
g. Subcontractors and Second Tier Subrecipients must work collaboratively with the agencies identified as Nebraska's Managed Care Organizations (MCO) to provide health care benefits and services to Medicaid and Children's Health Insurance Program (CHIP) enrollees. Providers delivering treatment services must be enrolled and sustain membership with the MCO.
h. The Subrecipient must receive prior written approval from DHHS before executing contracts or subawards with Subcontractors or Second Tier Subrecipients, and must make available, upon request by DHHS within ten (10) state business days of the request, a listing of the names of all subcontractors or Second Tier Subrecipients; the services all subcontractors or Second Tier Subrecipients provide; and the rates for all services paid by the Subrecipient to all subcontractors or Second Tier Subrecipients.
i. The Subrecipient must receive prior written approval from DHHS before Subrecipient, subcontractor or Second Tier Subrecipients engage in the practice of assessing or collecting client fees or co-pays for services.

9. The Subrecipient shall assist and cooperate with the orderly transition and transfer of subaward activities and operations to prevent the disruption of services delivered to children and families.

10. The Subrecipient will develop and implement a transition plan in the event this subaward reaches its term. As part of the transition plan, the Subrecipient shall:
a. Outline and implement appropriate preparations for a successor agency;
b. Outline and implement plans for:

i. Staffing;
ii. Use and transition of equipment;
iii. Transition of case management to successor agency;
iv. Migration of any data owned by the DHHS; and,
v. Dispute resolution between DHHS and Subrecipient in regards to cases, case loads, and reimbursement for services.

11. Subrecipient's obligations under this subaward will continue throughout the term of the subaward even if Subrecipient's actual and allowable costs exceed the Annual Do Not Exceed Amount (see Cost Proposal) These obligations include, but are not limited to, accepting new referrals from DHHS and service all children, youth, and families according to the terms of this subaward and well as a material increase in families served.

F. TRANSITION AND IMPLEMENTATION

1. Preliminary Implementation Plan:

The Bidder shall be responsible for submitting a preliminary implementation plan with its proposal. The plan must describe the Subrecipient's plan to comply with all the provisions of the RFP. The plan must also address staffing, facilities, and other operational issues as identified in the RFP, including tasks, deliverables and milestones necessary to implement the program.

2. Transition after Termination:

At the end of the subaward term or other subaward termination, Subrecipient will aid in the transition to any new arrangement or provider of services. The respective accrued interests or obligations incurred to date of termination must also be equitably settled. Upon termination or expiration of this subaward, DHHS will work with Subrecipient to transfer all services as efficiently as possible with the goal to have all necessary services transferred by the effective date of the expiration or termination of the subaward. However, in the event that a transfer of all necessary services is not possible, Subrecipient will continue to provide necessary services in accordance with all terms and conditions of this subaward until all necessary client services are completely transferred.

G. READINESS REVIEW

1. Prior to the Operational Start Date, DHHS will conduct an operational and financial readiness review of the Subrecipient, and will provide needed technical assistance. The Subrecipient must cooperate with DHHS's review process to assess the Subrecipient's operational readiness and ability to provide covered services to children and families as of the Operational Start Date. The Subrecipient will be permitted to commence operations only if the readiness review factors are met to DHHS's satisfaction.

Based on the results of the review, DHHS will issue a letter of findings and, if necessary, request a corrective action plan from the Subrecipient.

The readiness review may cover all provisions of the subaward with a particular focus on assessing the following areas:

- **a.** The adequacy of the distribution of providers for in-home and Resource Family care services;
- **b.** Staffing adequacy;
- **c.** Subcontracts / subawards;
- **d.** Quality assurance/continuous quality improvement;
- **e.** Case management;
- **f.** Utilization management;
- **g.** Financial management;
- **h.** Information processing and system testing;
- **i.** Continuity of care;
- **j.** Grievance and appeal process; and,
- **k.** During the readiness review, the Subrecipient must provide to DHHS staff access to Subrecipientstaff, operational documentation (including a demonstration of computer systems), private workspace, and the internet.

2. If the Subrecipient is unable to demonstrate its ability to meet the requirements of this subaward, as determined by DHHS, within the time frames specified by DHHS, DHHS may terminate this subaward.

H. FINANCIAL REQUIREMENTS

1. Cost Allocation Plan/Administrative Expenditures:

- **a.** The Subrecipient shall complete and submit a final Cost Allocation Plan to DHHS within ninety (90) days of Operational Start Date that outlines the administrative functions performed by the Subrecipient, and the plan for allocating the costs of performing those functions to activities or programs supported by the costs incurred. The Cost Allocation Plan and methodology shall be submitted to enable DHHS to claim federal administrative funds under Title IV-E. The document shall be in a format prescribed by DHHS. The Cost Allocation Plan will, at a minimum, include cost pools, allocation methodologies, and benefitting programs. The Subrecipient must input paid administrative expenditures that tie to its Cost Allocation Plan, and submit supporting financial documents as requested by DHHS, to include but not be limited to, payroll records, subcontracted expenditures, and operating expenditures on a monthly basis by no later than thirty (30) calendar days following the month expenditures were incurred. The Subrecipient must complete a monthly centralized random moment time study or other time tracking method as consistent with 45 CFR §§ 75 et seq. , developed and administered by the Subrecipient. The bidder shall submit a draft Cost Allocation Plan of development and implementation of their random moment time study or

other time tracking method with their proposal response. DHHS reserves the right to require the Subrecipient to implement and maintain a random moment time study.

b. The Cost Allocation Plan and methodology shall be consistent with all requirements of the Title IV-E program, and be in furtherance of all program objectives, as set forth by DHHS. Subrecipient shall modify its Cost Allocation Plan and/or methodology at least annually or within thirty (30) calendar days of written notice by DHHS of a modification or amendment that will ensure the maximization of federal dollars. DHHS will review and approve all modifications.

2. Additional DHHS Financial Requirements:

a. Monthly, DHHS will select a sample of individual expenditures and test for allowability and reasonableness, and that they are allocated to the correct funding source.

b. Annually, DHHS will complete a comprehensive on-site review of the Subrecipient's financial information; including additional expenditure testing, allocation of expenditures to the correct fund source, and review of financial and subcontract / subaward monitoring policies.

3. Source Documentation/Service Expenditures:

a. The Subrecipient and Second Tier Subrecipients must separate direct Resource Family care payments from other service delivery expenses and keep records of direct Resource Family care payments that are readily reviewable and traceable to source documentation in a format acceptable to DHHS including, but not limited to, payments to foster parents by check, electronic funds transfers, or other payment types.

b. The Subrecipient must develop and maintain a plan to track, report, and retain all information needed for Title IV-E foster care maintenance claiming. The Subrecipient shall do the following:

i. Provide all necessary documentation to establish the child's initial and ongoing eligibility for Title IV-E, including, but not limited to:

a) A completed copy of the Income and Resources Data (IM-18FC) form;

b) Financial and third party liability information related to the child, his or her parents, and all related family members living in the child's household;

c) Documentation of the child's status related to citizenship, such as a birth certificate or verification of lawful permanent residency;

d) A copy of the first court order pertaining to the child's physical removal from the parent or specified relative home;

e) A copy of the petition leading to the first court order pertaining to the child's removal, and any documentation referenced in the order; and

f) All subsequent court orders during the child's out-of-home placement.

ii. Provide all necessary documentation to establish that the service meets the criteria for a "foster care maintenance payment" in 42 U.S.C. 675];

iii. Provide all necessary documentation to establish that the placement resource meets the criteria for payment from Title IV-E funds. If the Subrecipient utilizes an out-of-state placement resource, the Subrecipient must secure and supply a copy of the license of the home or facility, if applicable, to DHHS and must cooperate with DHHS in obtaining other information needed to determine eligibility for payment from Title IV-E funds;

iv. Ensure that all requirements of Title IV-E pertaining to children for whom payment is requested are met;

v. At the request of DHHS, provide additional information, to enable DHHS to carry out its oversight and administrative responsibilities, including federal reviews and audits, state reviews and audits, and quality assurance reviews. The additional information shall be provided to DHHS within three (3) state business days of a written request by DHHS.

c. The Subrecipient shall input documentation for services provided to children and families in the DHHS N-FOCUS or successor computer system using a format prescribed by DHHS. The Subrecipient shall input documentation for all services provided, except ongoing case management activities, at its discretion but no later than forty-five (45) calendar days following the end of the month in which the service was provided. The documentation must be readily reviewable and traceable to source documentation and reconcile to Subrecipient's financial statements so as to qualify for Title IV-E claiming. The obligation to provide documentation to DHHS, including but not limited to, source documentation of all services provided shall survive the expiration or termination of this subaward. The required format will be provided to the awarded Subrecipient.

d. The Subrecipient must adjust its financial statements related to direct services if the paid claims change.

4. Foster Care Rates

a. In accordance with Neb. Rev. Stat. § 43-4215, on July 1, 2014 DHHS implemented new foster care reimbursement rates and methodology. DHHS will provide foster care rates to the Subrecipient, as well as any change in rates. The Subrecipient and Second Tier Subrecipients shall pay foster families using the rate methodology and same foster care maintenance rate paid to foster families by DHHS. Please see Attachment Five – Foster Care Reimbursement Rate Committee. The Subrecipient and Second Tier Subrecipient's shall pay child placing agencies using the same rate methodology and same administrative rate paid to child placing agencies for each child as determined by DHHS. DHHS reserves the right to revise the administrative rate to ensure that it remains a reasonable match with actual administrative costs.

b. To pay any foster parent at a rate exceeding the rates used by DHHS, Subrecipient must first submit a written request to exceed payment rates to DHHS. DHHS shall consider approving a rate higher than its foster parent rates in instances where the child has unique medical or behavioral needs, or a disability. DHHS must approve any proposed foster parent rates above the DHHS rates.

5. All other costs not listed in V.H13 below, and that are associated with the performance of this subaward, are the responsibility of the Subrecipient. This includes, but is not limited to: court ordered services for which Subrecipient is unable to secure alternate funding sources; and assistance with funeral costs, if requested by family or legal guardian, for any child who dies while in the legal custody of DHHS or while being actively served under this subaward without court involvement.

6. The Subrecipient shall follow all state and locally developed policies and protocols related to the authorization for the purchase of services for children, youth and families being served. This includes, but is not limited to, accessing other payment sources prior to utilizing child welfare or juvenile services funds. Said policies and protocols are currently available at: http://dhhs.ne.gov/children_family_services/.

7. Payment Timeliness

a. The Subrecipient shall make payment in full to the Subcontractors or Second Tier Subrecipients for all goods delivered or services rendered on or before forty-five (45) calendar days after the date of receipt by the Subrecipient of an invoice meeting the Subrecipient's requirements, as set forth in Subrecipient's written policy, protocol or contract / subaward terms with the Subrecipient. Payment to treatment Subrecipients that are delayed due to coordination of benefits with insurance providers will be paid on or before 180 calendar days after receipt of an invoice as described above. Nothing in this subaward is intended to create a third party beneficiary relationship with Subrecipients.

b. Notwithstanding the above, Subrecipient must make all payments before the final deadlines set forth in Section II.N. Contract and Grant Close-Out,

c. These provisions shall survive expiration or termination of the subaward.

8. Financial Statements

a. The Subrecipient shall provide monthly financial statements to DHHS within thirty (30) calendar days from the end of the month services were provided. The financial statements will include a balance sheet, income statement, and statement of cash flows in a format to be agreed upon during subaward negotiations. The financial statements will be prepared using the accrual basis of accounting and using Generally Accepted Accounting Principles (GAAP).

b. Thirty (30) calendar days following the end of each month, beginning thirty (30) days after Operational Start Date, an aging of accounts payable must be provided by Subrecipient to DHHS. The accounts payable aging will be consistent with the monthly financial statements provided to DHHS and list by subcontractor / Second Tier Subrecipient the amount owed to each vendor and: what portion of the amount owed has been due less than 30 days; what portion has been due between 30 days and 59 days; what portion has been due between 60 days and 89 days; what portion has been due between 90 days and 119 days; and what portion has been due 120 days or longer. In addition, a reconciliation of accrued expenses to the balance sheet must also be provided each month and year to DHHS. Nothing in this section is intended to limit access to Subrecipient's records and information as provided elsewhere in this subaward and the terms of this section shall survive expiration or termination of this subaward.

9. Equipment Costs.

a. In addition to the requirements contained in 45 CFR § 75.439 regarding equipment, Subrecipient shall not make purchases of equipment in excess of an aggregate amount of $25,000 (twenty five thousand dollars), unless DHHS has approved, in writing, prior to the purchase. Subrecipient shall not split or divide an equipment purchase into two or more purchases under $25,000 for the purpose or intent of avoiding this requirement. Subrecipient must submit any such approval request in writing to the Director of the Division of Children and Family Services, who will respond to Subrecipient's request in writing within fifteen (15) days after receipt thereof.

10. Bonus, Gift or Other Payment of Funds to Employees

a. The Subrecipient must obtain prior written approval from DHHS before issuing any bonus, gift, or other payment of funds beyond base pay or salary and the Subrecipient's normal employee benefit package provided to an employee, or prospective employee, which is paid from funds provided under this subaward. Subrecipient must submit any such approval request in writing to the Director of the Division of Children and Family Services, who will respond to Subrecipient's request in writing within fifteen (15) days after receipt thereof.

11. Marketing and Advertising Costs

a. The Subrecipient specifically agrees that no advertising costs shall be paid from the funds provided under this subaward unless those advertising costs are consistent with 45 CFR § 75.421. In clarifying the application of subparagraph (b)(4) of 75.421 to this subaward, only informational or educational material regarding services being rendered or required under this subaward are allowable under said provision.

12. Dues and Membership Costs

a. Subrecipient's dues and memberships in any business, technical, or profession organization, or any civic or community organization, must be approved by DHHS before the Subrecipient pays or commits to pay for such dues and membership, and must be consistent with the 45 CFR § 75 Subpart E. Employee dues and membership organizations are fringe benefits and should be approved according to the first paragraph of this subsection. Subrecipient must submit any such approval request in writing to the Director of the Division of Children and Family Services, who will respond to Subrecipient's request in writing within fifteen (15) days after receipt thereof.

13. Subrecipient not responsible for payment of the following:

a. Medical and Mental Health Services paid by Medicaid, private insurance or alternative funding source for children and parents served under this subaward;
b. Services funded by State Ward Education;
c. Maintenance cost for youth placed in the Youth Rehabilitation and Treatment Center at Kearney and Geneva;
d. Adoption and Guardianship Subsidies, and;
e. Case management and extended services for a young adult who has entered into a voluntary services and support agreement under the Bridge to Independence Program, except those requirements under said program that should be performed prior to the time the young adult reaches 19 years of age and is discharged from Resource Family care.

I. FEDERAL AND STATE LEGAL AND POLICY REQUIREMENTS

1. The Subrecipient must abide by all policy requirements of Nebraska Administrative Code; applicable state and federal statutes and regulations; any other applicable codes; applicable program guidance and administrative memos; and applicable written policy directives and interpretations from, or as directed by, DHHS.

2. In addition to the federal law cited above in section III.C., Compliance With Civil Rights Laws And Equal Opportunity Employment / Nondiscrimination, Federal Laws include also include but are not limited to:

a. Title IV of the Social Security Act, 42 U.S.C. §§ 601 – 687;
b. Regulations regarding the Title IV-E Program at 45 CFR §§ 1355 et seq. and 45 CFR §§ 1356 et seq., 45 CFR §§ 1357 et seq.;
c. The Health and Human Services Grant Guidance, 45 CFR §§ 75 et seq.;
d. P.L. 114-22 Justice for Victims of Trafficking Act of 2015;

- **e.** Preventing Sex Trafficking and Strengthening Families Act, at 5 U.S.C. §§ 552, 20 U.S.C. § 1001, 25 U.S.C. § 450b, 28 U.S.C. § 1738B and 534, 42 U.S.C. §§ 1301, 1315, 622, 627, 652, 653, 654, 654a, 659a, 664, 666, 670, 671, 673, 673b, 675, 677, 679 and 679b;
- **f.** Child and Family Services Improvement and Innovation Act at 42 U.S.C. 1305;
- **g.** CAPTA Reauthorization Act of 2010, 42 U.S.C. §§ 5101 et seq.; 42 U.S.C. §§ 5116 et seq.;
- **h.** P.L. 110-351, Fostering Connections to Success and Increasing Adoptions Act of 2008;
- **i.** P.L. 109-248, Adam Walsh Child Protection and Safety Act of 2006, codified at 34 U.S.C. § 20911;
- **j.** P.L. 105-89, Adoption and Safe Families Act of 1997;
- **k.** P.L. 95-608, Indian Child Welfare Act (ICWA) of 1978, 25 U.S.C. §§ 1901 – 1963;
- **l.** P.L. 106-169, Federal Independent Living Requirements (John H. Chafee Foster Care Independence Act);
- **m.** P.L. 103-277, Pro-Children Act of 1994, 20 U.S.C. §§ 6081 et seq.;
- **n.** Pub.L. 114–95, Every Student Succeeds Act of 2017; and
- **o.** Div E of Bipartisan Budget Act of 2018, HR 1892, Families First Prevention Services Act.

3. Federal Policy includes but is not limited to:

- **a.** HHS Grants Policy Statement, currently available at: https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf (or the current Grants Policy Statement, if a new one is issue during the term of this subaward);
- **b.** General Terms and Conditions of Mandatory Formula, Block and Entitlement Grant Programs administered by the Administration for Children and Families, currently available at: https://www.acf.hhs.gov/sites/default/files/assets/general_terms_and_conditions_mandatory.pdf; and,
- **c.** Any other applicable guidance from the Administration for Children and Families.

4. State Laws include but are not limited to:

- **a.** Nebraska Juvenile Code, Neb. Rev. Stat. §§ 43-245 through 43-2,129;
- **b.** Neb. Rev. Stat. § 68-1214;
- **c.** Neb. Rev. Stat. § 43-4204:
  - **i.** The Subrecipient must provide any and all necessary information, in a timely manner, requested by DHHS to complete any readiness assessment developed by DHHS. Said readiness assessment must, in part, assess the Subrecipient's readiness to execute contracts and begin preparations for any transition of case management services.
  - **ii.** The Subrecipient shall not directly provide more than thirty-five percent (35%) of direct services required under this subaward;
- **d.** Nebraska Indian Child Welfare Act, Neb. Rev. Stat. § 43-1502 through 43-1517;
- **e.** Foster Care Review Act, Neb. Rev. Stat. §§ 43-1301 et seq.;
- **f.** Court Appointed Special Advocate Act, Neb. Rev. Stat. §§ 43-3701 through 43-3720;
- **g.** Licensing and Approval Requirements:
  - **i.** All foster homes must be licensed or approved as defined in applicable policy, rules or regulations. DHHS will issue the license and is responsible for all licensing actions.
  - **ii.** Subrecipient shall ensure that persons providing Resource Family Service are in compliance with applicable Nebraska law, including, but not limited to, Neb. Rev. Stat. § 71-1902; and,
- **h.** Child Placement Practices:
  - **i.** All placements must be documented in N-FOCUS or successor computer program within 72 hours of a child's placement except in situations beyond the control of Subrecipient. For excepted situations, Subrecipient must work with DHHS to document placement as soon as possible.
  - **ii.** The Subrecipient shall obtain and maintain an active and ongoing Child-placing Agency license with DHHS, including the provision to license foster homes and relative foster homes.

5. Interstate Compacts

- **a.** Interstate Compact on the Placement of Children.
  - **i.** The Subrecipient must comply with the Interstate Compact on the Placement of Children (ICPC) process and policy regarding visiting state wards placed in other states.
- **b.** Interstate Compact on Adoption and Medical Assistance (ICAMA).

6. Waiver Demonstration

a. The Subrecipient must cooperate with DHHS with respect to any services or reporting required pursuant to the Title IV-E Waiver Demonstration Project Terms and Conditions and Initial Design and Implementation Report, as DHHS deems appropriate and applicable.

b. The Subrecipient and all subcontractors or Second Tier Subrecipients must comply with provider performance improvement measures in accordance with the Title IV-E Waiver Demonstration Project Terms and Conditions and Initial Design and Implementation Report administered by DHHS. The Subrecipient must include performance measures, indicators, and outcomes in agreements with its subcontractors and Second-Tier Subrecipients that mirror those DHHS has with its Subrecipients. Any changes to the performance measures, additional agreement language that could affect the implementation of provider performance improvement measures, or any other programmatic changes with Subrecipients must be approved by DHHS, in writing, prior to implementation. The Subrecipient must oversee the implementation of provider performance improvement measures with its subcontractors or Second-tier Subrecipient's. The Subrecipient must ensure its subcontractors and Second Tier Subrecipient's enter all necessary data as prescribed by DHHS. The Subrecipient must provide all documentation and data necessary for the completion of the Title IV-E Waiver Demonstration Project evaluation.

J. COST RECONCILIATON PROCEDURE

1. DHHS may, in its sole discretion, require reconciliations of payments made to the Subrecipient in excess of actual and allowable costs, but not more frequently than monthly. If Subrecipient's total actual and allowable costs pursuant to this Subaward are less than the total advance payments paid to the Subrecipient for the period of reconciliation, DHHS may withhold the difference from the next payment. If the total actual and allowable costs pursuant to this subaward exceed the total compensation paid for the period of reconciliation, DHHS shall reimburse Subrecipient for the difference.

2. If this Subaward is terminated early for any reason and terminated at any point other than the end of a subaward year DHHS will conduct a final reconciliation. If the total actual and allowable costs incurred pursuant to this subaward for that partial subaward year are less than the total compensation paid for that partial subaward year, Subrecipient shall repay the excess funds to DHHS within sixty (60) days of DHHS' written demand. DHHS may also withhold payments to recoup excess funds paid to Subrecipient. If the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS shall reimburse Subrecipient for the difference.

3. At the end of the term of the subaward and at the end of each renewal term, DHHS will conduct a final reconciliation. If the total actual and allowable costs reported pursuant to this subaward are less than the total payments made, Subrecipient shall repay the excess funds to DHHS within sixty (60) days of DHHS' written demand. If the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS shall reimburse Subrecipient for the difference.

4. In no case shall any payment or the total of payments made through the cost reconciliation process exceed the total annual Not To Exceed amount.

5. This provision shall survive the expiration or termination of this subaward.

K. INFORMATION SYSTEM REQUIREMENTS

1. The Subrecipient must use the state-provided case management system to perform all case management activities for services provided under this subaward. Connection to the state case management system must only be accomplished through state authorized connection and encryption methodology. Subrecipient employees are granted access to information systems and information created, collected, processed and stored on behalf of DHHS under the terms and conditions of this subaward, including but not limited to the Business Associate Provisions (Attachment Four), provided herein.

2. All information collected, processed, compiled and stored by the Subrecipient on behalf of DHHS under the terms and conditions defined in this subaward is the sole property of DHHS and subject to all privacy and security safeguards defined by DHHS and applicable federal guidance.

a. The Subrecipient must allow and provide DHHS access to any and all information and data collected related to the performance of this subaward.

b. Data systems created, owned, and maintained by the Subrecipient for the purpose of conducting case management in support of this subaward shall be configured per the guidance of paragraph V.K.6, and must have an independent assessment of the administrative, physical, technical and privacy controls conducted at least once every three years. Reports shall be provided to DHHS upon written request and in a format and time that is agreeable between the Subrecipient and DHHS.

3. The Subrecipient must assign a security administrator for all of its sites who will act as the liaison between the Subrecipient and DHHS. The security administrator, who must be identified in the proposal as part of the key personnel (see section VI, A, 2 Corporate Overview), will be responsible for:

- **a.** Immediately notifying DHHS when a Subrecipient employee is hired or leaves employment;
- **b.** Providing appropriate documentation to DHHS for the provisioning of user accounts;
- **c.** Validating all Subrecipient user accounts with DHHS annual;
- **d.** Conducting proper background checks for new employees;
- **e.** Immediately notifying DHHS in the event of a security incident involving misuse of the state-provided case management system or loss of client information per the state and federal guidance outlined in V.K.6; and,
- **f.** Ensuring security awareness and acceptable use training is conducted and documented for all staff on initial hire and annually thereafter. Documentation shall be provided to DHHS upon written request within three (3) business days.

4. The Subrecipient shall not request access for employees of subcontractors or Second Tier Subrecipients to state-provided case management systems without the express written consent of DHHS.

5. The Subrecipient must appoint a technology coordinator as the primary contact between the Subrecipient and DHHS to address IT related issues. The technology coordinator must be identified in the proposal as part of the key personnel (see section VI, A, 2 Corporate Overview.), The Subrecipient technology coordinator is responsible for the following:

- **a.** Purchasing, installing, configuring and managing all hardware and software, all computer hardware support, hardware and software upgrades, the movement of all computer equipment, any needed network support, server and LAN printer support and software installation and configuration of information systems owned by the Subrecipient for the performance of responsibilities associated with this subaward. National Institute of Standards and Technology Special Publication (NIST SP) 800-53 must be used as guidance for securing network and computing resources.
- **b.** Understanding that wireless laptops may be permitted under the terms and conditions of this subaward. Such laptop computers must be full disk encrypted. Subrecipient agrees to implement policies that address the physical security of mobile devices, the risk of using unsecured wireless connections, and rules of behavior that govern the appropriate use and safeguards Subrecipient employees must take when using mobile devices.
- **c.** Immediately notifying DHHS of any lost or stolen computer hardware that may have been used to access, process, or store client information.
- **d.** Providing DHHS with a detailed system security plan of any network infrastructure connecting to the agency network.
- **e.** Understanding that remote or home office work sites may be permitted under the terms of this subaward provided each location meets the compliance requirements as detailed in publications listed in V.K.6. All agents, employees, interns, volunteers, Second Tier Subrecipients or subcontractors take reasonable and appropriate actions to ensure such work sites meet compliance requirements when accessing DHHS information.
- **f.** Performing and documenting annual physical site reviews for all remote office and home office locations to ensure the security controls at remote or home office are met. The site safeguard reviews must include inspection of physical, administrative, technical and privacy safeguards implemented at each location. Documentation must include any noted deficiencies, recommendations, and actions taken to address noted deficiencies. Site review documentation must be made available upon request to DHHS agents or other applicable compliance officers with jurisdiction.

6. The Subrecipient must meet compliance requirements for all applicable state and federal physical, administrative, technical and privacy safeguard standards and abide by DHHS Information Technology Policies and Standards that govern the appropriate use of, disclosure of, privacy of, and security of information provided by DHHS or compiled by the Subrecipient on behalf of DHHS under the terms and conditions defined in this subaward. Such guidance includes, but is not limited to:

- **a.** Health Insurance Portability Accountability Act of 1996 (HIPAA) Privacy Rule 45 CFR §§160 et seq. and §§164 Subparts A and E;
- **b.** HIPAA –Security Rule 45 CFR §160 and §§164 Subparts A and C;
- **c.** Internal Revenue Service (IRS) - Publication 1075, Tax Information Security Guidelines for Federal, State and Local Agencies;
- **d.** Social Security Administration (SSA) - Computer Matching Agreement;

e. Nebraska Information Technology Commission (NITC) Information Technology Policies and Standards; and,

f. Centers for Medicare and Medicaid Services (CMS) Computer Matching Agreement.

L. RETAINAGE AND PERFORMANCE MEASUREMENTS

This is a performance-based subaward. The following approach, methodology, and measures will be applied in this subaward to ensure the Subrecipient provides effective outcomes for the children and families served.

1. Overview.

a. A performance target for each measure will be mutually agreed upon by DHHS and the Subrecipient prior to subaward execution.

b. DHHS shall initially withhold three percent (3%) of each monthly payment as retainage for an initial period of twelve (12) months after the Operational Start Date. After the first twelve (12) months, the percentage of retainage will be adjusted based on the Performance Measure (PM) score, as provided below. After the initial twelve (12) month period each designated period will be three (3) months.

c. If, at the end of the designated period, Subrecipient meets all of the performance measures identified in Section V.L. 2. (b) i – v, ,, the retainage amount will be returned to the Subrecipient, in full, within 45 days of the end of the designated period. If the Subrecipient cannot meet all of the performance measures identified in Section V.L. 2. (b) i – v, , DHHS shall retain the designated portion of the retainage amount until Subrecipient becomes compliant with performance measures. Each performance measure will constitute twenty percent (20%) of the total retainage amount.

d. Based on the PM Average, the percentage of retainage may also be adjusted upward or downward, as provided below.

2. Retainage Measures and Methodology.

a. Methodology

i. PM Average Calculation. Each Performance Measure identified in Section V.L.2.b will be assigned a PM Score, with one hundred (100) points awarded to the agreed-upon target. If the Subrecipient does not meet the agreed upon target, one point will be subtracted for every one percent (1%) deviation from the agreed-upon target. If the Subrecipient exceeds the agreed-upon target, one point will be added for every one percent (1%) deviation from the agreed-upon target. The PM Average will be the sum of each PM Score divided by five (5).

ii. Retainage Rate. At the end of each retainage period, the retainage rate shall be equal to the previous time period's retainage rate plus or minus a percentage that corresponds to a PM Average as listed in the table below.

PM Average	Percent Change
64.9 and below	0.5
65.0– 99.9	0.25
100 – 110.0	0
110.1 – 150.0	-0.25
150.1 and above	-0.5

iii. At no point during the term of this subaward shall the retainage rate be less than one percent (1%) or more than five percent (5%).

b. Performance Measures Tied to Retainage:

i. **Recurrence of Substantiated Maltreatment**. This outcome measures the rate of recurrence, expressed as a percentage, of substantiated maltreatment in a 12-month period in the Eastern Service Area, whether or not the child was involved with the court system. The Subrecipient is expected to achieve a lower % than the agreed upon target for recurrence of maltreatment.

ii. **Average Time to Successful Case Closure for Non-Court Involved Children.** This outcome measures the average time to case closure (in days) for Non-Court Involved

Children, on a rolling 12-month average, for non-court children who exited care. The Subrecipient is expected to achieve a lower % than the agreed-upon target for average length of stay for Non-Court Involved Children.

iii. **Rate of Removal of Non-Court Involved Children (in-home).** This outcome measures the average rate of removal, on a rolling 12-month average, children originally assigned to the Subrecipient as part of in-home, non-court involved cases. The Subrecipient is expected to maintain an equal or lower % than the agreed-upon target using evidence-based services designed to preserve families.

iv. **Median Months to Reunification for Court Involved Children, in foster care**. This outcome measures all children discharged from foster care to reunification who had been in foster care for 8 days or longer. The Subrecipient is expected to achieve a lower median months than the agreed-upon target for months to reunification for court involved children.

v. **Rate of Court Involved Children in Foster Care for 24 Months or More who Achieve Permanency.** This outcome incentivizes helping children with a longer than average stay in foster care achieve a positive permanency outcome. It measures the average time to achieve positive permanency (defined as Reunification, Adoption, or Guardianship) in years, on a rolling 12-month average, for court involved children. The Subrecipient is expected to achieve a lower % than the agreed-upon target..

3. Performance Measures Tied to Outcomes and Other Remedies:

a. Subrecipient performance is also measured through the Federal Data indicators which is population data. The data indicators assess operational measures for safety, permanency and well-being. The Subrecipient shall meet or exceed the following federal targets for each of the measures indicated in this RFP and for the life of the subaward:

i. **Safety Outcome – Maltreatment in Foster Care – Federal target - <7.00**
Of all children in foster care during a 12-month period, what is the rate of victimization, per day of care?

Numerator: Of the children in the denominator, the total number of substantiated or indicated reports of maltreatment (by any perpetrator) during a foster care episode within the 12 month period.
Denominator: Of the children in foster care during a 12 month period, the total number of days that these children were in foster care as of the end of the 12 month period.

ii. **Safety Outcome – Recurrence of Maltreatment – Federal target - <7.9%**
Of all children who were victims of substantiated or indicated maltreatment report during a 12 month period, what percent were victims of an additional substantiated or indicated maltreatment report within 12 months?

Numerator: Of the children in the denominator, the number who had another substantiated or indicated maltreatment report within 12 months of their initial report.
Denominator: The number of children with at least one substantiated or indicated maltreatment report in a 12 month period.

iii. **Average Rate of Removal of Non-Court Involved Children (in-home).** This outcome measures the average rate of removal, on a rolling 12-month average, children originally assigned to the Subrecipient as part of in-home, non-court involved cases. The Subrecipient is expected to maintain an equal or lower % than the agreed upon target using evidence-based services designed to preserve families.

iv. **Permanency Outcome – Permanency in 12 months for Children Entering Foster Care. - Federal target - >43.8%**
Of all children who enter foster care in a 12 month period, what percentage are discharged to permanency within 12 months of entering care?

Numerator: Number of children in the denominator who are discharged to permanency within 12 months of entering care.
Denominator: Number of children who enter foster care in a 12 month period.

v. **Permanency Outcome – Permanency in 12 months for Children in Care 12 to 23 Months. – Federal target - >46.2%**

Of all children in care on the first day of a 12-month period who had been in care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?

Numerator: Number of children in the denominator who discharged to permanency within 12 months of the first day in care.
Denominator: Number of children in care on the first day of a 12 month period who had been in care (in that episode) between 12 and 23 months.

vi. **Permanency Outcome – Permanency in 12 months for Children in Care 24 Months or more. – Federal target - >36.3%**

Of all children in care on the first day of a 12-month period who had been in care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?

Numerator: Number of children in the denominator who discharged to permanency within 12 months of the first day.
Denominator: Number of children in care on the first day of a 12 month period who had been in care (in that episode) for 24 months or more.

vii. **Permanency Outcome – Re-entry into Foster Care – Federal target - <8.3%**

Of all children who enter care in a 12-month period, who discharged within 12 months to reunification and live with relative or guardianship, what percent re-entered care within 12 months of their discharge?

Numerator: Number of children who re-enter foster care within 12 months of discharge.
Denominator: Number of children who enter care in a 12 month period who are discharged within 12 months to reunification, living with a relative or guardianship.

viii. **Permanency Outcome – Placement Stability. - Federal target - <4.12**

Of all children who enter foster care in a 12 month period, what is the rate of placement moves per day of foster care?

Numerator: Of the children in the denominator, the total number of placement moves during a 12 month period.
Denominator: Among the children who enter foster care in a 12 month period, the total number of days that these children were in foster care as of the end of the 12 month period.

ix. **Well-being Outcome – Sibling Placement.**

Children are entitled to live with other siblings in care when in the best interest of the child.

Numerator: The number of children who are placed with at least one other sibling in Out of Home (OOH) care.
Denominator: The number of children who have siblings in OOH placement on the last day of the month.

x. **Well-being Outcome – Relative/Kinship Placement.**

Children are entitled to live with relatives/kin while in care when in the best interest of the child.

Numerator: The number of children who are placed with a relative/kin while in OOH placement.
Denominator: The number of children who are in OOH placement on the last day of the month.

xi. **Well-being Outcome – Completed 12th Grade.**

Children aging out of state wardship that have completed the 12th grade.

Numerator: The number of children aging out of state wardship who have completed the 12th grade.
Denominator: Total number of children aging out of state wardship for reason of emancipation.

xii. Well-being Outcome – School stability.
Children are entitled to remain in their same school when in the best interest of the child.

Numerator: The number of children who are age 5 or older and attending the same school as prior to removal to OOH.
Denominator: The number of children who are age 5 or older in OOH placement on the last day of the month.

xiii. Well-being Outcome – Early Placement Stability.
For all children in care 6 to 12 continuous months during a designated 12 month period, the percent with two or more placement changes during their first 6 months in care.

Numerator: Number of children in care for 6 to 12 continuous months during the designated 12 month period who have changed placements 3 or more times.
Denominator: Number of children in care for 6 to 12 continuous months in the designated 12 month period.

xiv. Well-being Outcome – Placement Stability within 1 Year.
For all children in care 12 to 24 continuous months in a designated 12 month period, the percent with two or more placement changes during their first 12 months in care since their removal date.

Numerator: Number of children in care 12 to 24 continuous months during the designated 12 month time period who have changed placements 2 or more times.
Denominator: Number of children in care for 12 to 24 continuous months in the designated 12 month time period.

xv. Well-being Outcome – Placement Stability for Children in Care for Extended Time Periods.
For all children in care 18 continuous months or more in the designated 12 month period, the percent with three or more placement changes since their removal date.

Numerator: Number of children in care for 18 continuous months or more during the designated time period who have changed placements three or more times.
Denominator: Number of children in care for 18 continuous months or more in the designated 12 month time period.

xvi. Well-being Outcome – Case Manager Stability.
For all children in care 6 to 12 continuous months during a designated 12 month period, the percent with two or more case manager changes during their first 6 months in care.

Numerator: Number of children in care for 6 to 12 continuous months during the designated 12 month period who have changed case managers 2 or more times.
Denominator: Number of children in care for 6 to 12 continuous months in the designated 12 month period.

xvii. Well-being Outcome – Case Manager Changes within 1 Year.
For all children in care 12 to 24 continuous months in a designated 12 month period, the percent with three or more case manager changes during their first 12 months in care since their removal date.

Numerator: Number of children in care 12 to 24 continuous months during the designated 12 month time period who have changed case managers 3 or more times.
Denominator: Number of children in care for 12 to 24 continuous months in the designated 12 month time period.

xviii. Well-being Outcome – Case Manager Changes for Children in Care for Extended Time Periods.
For all children in care 18 continuous months or more in the designated 12 month

period, the percent with three or more case manager changes since their removal date.

Numerator: Number of children in care for 18 continuous months or more during the designated time period who have changed case manager three or more times.
Denominator: Number of children in care for 18 continuous months or more in the designated 12 month time period.

xix. Well-being Outcome – Non-Court Cases
For all children who were victims of a substantiated or indicated maltreatment report during a 12 month period and non-court services were offered what percent were victims of another substantiated or indicated maltreatment report within 12 months of closure of the non-court case.

Numerator: Of the children in the denominator, the number who had another substantiated or indicated maltreatment report within 12 months of closure of the non-court case.
Denominator: The number of children with at least one substantiated or indicated maltreatment report for which non-court services were offered in a 12 month period.

4. Performance Improvement Plan (PIP)
DHHS reserves the right to require a PIP be submitted at any point if performance measures as referenced in Section V. L Retainage and Performance Measurements are not being met.. The plan will be submitted in writing and must contain strategies to meet and maintain the identified outcome. This PIP shall be submitted within 14 Subrecipient business days of the request.

M. REPORTING REQUIREMENTS (DELIVERABLES)

1. Cost Allocation Plan

A cost allocation plan meeting the standards set forth in this RFP must be submitted to and approved by DHHS by no later than ninety (90) days after Operational Start Date. DHHS will not unreasonably withhold approval of such cost allocation plan.

2. Financial Reports

a. Financial statements must be provided by the Subrecipient to DHHS within thirty (30) calendar days of the end of each month. The financial statements must include a balance sheet, income statement, and statement of cash flows in a format to be agreed upon during subaward negotiations. The financial statements must be prepared using the accrual basis of accounting and using GAAP.

b. Thirty (30) calendar days following the end of each month, an aging of accounts payable must be provided by the Subrecipient to DHHS. The accounts payable aging must be consistent with the monthly financial statements provided to DHHS and list, by subcontractor or Second Tier Subrecipient, the amount owed to each subcontractor or Second Tier Subrecipient and what portion of the amount owed has been due less than thirty (30) days; what portion has been due between thirty (30) days and fifty-nine (59) days; what portion has been due between sixty (60) days and eighty-nine (89) days; what portion has been due between ninety (90) days and one hundred nineteen (119) days; and what portion has been due one hundred twenty (120) days or longer. In addition, a reconciliation of accrued expenses to the balance sheet must also be provided each month to the DHHS. Nothing in this section is intended to limit access to the Subrecipients records and information as provided elsewhere in this subaward and the terms of this section shall survive expiration or termination of this subaward.

3. Expenditures

a. The Subrecipient must track and report, quarterly and annually, all federal and state expenditures, including administrative costs, in a format to be agreed upon during subaward negotiations. This report shall be due on the 15th day following the end of the quarter and 15th day after the end of the subaward year. Tracking includes, but is not limited to, reconciling its monthly financial statements to invoices for services for purposes of claiming reimbursement under Title IV-E of the Social Security Act. The reconciliations must be readily reviewable and traceable to source documentation. Source documentation includes, but is not limited to: invoices, timesheets, and other billing documents; payments to foster parents and other providers by check, electronic funds transfer, or other types of payment; and contracts, subawards, and other

writings documenting the agreement of the parties relating to services and compensation. In the event that such reconciliation is not completed by the last day of the second month following the end of a reporting quarter, DHHS may elect to withhold the next advance payment until the reconciliation is completed. DHHS may also withhold the final payment necessary to effect reconciliation from any payment made.

4. State and Federal Reports

a. The Subrecipient shall provide any and all information requested, in writing, by DHHS that is deemed necessary to complete reports required by any applicable federal or state law or regulation, including but not limited to caseloads, training, coordination with Tribes, Foster and Adoptive Parent Recruitment and Retention Plans, monthly caseworker visits, Continuous Quality Improvement, and others.

5. Outcome Measures

a. The Subrecipient shall submit monthly reports on Outcome Measures as addressed in Section V, subsection L 2-3.

6. Performance Reviews

a. The Subrecipient shall submit a written monthly report for performance measures indicated in Section V, subsection L, Retainage and Performance Measurements

7. Foster Care

a. The Subrecipient shall provide a written quarterly report of licensed Resource Family (foster) homes recruited and retained during the month.

8. Training

a. The Subrecipient shall submit a quarterly report of training that occurred for case management staff, to include but not limited to training curricula, training rosters, and hours of training.

9. Grievances

a. The Subrecipient must provide to DHHS a quarterly report of all grievances about the performance or actions of the Subrecipient made by children, families or constituents.

10. Critical Incident Reports

a. The Subrecipient shall immediately report (verbally) to DHHS any Critical Incident. The term Critical Incident includes, but is not limited to:

i. Death of a child resulting from abuse or neglect;
ii. Near fatality, life threatening condition or serious injury of a child resulting from abuse or neglect;
iii. Suicide, or attempted suicide of a state ward or child who DHHS serves;
iv. Death of a state ward or child DHHS is working with by other means, accidental or non-accidental;
v. Death or non-accidental serious injury of a staff person while on the job;
vi. Allegations or arrests of a state ward or child who is served by DHHS is involved with for serious illegal/criminal activity (i.e. homicide; manslaughter; near fatality of another person; sexual assault; assault – first or second degree; aggravated or armed robbery; etc.,
vii. Any other event that is highly concerning, poses potential liability, or is of emerging public interest; and;
viii. Any incident that meets the definition of sexual abuse as defined in Neb. Rev. Stat. § 28-318.

b. The Subrecipient shall provide to DHHS a written report of the Critical Incident within four (4) hours on the DHHS-approved format.

11. Safety Standards:

- **a.** The Subrecipient shall immediately report any circumstances that would require a report pursuant to Neb. Rev. Stat. § 28-711 to the DHHS Hotline (1-800-652-1999), or appropriate law enforcement agency, or 911, if an emergency, in addition to the assigned DHHS personnel.
- **b.** The Subrecipient must provide documentation of its protocol after award of the subaward for reporting suspected abuse and neglect for staff in its employment and with any subcontractors or Second Tier Subrecipients.

12. Laws Violations by Employees

- **a.** The Subrecipient must report, within 24 hours, to DHHS, any non-traffic arrest or conviction of an employee who may have contact with children and families in the performance of this subaward.

N. CAPACITY BUILDING COMPONENT

1. DHHS will reimburse actual and allowable expenses incurred by the Subrecipient for reasonable and prudent incremental management, administrative, and support staff, as well as reasonable and prudent operating expenses incurred prior to Operational Start Date that are necessary to build capacity in Nebraska to support transition planning, staff recruitment, and service contract procurement. Such reimbursement of actual and allowable costs shall not exceed $300,000 (three hundred thousand dollars).

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "RFP for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP, agrees to the Terms and Conditions stated in this RFP unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The RFP for Contractual Services form must be signed using an indelible method (not electronically) and returned per the schedule of events in order to be considered for an award.

Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

Further, Sections II through VI must be completed and returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should describe its corporate structure. It should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized. Per Neb Rev Stat. § 43-4204, the Subrecipient must have a board of directors of which at least fifty-one percent of the membership is composed of Nebraska residents who are not employed by the Subrecipient or by a subcontractor of the Subrecipient. Failure to provide a plan that sufficiently addresses the statutory requirements, in the sole discretion of DHHS, may result in a rejection of any bid. Any new entity created will have to execute all final contractual documents, but the entity does not have to be created unless awarded the subaward. The bidder should describe how it will comply with the requirements of the governing board and financial liquidity as described in Neb. Rev. Stat. § 43-4204.

While the bidder does not have to be a "non-Federal entity," as defined by 45 CFR § 75.2 as it may be amended from time to time, the Subrecipients (if a new entity is created for the purposes of this contract) must be a "non-Federal entity" as provided in said regulation

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a subaward with the State of Nebraska should be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract / subaward number(s) and/or any other information available to identify such contract(s) / subaward(s). If no such contracts / subawards exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's proposal response is or was an employee of the State within the past twenty-four (24) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract / subaward terminated for default during the past ten (10) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past ten (10) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past ten (10) years, so declare.

If at any time during the past ten (10) years, the bidder has had a contract / subaward terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this RFP in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include:

a) The time period of the project;
b) The scheduled and actual completion dates;
c) The Subrecipient's responsibilities;
d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
e) Each project description should identify whether the work was performed as the prime Subrecipient or as a subcontractor. If a bidder performed as the prime Subrecipient the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. The bidder's financial management capacity including experience / ability to manage federal funds, financial stability, systems, and cost allocation plans.

iii. Subrecipient and subcontractor(s)/ Second Tier Subrecipient experience should be listed separately. Narrative descriptions submitted for subcontractors / Second Tier Subrecipient should be specifically identified as subcontractor Second Tier Subrecipient projects.

iv. If the work was performed as a subcontractor / Second Tier Subrecipient, the narrative description should identify the same information as requested for the Subrecipient above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor / Second Tier Subrecipient.

v. Bidder should describe previous experience with service the child welfare population or any other relevant experience with the child welfare population.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the subaward resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUBCONTRACTORS

If the bidder intends to subcontract / subaward, any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the subcontractor(s) / Second Tier Subrecipient(s);
ii. specific tasks for each subcontractor(s) / Second Tier Subrecipient(s);
iii. percentage of performance hours intended for each subcontract / subaward; and
iv. total percentage of subcontractor(s) / Second Tier Subrecipient(s) performance hours.

k. REFERENCES

The bidder should provide three references from a non-DHHS individual familiar with the bidders' corporate experience.

3. TECHNICAL APPROACH

The technical approach section of the Technical Proposal should include the following items:

a. Attachment Four – Business Associate Agreement
b. Attachment Six - Business Requirements Matrix;
c. Catalogue of In-Home Services;
d. Preliminary Implementation Plan;
e. Draft Cost Allocation Plan of development and implementation of Random Moment Time Study or other time tracking method; and
f. Transitional Plan

VII. COST PROPOSAL REQUIREMENTS

This section describes the requirements to be addressed by bidders in preparing the State's Cost Proposal. The bidder must use the State's Cost Proposal. The bidder should submit the State's Cost Proposal in accordance with Section I Submission of Proposal.

THE STATE'S COST PROPOSAL AND ANY OTHER COST DOCUMENT SUBMITTED WITH THE PROPOSAL SHALL NOT BE CONSIDERED CONFIDENTIAL OR PROPRIETARY AND IS CONSIDERED A PUBLIC RECORD IN THE STATE OF NEBRASKA AND WILL BE POSTED TO A PUBLIC WEBSITE.

A. COST PROPOSAL

This RFP is not for a fee-for-service contract, but to award a subaward pursuant to federal law. Therefore, DHHS may not pay a profit, and may only pay Subrecipient up to the total of its actual and allowable costs, as defined herein. In its Cost Proposal the Subrecipient shall provide a total Not To Exceed amount for each subaward year. Subrecipient may receive payment or reimbursement up to, but not exceeding, that Total Not to Exceed Amount, but is not guaranteed that amount, as it may only be paid up to its actual and allowable costs of providing the services under this subaward.

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

B. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the RFP. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Form A
Bidder Contact Sheet
Request for Proposal Number 5995 Z1

Form A should be completed and submitted with each response to this RFP. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free work place.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

______I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	
COMPLETE ADDRESS:	
TELEPHONE NUMBER:	
FAX NUMBER:	
DATE:	
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	

5995 Z1 ATTACHMENT ONE – AWARD OF INITIAL FUNDS

SUBRECIPIENT INFORMATION	
Subrecipient Name	
Subrecipient DUNS Number	
Parent DUNS Number	
Principal Place of Performance (City/State/Country/Zip Code + 4)	
Nebraska Congressional District	Choose an item.

FUNDING TOTALS	
Total Amount of Federal Funds Obligated	$
Total Amount of State Cash Funds Obligated	$
Total Amount of State General Funds Obligated	$
Total Amount of Federal Award Committed to Subrecipient	*Same as Total Subaward below*
TOTAL SUBAWARD	0

Federal Agency Name	Catalog of Federal Domestic Assistance (CFDA) Name	CFDA Number	Federal Award Date	Federal Award Identifier Number (FAIN)	Amount of Federal Funds Obligated
Administration for Children and Families	Title IV-E Foster Care	93.658	October 1, 2018	G-1901NEFOST	$
			Click here to enter a date.		$

Eastern Service Area

Operations Manual

Children and Family
Case Management Contract

January 23, 2018

Operations Manual

Table of Contents

January 23, 2018

1. Purpose of the Operations Manual
2. Roles and Responsibilities
3. Caseload Ratio Requirements
4. Documentation/File Retention
5. Record Keeping
6. Transportation Standards
7. Foster/Adoptive Home Studies and Approval Studies
8. Required Reports
9. Continuous Quality Improvement
10. Insurance Requirements
11. Professional Development and Training
12. Performance Accountability
13. Case Transfer
14. Independent Living
15. Foster Care Rates and Adoption/Guardianship Subsidies

1) Purpose of the Operations Manual

The subrecipient is required to follow all DHHS regulations, policies and practice memos as well as state and federal law. The purpose of the Operations Manual is to outline processes that are specific to the day to day operations of the Eastern Service Area (ESA) that are not included in Department of Health and Human Services Regulations, Policies, Procedures and the Children and Families Case Management subaward with the subrecipient . The Operations Manual is an attachment to the subaward and may be amended as needed by agreement of the parties In accordance with the process set forth hereinafter.

The Operations Manual provides direction to the subrecipient in greater detail on the expectations for standardization in the operation and delivery of case management and related services.

1) The Operations Manual will be reviewed and amended as agreed to by the parties. A request by the subrecipient to amend the Operations Manual shall be made in writing to the subaward liaison or Eastern Service Area Administrator. The request shall include:
   a) Identification of the originator of the request.
   b) The date the request was submitted.
   c) The section of the Operations Manual that needs to be changed.
   d) The proposed change.
   e) The reason the change is requested.
   f) Proposed time frames associated with the change.

2) The DHHS subaward liaison / Eastern Service Area Administrator will convene a representative group of both parties to review the requested amendment.
3) The Operations Manual may be modified only by written amendment, drafted by DHHS Eastern Service Area Administrator, and signed by both parties with respective dates.

4) The most current version of and any amendments to the Operations Manual will be posted on the DHHS Division of Children and Family Services Website.

2) Subrecipient and DHHS Roles and Responsibilities

The roles and responsibilities outlined in this section are not intended to replace policy or DHHS regulations. The purpose of the role and responsibility matrix is to further define the responsibilities associated with the day to day operations of delivering case management to children and families in the ESA.

Referrals to Subrecipient:

The subrecipient shall accept all referrals from DHHS. Referrals to the subrecipient will be made via a single referral line established by the Subrecipient. The subrecipient must have a method to accept these referrals 24 hours a day/7 days a week for Coordinated Response. For referrals to ongoing case management, referrals will be accepted 8:00 a.m. to 5:00 p.m. Monday through Friday only. A standard information and referral form will be established and utilized for each referral and will include all information known to DHHS at the time of referral.

DHHS will make referrals to NFC to access services for families during the Initial Assessment phase when a safety threat is identified. DHHS will refer families for ongoing case management at the completion of the SDM Risk Assessment (30 days) when there is not a safety threat identified but families are determined to be a high or very high risk and have voluntarily accepted ongoing case management services. Court involved cases initiated through Coordinated Response will be referred to NFC for ongoing case management following a staffing which will occur at such intervals as both DHHS and NFC have agreed upon. Transition of case management responsibilities will be effective immediately following the Protective Custody Hearing .

At the time of referral for Coordinated Response Services Access, DHHS will determine and communicate to the subrecipient via phone the response time required for the subrecipient's response and whether the response must be in person, for a

specified need such as placement and/or flexible funding items. When there is a need for immediate safety planning services or a placement is needed, the subrecipient shall respond within two (2) hours unless otherwise directed by DHHS. Subrecipient shall respond to all other referrals for services access within 24 hours. A response is defined as direct phone or face to face contact with the family who is the subject of the referral. In a two (2) hour response, the subrecipient may be required to meet the DHHS Child and Family Services Specialist at the family home to arrange safety services, to facilitate and ensure a safety provider will respond to the home or to secure placement for a child(ren) being removed from the family home. In the event out-of-home placement is required the subrecipient is responsible for providing supervision to the child(ren) if agency based placement is not located within three (3) hours of the request for Agency Based Foster Care. When requested the subrecipient shall participate in the intial family team meeting to be held within 72 hours of referral as arranged and facilitated by DHHS.

If a referral is made to subrecipient during the Initial Assessment phase, subrecipient shall provide DHHS with recommendations for services, interventions and strategies to address safety concerns identified by DHHS. The subrecipient shall initiate servicesin a timely manner.

DHHS is responsible to enter NFOCUS organization role (either “service provision” or “case management” for subrecipient) and legal status of all children in the family. At the time of case closure, DHHS is responsible to update the legal status of all children and update the organization role on NFOCUS.

Below matrix outlines the separation of roles between DHHS and subrecipient under the Coordinated Response Initiative which takes effect July 1, 2016.

Coordinated Response Initiative	
DHHS	**NFC**
• DHHS is responsible for and shall complete initial assessments (i.e., investigations), including all initial safety and risk assessments, of reports of child abuse or neglect. • When DHHS identifies a safety threat, need for safety planning (in-home or out-of-home), DHHS will make a referral for an intervention related to a safety threat and/or safety plan. • DHHS is the sole case manager responsible for the monitoring and managing of the safety plan while listed as primary worker. Primary worker transfer will occur after protective custody hearing on court involved cases and at the completion of risk assessment on non court involved cases. NFC will become primary worker after completion of the case transfer. DHHS will follow mutually agreed upon transfer process at time of case management referral. • DHHS is responsible for monitoring of and modification to the safety plan while holding primary case management. • DHHS is responsible to attend and to present the safety plan at the protective custody hearing. DHHS will communicate with all legal parties. DHHS shall provide a written plan when reunification is recommended at protective custody hearing. . • DHHS will coordinate with probation if they have an active docket. • DHHS is responsible for locating, approving, and completing walk-throughs for any relative or kinship placements while assigned as primary worker. DHHS is responsible for completing appropriate relative placement packets within 12 hours of placement (request to load, W9, background check cover sheet w/signature). The request to load form	• NFC shall maintain adequate capacity of appropriate services, interventions, strategies, or resources, to address safety concerns identified by DHHS prior to transfer of and after transfer of ongoing case management from DHHS to NFC • NFC will regularly review capacity and interventions needed to maintain ongoing access to safety services in order to prevent removals and maintain in-home safety plans. • NFC shall maintain the ability to accept safety service referrals 24/7 via the NFC intake process This will include 2-hour maximum on-site response with service implementation for in-home safety planning. For out of home safety placement needs, NFC shall respond immediately to begin identifying and securing appropriate placement. • NFC shall identify non-kin out-of-home placement options and will provide hourly email updates to the assigned IA staff until placement is located. This update will include most current placement search results. This non-kin search may occur concurrently with DHHS's efforts to locate relative/kinship placements. If after 3 hours, no out of home placement is located, NFC will be responsible to provide supervision of the child while continuing to search for and secure placement. • NFC shall communicate with the referring IA staff to identify the assigned service providers that will be responding to the home. This will include contact information for the identified provider. Provider shall make contact with the assigned IA staff prior to initiating any interventions. • Any provider of a safety service will provide written documentation to the

will serve as the referral for kinship homestudy. • DHHS will determine level of supervision needed for safety planning purposes while primary assigned worker. • DHHS is responsible for all monthly contacts, team meetings, placement changes, safety plan modifications, and all other case management duties while assigned as primary case manager. • DHHS will complete initial FTM if still primary case manager 15 days from legal status change. • Initial SDM Risk tool shall be completed within 30 days of Intake • DHHS will communicate with the assigned County Attorney if not in support of the removal. • Complete the initial visitation plan and document in NFOCUS within 72 hours of removal. • DHHS will ensure placement is updated in NFOCUS within 72 hours of placement occurrence. • DHHS will provide information for kinship support services and make referral to NFC • DHHS will identify and refer when a need for Family Finding services exists. • DHHS will refer to NFC for coordination and payment of any good or service required to maintain safety in the parental home, including but not limited to in home safety services, transportation, hotel, beds, supervision/monitoring, respite, etc. • DHHS will complete superintendent letter for any child placed out of home. • DHHS will complete EDN referral per DHHS policy • DHHS will ensure foster care physical is scheduled within 14 days of removal and documented in NFOCUS. • DHHS will document any known psychotropic medication prescribed to the minor at time of foster care placement.	assigned IA staff no less than weekly and immediately for drug testing or concerns with the safety plan. • NFC will identify visitation provider for children placed out-of-home. Visitation with parents will begin as soon as possible but no later than 3 calendar days after removal. NFC will develop appropriate safety interventions within it's network to meet the current and future needs of our community and families. • NFC will provide Family Finding services for all children not initially placed in kin/relative care. • NFC will make initial contact with the family within 24 hours of referral. • NFC will complete the relative/kinship homestudy within 30 days of placement. • NFC will secure kinship support services when referred. • NFC will obtain requested goods and services to support relative/kinship placement or in home safety plan placement. • NFC will secure requested evaluations to expedite reunification or case closure • NFC will secure appropriate interventions to support the DHHS plan to reunify or close. • NFC will attend the protective custody hearing • NFC shall schedule a FTM within 72 hours of referral to ongoing case management. • NFC Administration will review unsafe, non-court if it will not transfer to ongoing within 40 days of intake. • NFC will accept all referrals for case management in accordance with mutually agreed upon transfer process.

• DHHS will complete IMFC paperwork. • DHHS will complete applicable relative notices and notice to the court per DHHS policy while primary case manager • DHHS will follow all requirements of ICWA identifications and notifications in accordance with DHHS policy. DHHS will document all ICWA information that is known while serving as primary case manager. • DHHS is responsible for completing the ICPC requirements when placing at time of removal. • DHHS will identify possible evaluations, or therapeutic interventions when applicable, that may assist with case closure or reunification by protective custody hearing DHHS will refer to NFC for coordination of recommended evaluations or service that are necessary prior to transfer of case management. • DHHS will coordinate with legal parties and DHHS legal when recommending reunification or closure at protective custody. • If not recommending case closure at the protective custody hearing, DHHS will refer to NFC for ongoing case management prior to scheduled court date. (NFC will not make contact with family until after court hearing). • DHHS will respond to any issues or concerns from the family while assigned primary case management. • DHHS will update child's legal status in NFOCUS. • DHHS Administration will review families assessed to be unsafe with no pending legal filing. if it will not transfer to ongoing within 40 days of intake.	

Structured Decision Making:
The subrecipient shall be trained in and utilize the Structured Decision Making® model (SDM) assessment tools throughout the life of the case.

Intake:
The subrecipient shall not create, staff or operate a reporting hotline system for accepting, screening or assigning suspected abuse/neglect. The DHHS shall maintain the single statewide reporting hotline. The subrecipient shall report any instances of suspected child abuse/neglect to the DHHS statewide hotline at 1-800-652-1999 as required mandatory reporters under Neb. Rev. Statute § 28-710.

Initial Assessment:
The subrecipient will not be responsible for completion of initial safety and risk assessments of new allegations of abuse/neglect on families. All accepted allegations of child abuse/neglect will be assigned to a DHHS Initial Assessment Child and Family Services Specialist (CFSS). The subrecipient shall not enter findings. All findings will be entered by DHHS staff.

If the subrecipient is already involved with a family in a court or non-court involved case, the subrecipient will be involved in the interviews and collateral information. The subrecipient will be responsible to complete the safety assessment .DHHS will review and approve the safety assessment. Information gathered during the course of the DHHS IA investigation will be added to the safety assessment by the assigned CFS Specialist If the subrecipient is completing an affidavit on an active court or non-court involved family as a result of the safety assessment, a DHHS administrator will review the affidavit prior to subrecipient submission. DHHS will determine if further face to face interviews are necessary in situations where the subrecipient has already completed an affidavit. Any additional information gatherered will be added to the assessment by DHHS.

Safety Planning:

Safety planning is the responsibility of the DHHS CFS Specialist throughout the Initial Assessment phase. DHHS will identify specific safety threats, safety plan needs and outcomes necessary to be coordinated by the subrecipient for the purposes of safety planning. The subrecipient shall make necessary referrals to subcontractors and second tier subrecipients or directly provide for service interventions adequate to manage and control for safety in the home. The subrecipient is responsible for monitoring of the interventions and strategies utilized to achieve outcomes identified within the Safety Plan. DHHS is responsible to identify potential informal participants in the safety plan and to gather information necessary for DHHS to complete these background checks and determine suitability. DHHS is responsible for the decision to approve safety plan participants recommended by the subrecipient.

The subrecipient will notify DHHS immediately of any changes in circumstance or concern within a safety plan. This notification will be made verbally to the DHHS CFS Specialist assigned or to the coverage Supervisor if after hours.

Any contact with the parents during the initial assessment phase will be discussed with the DHHS CFS Specialist and completed jointly whenever possible. DHHS CFS Specialist will inform the subrecipient of any police holds or other reasons why contacts should be controlled or not occur. Safety plans, including visitation plans, will not be modified by the subrecipient during the initial assessment phase.

Out of Home Assessments and Placement Concerns:

The subrecipient is not responsible for and will not conduct “out of home assessments” on intakes accepted for placement concerns on allegations accepted for abuse/neglect occurring in out of home settings (including foster homes, daycare, group homes, other facilities). DHHS will coordinate with subrecipient in gathering information and monitoring of safety plans needed for children in placement. The subrecipient will work with DHHS to complete the SDM tool - Assessment of Placement, Safety and Suitability

(APSS) which will determine any necessary action needed in the placement. The subrecipient shall enforce and monitor corrective actions as determined by the APSS to support the placement home. DHHS is responsible for any licensing actions needed on a home or facility licensed by DHHS.

Out of Home Placements:

The subrecipient will place children with family or with adults known to the children whenever it is safe to do so and will make every effort to minimize the level of trauma experienced by the child during initial placement or any placement change.

The subrecipient will consider the proximity of the placement to the child's home school when making placement decisions. When it is not in the child's best interest to attend their home school, the subrecipient will make provisions for immediate enrollment in a new school and will ensure that all educational records are shared with the new school at or before time of admission.

The subrecipient shall ensure that a child in need of out-of-home care will be placed in a safe, appropriate, and approved or licensed home or facility. The subrecipient is responsible for locating and securing all out of home placements. Non-custodial parent, relative and kinship support and placement options will be identified and secured before agency placement. The subrecipient shall ensure that the best interest of the child is considered and supported in all placements, to include best match, the child's home school, siblings being placed together, proximity to parents and other siblings and any special needs. The subrecipient shall document "child characteristics" in NFOCUS to assist with suitability of placement with child's unique needs. The subrecipient shall provide all necessary supports to the foster placement to safely maintain the child in their home. The subrecipient shall provide support and training to all relative and kinship homes if not affiliated with an agency. The subrecipient shall collaborate with its provider network to maintain an adequate capacity of available foster placements comparative to the number of children in out of home care, including specific age group, special need options and ability to maintain the child's home school location.

When an initial out of home placement is needed during an Initial Assessment, a service referral will be made to the subrecipient by DHHS in accordance with the referral process. The subrecipient will be responsible to locate an out of home placement that is in the best interest of the child(ren) considering the child's home school, siblings being placed together, proximity to parents and any special needs of the child. Prior to utilizing agency-based foster care, DHHS will explore and rule out all non-custodial parents, relatives and kinship homes. DHHS will make a referral to the subrecipient for Family Finding services as needed and will identify and notify all relatives and kin in writing within thirty (30) days of the initial removal. During Initial Assessement, DHHS will document all identified family and kin in the NFOCUS kinship screens. The subrecipient will continue to document identified family and kin as needed throughout ongoing case management. During the Initial Assessment phase, DHHS will generate and send the notice to all relatives/kin identified and send the notice to the Court of all relatives/kin notified consistent with Neb Rev. Statute. After case management has been referred to the subrecipient and new relatives/kin are identified, the subrecipeint will generate and send all relative/kin notifications and send the notice to the Court

DHHS is responsible for the walk through and collecting of information and consents to complete the background checks on kinship/relative homes during Intial Assessment. The Subrecipient is responsible for walkthrough and collecting of information and consents to complete the background checks on kinship/relative homes throughout the course of ongoing case management. DHHS and/or Subrecipient will complete the background check and document the results in NFOCUS kinship narrative.

When it is necessary to utilize agency-based foster care, the subrecipient will obtain approval from the agency responsible for supporting the foster home prior to placement or within 24 hours of any emergency placement. The subrecipient will also notify the foster care agency of all other children placed in the foster home to address the safety and best interest of all children in the home.

The Subrecipient will follow Court procedures for notification and approval of all placement changes. Placement notice to the Court and legal parties must be provided no less than seven (7) calendar days prior to effective date of the change in placement. The subrecipient shall arrange for and carry out the placement change once approval is received from the Court. The subrecipient shall document all placement changes in NFOCUS within 72 hours of the change of placement. Emergency placement changes require notice to the Court within 24 hours.

The subrecipient is responsible for providing the "Statement of Disclosure" to the foster parent and obtaining the foster parent's signature after providing disclosure to the foster placement and foster care agency of all known information specific to the child, including medical, behavioral and educational information.

Background Checks:

The subrecipient is not responsible for and shall not complete background checks on non-custodial or relative/kinship placements and/or safety plan participants. DHHS is responsible for the completion of these background checks. DHHS is responsible for obtaining all necessary information and consents to complete said check during Initial Assessment. The subrecipient is responsible for obtaining and submitting all necessary information and consents to complete background checks to DHHS throughout the course of ongoing case management. DHHS will then complete the full background check and document results in NFOCUS kinship narrative. DHHS will also provide relevant background check information to the subrecipient for the hard copy file.

Approval for Placement in an Unlicensed Home:

Subrecipient will follow all statute, policy and regulation regarding placements.
Initial Assessment:
DHHS shall identify all non-custodial, relative or kinship options for placement during Initial Assessment when needed. DHHS shall complete the paperwork to request a full

background check.   DHHS shall complete the initial walk through of the entire residence to ensure that the home is safe. DHHS shall complete and submit the "Request for Approved Status" packet to DHHS local Resource Development Unit when complete. DHHS shall submit documentation required for payment of relative or kinship placement, as well as documentation required for initiation of the home study to the subreciepent.

Ongoing Case Management:

The subrecipient shall identify all non-custodial, relative or kinship options for placement at time of needed placement. The subrecipient shall complete the paperwork and submit to DHHS to request a full background check.   The subrecipient shall complete the initial walk through of the entire residence to assess for safety in the home.   The subrecipient shall complete and submit the "Request for Approved Status" packet to DHHS local Resource Development Unit when complete. Upon approval, DHHS will load the home as an "organization" in NFOCUS. The home cannot be loaded onto NFOCUS without this "Request for Approved Status" packet. This must be completed within 48 hours of placement so that the placement change on NFOCUS can occur within 72 hours of placement. Within thirty (30) days of placement, a full home study will be completed and forwarded to the DHHS local Resource Development unit to approve continued placement in the home.

Ongoing Case Management:

The subrecipient is responsible for ongoing case management as defined in statute, DHHS regulations, policy, administrative memos and local protocol for both court involved and non-court involved families. The responsibilities and definitions of ongoing case management are outlined in program guidance and policy.

Subrecipient is responsible for updating all legal status and organization role types. Subrecipient is responsible for adding individuals to the master case/program case for purposes of providing services.   Subrecipient is responsible for ensuring all

assessments and udpates are completed before closing the CFS case on NFOCUS. Subrecipient will send all hard files to DHHS upon closing.

The subrecipient is responsible for referral and provision of all necessary supports, services and interventions to address the conditions identified in the Safety/Risk Assessments and Family Strengths and Needs Assessments or otherwise identified by the family team. The subrecipient shall provide timely services and interventions that are individualized, accessible, culturally competent, and linguistically appropriate and trauma informed. The subrecipient is responsible for documentation of all contacts with the child/family/providers, progress reports, assessments/evaluations/reports and any other information related to the family. The subrecipient shall provide or arrange for child and family transportation as needed related to safety and the case plan. All documentation must be entered into NFOCUS within three (3) business days of occurrence.

All children in out of home care will have an active Parenting Time plan that is developed with the family to identify the frequency, supervision and location of the visits between parents, siblings, and child. Children who are placed in out of home care shall have an initial visit with their parents no more than three (3) calendar days after the child's removal from their home. Parenting time should be developed in accordance with the Nebraska Supreme Court Guidelines specific to frequency and duration. The subrecipient shall utilize documentation and observation of parenting time to assist with the assessment process. Parenting Time reports from providers will be documented in NFOCUS.

The subrecipient shall develop a case plan in collaboration with the family to identify needs, strengths and strategies to assist the family. The case plan will be developed and documented in NFOCUS within policy timeframes. The subrecipient will utilize the Family Strengths and Needs Assessment and information from family team meetings to assist in developing this case plan. The subrecipient shall work with the family to determine the permanency objective, concurrent plan when appropriate and timeframes

to achieve permanency, as well as specific outcomes and needs. Case plans must include signatures of the parents.

The subrecipient shall evaluate family progress through gathering information from service providers, Structured Decision Making ® assessments and family team input.

The subrecipient shall serve all non-court families in accordance with the same policies, procedures and expectations for service delivery as court involved families.

The subrecipient will complete and submit court reports to all legal parties no less than 3 business days before the court hearing or as ordered by the Court. DHHS legal will be available to the subrecipient for legal staffings and to request early hearings or other motions.

The subrecipient shall comply with all court orders. The subrecipient shall attend all court hearings and will be prepared to provide effective testimony on assessment results of Structured Decision Making ® tools and recommendations related to the child's best interest. Testimony provided by an expert witness will be at the subrecipient's expense. The subrecipient will adequately prepare children to attend court hearings. Children are required to attend court hearings unless otherwise directed by the Court or DHHS. The subrecipient shall refer and staff families with the county attorney's office pursuant to the Adoption and Safe Families Act (ASFA) at the time a child is in out of home placement 15 months out of the last 22 months.

The subrecipient will work with the Court and DHHS regarding court orders that do not meet federal and state law.

The subrecipient shall conduct and document face to face contacts with each child and parent each month per regulation and policy. The frequency of contacts is determined by the risk level within the Structured Decision Making risk assessment. Prior to the

referral for ongoing case management, the subrecipient shall coordinate all contacts with the DHHS Initial Assessment worker.

DHHS shall generate the School Notification letter and deliver this letter to the child's respective school district when a child becomes a state ward and when wardship ends. Children shall remain in their home school unless it is not in their best interest. If the child is placed out of the parental home, the subrecipient is responsible for arranging transportation to maintain school placement. The subrecipient shall complete the Educational Court Report attachment when applicable. The subrecipient shall attend all Individual Education Plan (IEP) or Multi-Disciplinary Team (MDT) meetings regarding the child. The subrecipient will review and include in the case file all grades, report cards, progress reports, IEP reports, etc. to meet the child's educational needs. The subrecipient shall submit the Early Childhood Development referral when applicable and follow through with recommended services/assessments.

The subrecipient shall work with DHHS legal to notify the respective tribe when a child is reported to have Native American heritage, is a member or is eligible to be a member of a federally recognized Indian tribe. The subrecipient shall provide to DHHS legal any potential tribal affiliation and demographic information necessary to provide said notice.

Per subaward amendment dated Jan 2, 2018, DHHS delegates to NFC the ability to provide consents for medical, mental health and substance abuse treatment of state wards, except in the following situations; end of life decisions, termination of a wards pregnancy, transplant surgery as outlined in DHHS policy as decisions which require central office review/approval. Subrecipient is responsible to follow DHHS policy in documentation of said informed consents given. When parental rights are intact, subrecipient is required to obtain parental approval on medical procedures.

The subrecipient is responsible to develop and sustain an array of services and supports designed to meet the unique needs of children and families. All services and supports must be accessible to all children and families served by the subrecipient in

the Eastern Service Area. The service array will include services and supports that assess the strengths and needs of children and families; addresses the need of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable and assist children in foster and adoptive placements achieve permanency. The service array must be inclusive of practices that are evidence based, trauma informed and culturally and linguistically appropriate.

The subrecipient shall ensure that all state wards receive well child checks, medical care, dental care and vision care and assist in coordination of any follow up care needed. All children placed in out of home care must have an initial physical exam within 15 days of their removal. DHHS is responsible for accessing this medical exam at time of removal. For non-wards, the subrecipient shall assist the parent and/or child in accessing medical, dental and vision services.

When parental rights are intact, the subrecipient may help a parent complete an application for Developmental Disabilities services for a potentially eligible child and coordinate accessing and submitting all necessary assessments for the purposes of eligibility determination. Both the parent and the subrecipient need to sign the application. If parental rights are not intact, the subrecipient must not sign an application for such services without DHHS consent

The subrecipient shall work with the family to access mental health and substance abuse services as needed in connection with the Managed Care Organization/Administrative Service Organization (MCO/ASO) for those individuals who are Medicaid eligible. For non-Medicaid eligible individuals, the subrecipient shall assist in referrals and coordination to access community resources.

The subrecipient shall provide to the Foster Care Review Office (FCRO) access to the family file as required by statute. The subrecipient shall document that a review was

completed in a program case narrative in NFOCUS. The subrecipient shall attend FCRO meetings as requested and respond to FCRO questionnaires

Adoption and Guardianship:

The subrecipient shall develop an adoption recruitment plan for the ESA . The subrecipient and subcontractors and second tier subrecipients providing foster care are responsible to develop a pool of well-trained and supported foster care families to provide placement stability and permanency to children in need of foster care. The subrecipient will collaborate with DHHS to develop the Eastern Service Area Diligent Recruitment and Retention of Foster Families Plan. The subrecipient will be responsible for the implementation of the plan and will provide progress reports to DHHS upon request. The subrecipient is responsible to monitor subcontractors and second tier subrecipient's implementation of the plan and will provide progress reports to DHHS upon request. The Diligent Recruitment and Retention of Foster Families Plan will be inclusive of all federal requirements associated with this plan.

The subrecipient shall place children on the Adoption Exchange via DHHS policy and upon the approval of central office. The subrecipient shall respond to any inquiries from potential adoptive placements. The subrecipient shall complete the Adoptive Placement Agreement including all disclosures of information per regulation and policy. The subrecipient shall provide for or arrange for relinquishment counseling as needed. The subrecipient shall draft relinquishment paperwork for DHHS approval. Upon approval by DHHS, the subrecipient shall facilitate the relinquishment meeting . Per statute, DHHS must review and issue the formal letter of acceptance to the parent. The subrecipient shall not give consent to adoption or sign the adoption consent paperwork.

The subrecipient shall prepare any needed due diligence affidavit. The subrecipient shall complete the Adoption Home Study. The subrecipient shall not negotiate the

adoption subsidies or approve the adoption subsidy paperwork. The subrecipient shall provide all documentation to DHHS that is necessary to support a financial subsidy. The subrecipient shall complete the Adoption Packet paperwork and submit to DHHS who will submit to the adoption attorney. The Subrecipient shall provide financial payment for the adoption attorney if not approved in the subsidy.

When a licensed foster home expresses an interest in placement of children into their home for the purposes of adoption, the subrecipient shall inquire about their willingness to be entered onto the state and national adoption registry. If the licensed foster home agrees, the subrecipient shall enter the family information onto the state and federal registry.

The subrecipient shall not negotiate guardianship subsidies or complete guardianship subsidy paperwork.   The subrecipient shall provide all needed documentation to DHHS to support a guardianship subsidy.

Dual Adjudicated Youth:

A small population of youth will be referredfor case management who are also adjudicated 43-247 (1), 43-247 (2), 43-247 (3b) or 43-247 (4).   For these youth, the subrecipient shall not make recommendations or decisions to commit youth to the Youth Rehabilitation and Treatment Center (YRTC) or recommendations or decisions to parole a youth from the YRTC. These decisions will remain the responsibility of the DHHS.   If a youth is committed to YRTC and is also referred to the subrecipient, the subrecipient shall coordinate with the YRTC for placement and services. Any youth remaining on DHHS Parole, shall be served by the subrecipient and all community based services provided under the Conditions of Parole individualized plan.

Inter-state Compact on the Placement of Children (ICPC):

The subrecipient shall comply with all ICPC regulations when seeking a placement out of state. The subrecipient shall prepare ICPC paperwork and submit to DHHS central office to initiate a request for placement out of state. Upon ICPC approval, the subrecipient shall facilitate the placement out of state and ensure foster care payment as needed. The subrecipient shall ensure that the child's needs can be met in this out of state placement and coordinate any services prior to placement.

The subrecipient shall maintain monthly face to face contact with any child placed in a facility/congregate setting out of state and document this face to face contact on NFOCUS. The subrecipient shall not have monthly face to face contact with those youth placed in family home settings per ICPC regulations. The subrecipient shall communicate with the receiving state as needed.

The subrecipient will have no responsibility for youth placed in Nebraska from another state, unless a new Child Welfare case is opened in Nebraska and subsequently referred to the subrecipient.

Licensed Foster Homes:

The subrecipient shall collaborate with the provider network to recruit, train and support foster homes to support placement needs within the service area. The subrecipient and subcontractors and second tier subrecipients providing foster care are responsible to develop a pool of well-trained and supported foster care families to provide placement stability and permanency to children in need of foster care. The subrecipient will collaborate with DHHS to develop the Eastern Service Area Diligent Recruitment and Retention of Foster Families Plan. The subrecipient will be responsible for the

implementation of the plan and will provide progress reports to DHHS upon request. The subrecipient is responsible to monitor subcontractors and second tier subrecipient's implementation of the plan and will provide progress reports to DHHS upon request. The Diligent Recruitment and Retention of Foster Families Plan will be inclusive of all federal requirements associated with this plan. The subrecipient shall ensure that there is a sufficient capacity of homes to meet the diverse needs and ages of children needing out of home placement. The subrecipient shall provide or arrange for supportive services as needed within the foster home.

The subrecipient shall not approve or issue licenses but shall recommend to DHHS initial and renewal licensing of foster/adoptive homes per timeframes in regulation and policy. The subrecipient shall obtain information and submit request to DHHS to complete background checks. The subrecipient shall complete a home study utilizing the DHHS home study format. The subrecipient shall ensure all required information is included in the licensing packet and submitted to DHHS for approval and license issuance.

The subrecipient shall provide all information to load the home onto NFOCUS for post placement kinship homes to DHHS Resource Development. The subrecipient shall load the full home study onto NFOCUS for post placement kinship homes. DHHS shall scan the background checks into NFOCUS.

The subrecipient shall ensure the licensed homes directly supported by the subrecipient will comply with licensing standards and statutes related to licensed foster homes. The subrecipient shall report to DHHS any licensing complaints or violations. DHHS will be responsible for accepted allegations and any licensing action. The subrecipient shall develop a corrective action plan as needed and document compliance of said plan on NFOCUS.

The subrecipient will utilize Trauma Informed Partnering for Safety and Permanence-Model Approach to Partnership in Parenting (TIPS-MAPP) for foster parent training with all subcontractors and second tier subrecipients who are providing foster care.

Dispute Resolution:

In situations when the subrecipient and DHHS are in disagreement, the resolution process will proceed as follows:

Subrecipient Director and DHHS Administrator will review and present information to their respective manager.

Subrecipient COO and DHHS Service Area Administrator will review and discuss. If unable to agree, matter will be forwarded to Subrecipient CEO and DHHS Deputy Director. If still unable to agree, the Director of the Division of Children and Family Services will be the final decision maker.

Incident Reporting:

The subreceprient shall follow subaward requirements regarding incident reporting. The subrecipient shall immediately report any missing child or child who has eloped to DHHS and Law Enforcement. The subrecipient shall immediately complete the Protective Service Alert template to central office whenever a child is missing.

3) Caseload Ratio Requirements

The subrecipient will have staffing capacity to be in compliance with state statutes and will report caseload size and supervisory caseload ratios in aggregate form to DHHS upon request. Neb. Rev. Stat. §68-1207

4) Documentation/File Retention

The subrecipient will be responsible for maintaining the official family file for each child/family. This family file includes documentation maintained in N-FOCUS, as well as the paper hard file. All documents, including Initial Assessment files, State Ward files, non-court files and foster family files are to be imaged into NFOCUS. The

subrecipient shall shred or return all documents once scanned into NFOCUS. The following documents should be maintained in the hard file:

- Any certified document containing a raised seal such as a birth certificate or certified court order;
- Signed relinquishment of parental rights;
- Original documents necessary for an adoption or evidence in the court room;
- Any document that is not readily or easily readable once imaged;
- Social security card
- Photographs, cards or other keepsakes that may be valuable to the family.

N-FOCUS Documentation

1. The subrecipient will utilize N-FOCUS to document all case activities pertaining to referred children and families.
2. The subrecipient will document all case activities on N-FOCUS within three (3) business days of completion of activities above unless otherwise specified.
3. Documentation must be factual and include behavioral, cognitive and emotional indicators that are directly related to the caretaker's ability to achieve the goals identified in the case plan/court report, reasonable efforts and best interest of children. This data may also be used for purposes of federal measures, and must be sufficient to meet the federal requirements.
4. All Structured Decision Making ® assessments are to be documented in the respective icons on NFOCUS.

At time of case closure, the subrecipient shall utilize the Case Closing Checklist for completing case closure and hand deliver the hard case file to DHHS per case closing administrative memo. Subrecipient will complete this checklist and provide case to DHHS within 72 hours of closure. Subrecipient is responsible to modify/close legal status and organization type.

5) Record Keeping

1. The subrecipient agrees to keep an individual record on each foster or adoptive family. At a minimum the record will include copies of:
   A. Criminal History Records Check
   B. References
   C. Current and historical home studies
   D. The license issued by the state
   E. All training the family has received

2. The subrecipient agrees to keep records of all the following information:
   A. Quality assurance review activities and results;
   B. Documentation of all pre-service and ongoing training provided to subrecipient's staff;
   C. Educational and credentialing requirements;
   D. Background check information on all staff;

6) Transportation Standards

The subrecipient shall comply with all applicable Public Service Commission regulations and requirements to the extent they apply to the subrecipient's activities in the performance of this subaward . When children, youth and families are transported by employees, subrecipients, foster and/or adoptive parents, volunteers, or interns of the subrecipient, the transporter must:

A. Be at least 19 years of age, (except immediate family and foster family members);
B. The subrecipient shall utilize an escort for all commercial transportation services for children ages 12 and under or as needed for a child ages 13 through 18;
C. Have proof of a current and valid driver's license;
D. Have no more than six points assessed against his/her Nebraska driver's license, or meet a comparable standard in the state where s/he is licensed to drive. This requirement does not apply to immediate family, foster parent, and/or adoptive parent;
E. Currently have no limitations that would interfere with safe driving;
F. Use seat belts and child passenger restraint devices as required by law;
G. Not smoke while transporting;
H. Not transport while under the influence of alcohol or any drug that impairs the ability to drive safely;
I. Not provide transportation if s/he has a communicable disease which may pose a threat to the health and well-being of the client;
J. Complete a defensive driving course as sanctioned by the Nebraska Safety Council or similar agency. This requirement does not apply to immediate family, foster parents, and/or adoptive parents;
K. Have and maintain the minimum automobile liability and medical insurance coverage as required by law;
L. Utilize secure transportation in compliance with DHHS requirements.

7) Foster/Adoptive Home Studies and Approval Studies

The subrecipient is responsible for assuring all home studies are completed as directed in regulation and DHHS policy. This includes home studies for a licensed foster home, relative foster home, kinship foster home, or an adoptive home. All home studies are to be completed on the format designated by DHHS.

An individual who conducts foster/adoptive home studies or approval home studies shall have at a minimum a bachelor's degree in human services or a related field or five years of full time equivalent experience in child welfare programming and a high school diploma or GED. (474 NAC 6-009.02D Casework qualifications)

The following background checks must also be completed on individuals who conduct any home study:

- The Nebraska Child Abuse and Neglect Central Registry
- The Nebraska Adult Abuse and Neglect Central Registry
- The Nebraska State Patrol
- Sexual Offender Registry

An Adoption Home Study must be completed by DHHS or a licensed child placing agency which meets the licensing requirements to provide adoption services. This home study must be completed within one (1) year prior to finalization of the adoption.

The subrecipient shall license approved homes when homes meet the licensing requirements based on Regulations and DHHS policy to maximize access to title IV-E funding. The subrecipient shall recommend licensing waivers for relatives to DHHS.

8) Required Reports

The subrecipient will adhere to the following schedule of Reporting Periods and Due Dates:

Monthly Reports	**Reporting Periods**	**Due Dates**
__ January	January 1 – January 31	February 28/29
__ February	February 1 – February 28/29	March 31
__ March	March 1 – March 31	April 30
__ April	April 1 – April 30	May 31
__ May	May 1 – May 31	June 30
__ June	June 1 – June 30	July 31
__ July	July 1 – July 31	August 31
__ August	August 1 – August 31	September 30
__ September	September 1 – September 30	October 31
__ October	October 1 – October 31	November 30
__ November	November 1 – November 30	December 31
__ December	December 1 – December 31	January 31
Quarterly Reports	**Reporting Periods**	**Due Dates**
__ Quarter 1	July 1 – September 30	October 30
__ Quarter 2	October 1 – December 31	January 30
__ Quarter 3	January 1 – March 31	April 30
__ Quarter 4	April 1 – June 30	July 30
Annual Reports	**Reporting Periods**	**Due Dates**
__ Annual Progress and Services Report	June 1 – May 31	May 31
__ Annual Financial Report	Subrecipient Fiscal Year	Within 6 months of the Subrecipient Fiscal Year

Monthly Finance Reports:

Monthly financial statements will be provided by the subrecipient to DHHS within 30 calendar days of the end of the month. The financial statements will include a balance sheet, income statement, and statement of cash flows in a format that is acceptable to DHHS. The financial statements will be prepared using the accrual basis of accounting and using generally accepted accounting principles (GAAP).

Thirty (30) calendar days following the end of each month beginning August 2015, an aging of accounts payable must be provided by the subrecipient to DHHS. The accounts payable aging will be consistent with the monthly financial statements provided to DHHS and list by vendor the amount owed to each vendor and; what portion of the amount owed has been due less than 30 days; what portion has been due between 30 days and 59 days; what portion has been due between 60 days and 89 days; what portion has been due between 90 days and 119 days; and what portion has been due 120 days or longer. In addition, a reconciliation of accrued expenses to the balance sheet will also be provided each month to the DHHS. Nothing in this section is intended to limit access to the subrecipient's records and information as provided elsewhere in this subaward and the terms of this section shall survive termination of this subaward.

Quarterly Reports

Quarterly reports shall include the following information:

Personnel Files:

a. Report data as outlined in the Personal File Review tool (form provided by DHHS), analysis of the data and activities to improve the data in the future.

Foster Parent Recruitment and Retention:

Subrecipient will submit data and information related to foster parent recruitment and retention utilizing the statewide reporting template utilized by all foster care providers.

Caseload and Training Reporting:

Information from the subrecipient is required to be submitted for these reports:

1) Annual training data for the APSR and the training system factors; this data is required annually from subrecipient by May 15th of each calendar year.
2) Monthly IV-E Report in a format requested by DHHS
3) As required by Nebraska Statutues, 68-1202, 68-1207, and 68-1207, the 1160 Legislative Report is submitted annually, due to the legislature in September of each calendar year.

No less than 45 days prior to the annual report being due, DHHS will request specific information from the subrecipient for that annual reporting content as the format can be modified from year to year. .

An established reporting format will be provided to the subrecipient for the monthly IV-E report data needed.

The subrecipient will maintain data and records on monthly staffing and turnover rates to be provided to DHHS upon request.

Annual Reports

The Annual Report shall include a description of the specific accomplishments and progress achieved to date in the past year regarding improved outcomes for children and families, as well as providing a more comprehensive, coordinated, and effective child and family services continuum. The Eastern Service Area Administrator will be the point of contact with subrecipient for all reporting and APSR information requests.

Included in the Annual Report, for the below items, describe the steps the agency will take to expand and strengthen the range of existing services and to develop and implement services to improve child outcomes. Explain planned activities, new strategies for improvement, and the method(s) to measure progress in the upcoming year:

Collaboration

a. Describe activities in the ongoing process of coordination and collaboration efforts conducted across the entire spectrum of the child and family service delivery system. This should include stakeholder or partner involvement in the review of progress made in the past year and expected updates for the coming year.
b. Provide an update on how the agency has demonstrated meaningful collaboration with the courts.

Coordination with Tribes

The subrecipient will describe the specific activities that have been or will be undertaken to improve or maintain a relationship with the Tribes and compliance with ICWA. Include information on any changes to procedures, and/or a description of trainings implemented to increase compliance with ICWA.

Disaster Plan:

The subrecipient will report any impact as a result of any disaster in the past year that affected subrecipient's ability to provide services. (ie – floods, tornados, fires, blizzards, etc) The subrecipient will describe how its disaster plan was used, the effectiveness of the plan and any changes made.

Foster & Adoptive Parent Recruitment and Retention Plans:

Subrecipient will submit data and information related to foster parent recruitment and retention utilizing the statewide reporting template utilized by all foster care providers.

Monthly Caseworker Visits

The subrecipient will describe the action steps the subrecipient is taking to ensure that, 95 percent of children in foster care are visited on a monthly basis by their workers, and that the majority of the visits occur in the residence of the child.

Inter-Country Adoptions

The subrecipient will report the number of children who were adopted from other countries and who entered into state custody as a result of the disruption of a placement for adoption or the dissolution of an adoption, the agencies who handled the placement or adoption, the plans for the child, and the reasons for the disruption or dissolution.

Continuous Quality Improvement:

The subrecipient will describe how the agency utilizes continuous quality improvement to monitor and improve the agency's performance as well as subcontractors and second tier recipient's performance.

Independent Living:

The subrecipient will describe specific accomplishments and planned activities to:

a) assist youth to successfully transition to adulthood;

b) assist youth with receiving the education, training, and services necessary to obtain employment;

c) assist youth to prepare for and enter post-secondary training and educational institutions;

d) provide emotional support to youth aging out of foster care through mentors and the promotion of interactions with dedicated adults;

e) provide financial, housing, counseling, employment, education and other appropriate services and support to former foster care recipients between 18 and 21 years of age

f) provide services to youth who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption;

g) the population(s) to be served;

h) the geographic areas where the services will be available; and

i) the estimated number of youth to be served

j) the activities to coordinate services with other Federal and State programs for youth;

The subrecipient will provide information on specific training that was conducted and planned to assist foster parents, adoptive parents, group home staff, and Subrecipient staff will understand and support adolescents preparing for independent living;

<u>Use of Promising Practices and Evidence-Based Models</u>

a) Describe specific promising practices or evidence based models being utilized or developed within agency and/or subcontractors and second tier subrecipients.
b) Describe method in which fidelity is being applied to reported evidence based models or promising practices.
c) Describe fidelity data collected and analyzed to determine effectiveness of models used.

<u>Protocol for Reporting Suspected Abuse and Neglect</u>

The subrecipient will describe internal protocol for reporting suspected abuse and/or neglect as required by state mandatory reporting laws.

<u>Insurance</u>

a. Copies of Certificate of Insurance
b. Policy regarding Subrecipient

Annual Finance Report

The subrecipient shall provide an annual financial report that includes the following attachments:

a. Audited Financial Statement
b. Internal Revenue Service Form 990

9) Continuous Quality Improvement

The subrecipient shall work with DHHS to complete all necessary Continuous Quality Improvement (CQI) activities. CQI activities include but are not limited to:

A. **Federal Compliance**

1) State Mini and Full Child and Family Services Reviews (CFSR)

(a) The DHHS team will be responsible for the ongoing organization of reviewers, pulling case samples, coordinating logistics with local service area staff and writing the final report.

(b) The subrecipient will prepare case files and make them available to the DHHS quality assurance team for the reviews.

(c) The subrecipient will work with the DHHS quality assurance team to schedule CFSR case interviews with the case manager, parents, foster parents, child, providers and other case participants when applicable

2) Federal CFSR Review

(a) The subrecipient, at its expense, will provide requested support to meet federal requirements set forth in the round 3 of the CFSR. This includes the completion of the Statewide Assessment in 2015/2016 and for round 3 federal site review scheduled for 2017.

B. **State Continuous Quality Improvement**

1) Statewide CQI Team

(a) The subrecipient will attend and participate in all statewide CQI meetings.

2) Local Service Area CQI Team

(a) The subrecipient will facilitate and participate in all local service area CQI meetings and activities. Activities include ongoing CQI

work groups assigned to focus on specific Service Area CQI priorities.

3) Statewide & Local Quality Assurance Reviews

(a) The subrecipient will provide requested information and work with the DHHS CQI team and the local DHHS administration to complete all necessary statewide and Service Area Quality Assurance Reviews.

4) Out-of-Home Care facilities: Licensing of Foster and Adoptive Homes and Approval of Relative Homes and Child Specific Homes

(a) DHHS will review all licensing packets and approved homes to determine that the subrecipient is completing that all licensing/approval requirements and time frames are being met.

(b) The subrecipient will inform all licensed and approved foster homes that DHHS may arrange visits (announced or unannounced) to conduct compliance checks of the licensed home.

(c) DHHS will review a sample of completed home studies for content and timeliness.

(d) DHHS will review a sample of subrecipient's home studies using a review tool and guidebook.

5) Personnel File Review

(a) Every two years, DHHS will review the subrecipient's personnel files of staff who have direct contact with children and families.

(b) The subrecipient will review a random sample of personnel files of each subcontractor staff that has direct contact with children and families, except as described in section (C) below. The sample methodology will be provided by DHHS. The sample size for each subcontractor will follow the schedule below:

a. The subrecipient will select a point in time prior to identify a random sampling of personnel files,

b. The subrecipient will not be required to review a random sampling of personnel files of those subcontractors and second tier subrecipients that are subject to regulation, licensing, or certification requirements that include background checks on themselves or their staff. Such subcontractors and second tier subrecipients may include, but not be limited to, hospitals, residential treatment centers, drug testing facilities, licensed medical and mental health professionals. Furthermore, the subrecipient will not be required to review a random sample of personnel files of service providers located out of state that the subrecipient is required to utilize because of a court order. The subrecipient will provide to the subaward liaison, a list of subcontractors that will not undergo a random sample of personnel file reviews.

6) Site Visits

(a) The subrecipient will cooperate and participate with any direct observations of subrecipient staff by DHHS and/or observations of subrecipient staff interactions between children and families.

10) Insurance Requirements

The subrecipient shall not commence work under this subaward until he or she has obtained all the insurance required hereunder and such insurance has been approved by the State. The subrecipient shall not allow any subcontractor to commence work on his or her subcontract until all similar insurance required of the subcontractor has been obtained and approved by the State (or subrecipient). Approval of the insurance by the State shall not limit, relieve or decrease the liability of the subrecipient hereunder. If by the terms of any insurance a mandatory deductible is required, or if the subrecipient elects to increase the mandatory deductible amount, the subrecipient shall be responsible for payment of the amount of the deductible in the event of a paid claim.

1. Workers' Compensation Insurance: The subrecipient shall take out and maintain

during the life of this subaward the statutory Workers' Compensation and Employer's Liability Insurance for all of the subrecipient's employees to be engaged in work on the project under this subaward and, in case any such work is sublet, the subrecipient shall require the subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor 's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. Where applicable, this policy shall provide USL&H coverage. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. Commercial General Liability Insurance and Commercial Automobile Liability Insurance. The subrecipient shall take out and maintain during the life of this subaward such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect subrecipient and any subcontractor performing work covered by this subaward from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this subaward , whether such operation be by the subrecipient or by any subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter. The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury and Subaward Liability coverage. The policy shall include the State, and others as required by the subaward documents, as an Additional Insured. This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned and Hired vehicles.

3. Insurance Coverage Amounts Required

   A. Workers' Compensation and Employer's Liability

      (1) Coverage A Statutory Coverage B

(2) Bodily Injury by Accident $100,000 each accident

(3) Bodily Injury by Disease $500,000 policy limit

(4) Bodily Injury by Disease $100,000 each employee

B. Commercial General Liability

(1) General Aggregate $2,000,000

(2) Products/Completed Operations Aggregate $2,000,000

(3) Personal/Advertising Injury $1,000,000 any one person

(4) Bodily Injury/Property Damage $1,000,000 per occurrence

(5) Fire Damage $50,000 any one fire

(6) Medical Payments $5,000 any one person

C. Commercial Automobile Liability

(1) Bodily Injury/Property Damage $1,000,000 combined single limit

D. Umbrella/Excess Liability

(1) Over Primary Insurance $1,000,000 per occurrence

4. Evidence of Coverage

A. The subrecipient shall furnish the DHHS with a certificate of insurance coverage complying with the above requirements. The certificates shall include the name of the company, policy numbers, effective dates, dates of expiration and amounts and types of coverage afforded. If the State is damaged by the failure of the subrecipient to maintain such insurance, then the subrecipient shall be responsible for all reasonable costs properly attributable thereto. Notice of cancellation of any required insurance policy must be submitted to DHHS when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

11) Professional Development/Training

1. Both DHHS and the subrecipient will provide for the professional development of staff through different training opportunities. DHHS and the subrecipient will coordinate training efforts to ensure that staff from both agencies have every opportunity for professional development. DHHS and the subrecipient will share training curriculum and work to cross-train staff on the day to day operations.

   A. Initial and Ongoing Case Management Training

      (1) Pursuant to LB853, All Family Permanency Specialists and Family Permanency Specialist Supervisors must participate in mandatory pre-service training related to Child and Family Services. All subrecipients who are deemed an organization under subaward with DHHS shall use the same program for initial training used for all Child and Family Services Specialists employed by DHHS. All Family Permanency Specialists shall complete a formal assessment process after initial training to demonstrate competency prior to assuming responsibilities as case managers.

      (2) The subrecipient will provide training progress reports and assessment scores on all Family Permanency Specialists participating in pre-service training to DHHS upon request to ensure competency.

      (3) In addition to pre-service training each Family Permanency Specialist and Family Permanency Specialist Supervisor must have a minimum of 24 hours of ongoing training per calendar year. The training received will support the development of skills to be a more effective Family Permanency Specialist or Family Permanency Specialist Supervisor

2. If a Family Permanency Specialist or Family Permanency Specialist Supervisor has previously completed DHHS's New Worker Training, the subrecipient may submit a written request to DHHS's Service Area Administrator to waive the requirement that the Family Permanency Specialist repeat training.

12) Professional Accountability

1. The subrecipient will meet specific performance and accountability targets that impact the safety, permanency, and well-being of children.
2. The subrecipient will work collaboratively with DHHS to develop and implement an effective performance program improvement plan (PIP.). All outcomes will be posted on DHHS's Website for public viewing.
3. The subrecipient and DHHS will review the data measures regularly through CQI activities and as otherwise needed. Outcome measures will be determined through mini CFSR and federal CFSR.
4. The performance measures described below will be measured effective the date the subrecipient assumes case management activities for the family.

OUTCOME#1: Safety

Children are first and foremost protected from Abuse and Neglect

INDICATOR 1a:

The sub recipient will ensure that less than 7.9% of the children experience recurrence of maltreatment within 12 months. This measure utilizes CFSR Round III as a basis and is limited to instances where NFC has an open case

Definition of Federal Measure:

- Of all children who were victims of a substantiated or indicated maltreatment report during a 12-month period, what percent were victims of another substantiated or indicated maltreatment report within 12 months?
  - *This is Federal Measure that reports on a rolling 24 month period. The children included in this report were victims of abuse or neglect during the first 12 months of the 24 month period. If the child was a victim of a subsequent abuse or neglect incident within 12 months of the first incident of abuse or neglect they appear on this report. Victims are defined as children where the court or DHHS has substantiated the allegations.*

INDICATOR 1b:

The sub recipient will ensure the rate of maltreatment per day for youth in foster care is less than 7.0.

Definition of Federal Measure:

- Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care?
  - *This is a Federal Measure that reports on a rolling 12 month period.. This measure includes all children currently in foster or group care and children formerly in foster and group care who are now placed with their parents. The rate is the number of youth maltreated by any perpetrator including foster parents, parents, relatives or others per 100,000 days in care.*

OUTCOME #2: Permanency

Children will experience stability and permanency.

INDICATOR 2a:

The sub recipient will ensure the rate of placement moves per day of foster care for children who enter care in a 12 month period is less than 4.12.

Definition of Federal Measure:

- *Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?*
  - *This is the Federal Measure that reports on a rolling 12 month period. Of all the children who enter out-of-home care during a 12-month period, the number of placement moves per 1000 days of care. The first placement does not count as a move*

.

INDICATOR 2b:

The sub recipient will achieve a 43.8% score for Permanency in 12 months for children entering into Foster Care.

Definition of Federal Measure:

- *Of all children who enter foster care in a 12-month period, what percentage are discharged to permanency within 12 months of entering foster care?*
  - *This is a Federal Measure that reports on a rolling 36 months of data. . Of all children entering care 2 years prior and who remained in care for 8 days or longer, the percent who met either of the following criteria: (1) the*

child was discharged to reunification, adoption or guardianship in less than 12 months from the date of entry into care, or (2) the child was placed in a trial home visit in less than 11 months from the date of entry into foster care and the trial home visit was the last placement setting prior to discharge to reunification. This is an entry cohort measure.
    - *Data Source: N-FOCUS Round 3 Federal Measures*

INDICATOR 2c:

The sub recipient will achieve a 46.2% score for Permanency in 12 months for children in care 12 to 23 months.

Definition of Federal Measure:

- *Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) for 24 months or more, what percentage are discharged to permanency within 12 months of the first day?*
    - *This is Federal Measure that reports on a rolling 12 month period. Of all the children in care 12 to 23 months as of the first date of the reporting year, the percent who are discharged to permanency within 12 months of the first day of the reporting year. Permanency is defined as reunification, adoption or guardianship.*

INDICATOR 2d:

The sub recipient will achieve a 36.3% score for Permanency in 12 months for children in care 24 Months or More.

Definition of Federal Measure:

- *Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) for 24 months or more, what percentage are discharged to permanency within 12 months of the first day?*
    - *This is Federal Measure that reports on a rolling 12 month period. Of all the children in care 24 month or more as of the first date of the reporting year, the percent who are discharged to permanency within 12 months of the first day of the reporting year. Permanency is defined as reunification, adoption or guardianship.*

INDICATOR 2e:

The sub recipient will ensure that less than 8.3% of the children re-enter into care within 12 months of discharge.

Definition of Federal Measure:

- Of all children who enter foster care in a 12-month period who were discharged within 12 months to reunification, living with a relative, or guardianship, what percentage re-entered foster care within 12 months of their discharge?

- *This is a Federal Measure that reports on a rolling 36 months of data. Of all children entering care 2 years prior, who remained care for 8 days or longer, and who were discharged to reunification or guardianship as defined in the 'Youth Entering Out-of-Home Care Permanency in 12 Months measure, the percent who re-enter care within 12 months of discharge.*
- *Data Source: N-FOCUS Round 3 Federal Measures*

INDICATOR 2f:

The subrecipient will achieve a 95% monthly visitation rate for all youth in their care.

Definition of Measure: Case managers will have monthly face to face visit with children for both court and non-court involved youth.

INDICATOR 2g:

The subrecipient will achieve a 100% rate of documenting all placement locations/changes within 72 hours of the placement for all out of home youth.

<u>OUTCOME #3: Well-Being</u>

Families have enhanced capacity to provide for their children's needs.

Children receive adequate services to meet their needs.

INDICATOR 3a:

The subrecipient will achieve a 95% Substantially Achieved score for CFSR Item 15.

Definition of Federal Measure: During Period under review, the frequency and quality of visits between caseworkers and the mothers and fathers of the children are sufficient to ensure the safety, permanency and well-being and promote achievement of the case goals.

INDICATOR 3b:

The subrecipient will achieve a 95% Substantially Achieved score for CFSR Item 16.

Definition of Federal Measure: During Period under review, the agency made concerted efforts to assess the child's educational needs.

INDICATOR 3c:

The subrecipient will achieve a 95% Substantially Achieved score for CFSR Item 17.

Definition of Federal Measure: During Period under review, the agency made concerted efforts to address the physical health needs of the children, including dental needs.

INDICATOR 3d:

The subrecipient will achieve a 95% Substantially Achieved score for CFSR Item 18.

Definition of Federal Measure: During Period under review, the agency made concerted efforts to address the mental/behavioral health needs of the children.

13) Case Transfer

The subrecipient is responsible for all services and case management for families referred by the Eastern Service Area, including cases that are transferred into the Eastern Service Area from another Service Area. If the family relocates from the Eastern Service Area, responsibility for case management and service provision will be transitioned to the respective Service Area where the family has moved in accordance with policy. DHHS shall review, approve or deny all requests for transfer out of the Eastern Service Area and shall refer any families transferring into the Eastern Service Area.

14) Independent Living for Youth

1. The subrecipient agrees to develop an individualized Transitional Living Plan with the involvement and leadership of youth, which describes how youth of various ages and stages of independent living will be assisted in the following areas:
   A. Education;
   B. Employment;
   C. Health coverage, including the child's potential eligibility of Medicaid coverage under Affordable Care Act;
   D. Financial Assistance, including education on credit card financing, banking and other services;
   E. Housing;
   F. Developing and maintaining a solid support system;
   G. Transition to adult services, if the needs assessment indicates that the child is reasonably likely to need or be eligible for services.

2. The subrecipient will:
   A. Assist state wards in completing the Ansell-Casey Skills Assessment upon their 15th birthday and yearly thereafter until they successfully reach permanency.
   B. Assist youth age 14 or older who are in foster care to obtain a consumer credit report on an annual basis.
   C. Before the child reaches 19 years of age, the CFS Specialist shall provide the youth a certified copy of the youth's birth certificate and facilitate securing a federal social security card.
   D. Coordinate services to youth who have achieved Independent Living through Permanency Goal.
   E. Coordinate service to state wards that exit care after age 16 by achieving permanency through adoption and/or relative guardianship.

F. Coordinate services to youth from other states who currently reside in Nebraska and fall under A, B and C and are eligible by federal standards.

3. The subrecipient is not responsible for coordinating Independent Living services:
   A. For youth served in the adult developmental disability system who are age 19 or older.
   B. For children who return home through reunification. For individuals during the time of adult incarceration.
   C. For youth that are residing in another state.

4. The subrecipient will be responsible to report data for the National Youth in Transition Database (NYTD).
   A. The subrecipient will make efforts to locate youth and ensure survey completion on youth required to be reported to the National Youth in Transition Database.

5. The subrecipient will annually provide to any youth who are age 16 or older information about Bridge to Independence program and how to apply for the program. The subrecipient will cooperate with requests from and meetings organized by the Bridge to Independence staff in order to assist the youth be better informed about the Bridge to Independence program.

6. The subrecipient will refer appropriate youth to the Regional Behavioral Health system in compliance with existing policy.

15) Foster Care Rates and Adoption/Guardianship Subsidies

The subrecipient will follow DHHS regulation and policy regarding rates paid to foster care providers. The subrecipient will work with foster parents to ensure they understand the foster family rate is intended to support the family/child needs to meet the desired outcome of placement stability. Subsidy payments are determined by the level of the caregiver responsibility and the needs of the child; and not by the income or resource needs of the foster parents/adoptive parents. Reference link for specific levels and rates. http://dhhs.ne.gov/children_family_services/Documents/AM%204-2015.pdf

In order to determine the rate at which a foster parent is reimbursed for the care of a child placed in their home, two documents must be completed by the subrecipient:

- The Structured Decision Making ® Family Strengths and Needs Assessment (FSNA) or the Child and Adolescent Strengths and Needs Assessment (CANS);

AND

- The Nebraska Caregiver Responsibility Tool (NCR)

The subrecipient will complete the NCR tool during a face to face meeting with the foster parent(s), and the foster care agency representative if the foster parent is supported by a contracted agency. The subrecipient, foster parent, and foster care agency representative (when present), must sign and date the NCR tool to document their participation.

The level of parenting the foster parent agrees to provide, along with the age of the child, will determine the daily reimbursement rate calculated through NFOCUS. The initial NCR must be completed within thirty (30) calendar days after the child's removal. The NCR tool must be scanned into NFOCUS.

ATTACHMENT THREE
RPF 5995 Z1 FULL SERVICE CASE MANAGEMENT

Date	Residential	Relative/Kin Care	Foster Care	Other	Total Out of Home	In Home	Alternative Response	Total	Service Area
6/1/2018	79	845	566	69	1559	941	196	2696	ESA
5/1/2018	84	875	588	58	1605	900	157	2662	ESA
4/1/2018	86	889	565	50	1590	943	156	2689	ESA
3/1/2018	95	894	569	62	1620	855	164	2639	ESA
2/1/2018	94	875	551	58	1578	906	171	2655	ESA
1/1/2018	92	876	550	59	1577	793	237	2607	ESA
12/1/2017	93	873	565	61	1592	788	235	2615	ESA
11/1/2017	85	928	585	62	1660	859	247	2766	ESA
10/1/2017	89	923	576	64	1652	830	272	2754	ESA
9/1/2017	76	910	576	73	1635	913	271	2819	ESA
8/1/2017	63	904	589	73	1629	884	282	2795	ESA
7/1/2017	70	913	594	68	1645	929	272	2846	ESA
6/1/2017	69	904	586	72	1631	937	276	2844	ESA
5/1/2017	73	874	592	72	1611	942	277	2830	ESA
4/1/2017	77	900	577	69	1623	956	221	2800	ESA
3/1/2017	81	905	544	64	1594	850	227	2671	ESA
2/1/2017	88	899	532	65	1584	854	206	2644	ESA
1/1/2017	83	896	540	67	1586	817	174	2577	ESA
12/1/2016	90	899	562	70	1621	795	152	2568	ESA
11/1/2016	88	920	580	73	1661	729	140	2530	ESA
10/1/2016	83	951	573	74	1681	769	97	2547	ESA
9/1/2016	75	915	568	71	1629	747	107	2483	ESA
8/1/2016	76	890	573	60	1599	801	86	2486	ESA
7/1/2016	76	886	572	59	1593	831	68	2492	ESA
6/1/2016	78	902	554	63	1597	857	58	2512	ESA
5/1/2016	81	893	571	63	1608	901	49	2558	ESA
3/1/2016	83	831	564	60	1538	844	46	2428	ESA
2/1/2016	80	809	578	58	1525	797	31	2353	ESA
1/1/2016	82	785	556	48	1471	799	25	2295	ESA
12/1/2015	84	737	560	46	1427	781	35	2243	ESA
11/1/2015	81	751	583	58	1473	815	37	2325	ESA
10/1/2015	84	729	577	57	1447	834	32	2313	ESA
9/1/2015	86	725	544	63	1418	856	39	2313	ESA
8/1/2015	86	744	567	47	1444	829	59	2332	ESA
7/1/2015	88	715	586	43	1432	826	65	2323	ESA
6/1/2015	86	710	583	49	1428	833	57	2318	ESA
5/1/2015	93	723	573	51	1440	860	52	2352	ESA
4/1/2015	97	699	573	39	1408	828	42	2278	ESA
3/1/2015	92	689	522	51	1354	852	36	2242	ESA
2/1/2015	96	658	533	51	1338	819	37	2194	ESA
1/1/2015	87	656	525	50	1318	779	30	2127	ESA
12/1/2014	91	666	509	52	1318	803	26	2147	ESA
11/1/2014	99	688	558	56	1401	836	14	2251	ESA
10/1/2014	95	670	568	61	1394	892	0	2286	ESA

9/1/2014	100	638	591	51	1380	937	0	2317	ESA
8/1/2014	107	638	589	52	1386	933	0	2319	ESA
7/1/2014	109	634	582	74	1399	988	0	2387	ESA

A. **BUSINESS ASSOCIATE AGREEMENT (BAA) PROVISIONS**

1. TERMS.
   a. BUSINESS ASSOCIATE. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to the party in this subaward, shall mean Subrecipient.

   b. COVERED ENTITY. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the party to this subaward, shall mean DHHS.

   c. HIPAA RULES. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

   d. OTHER TERMS. The following terms shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Unsecured Protected Health Information, and Use. The term Subrecipient shall have the meaning set forth in 2 CFR § 200.93 / 45 CFR § 75.2. Contractor as used herein shall mean the same as the term Subcontractor in the HIPAA Rules.

2. THE SUBRECIPIENT shall do the following:
   a. Not use or disclose Protected Health Information other than as permitted or required by this subaward or as required by law. Subrecipient may use Protected Health Information for the purposes of managing its internal business processes relating to its functions and performance under this subaward. Use or disclosure must be consistent with DHHS' minimum necessary policies and procedures.
   b. Implement and maintain appropriate administrative, physical, and technical safeguards to prevent access to and the unauthorized use and disclosure of Protected Health Information. Comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information, to prevent use or disclosure of Protected Health Information other than as provided for in this subaward and assess potential risks and vulnerabilities to the individual health data in its care and custody and develop, implement, and maintain reasonable security measures.
   c. To the extent Subrecipient is to carry out one or more of the DHHS' obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to DHHS in the performance of such obligations. Subrecipient may not use or disclosure Protected Health Information in a manner that would violate Subpart E of 45 CFR Part 164 if done by DHHS.
   d. In accordance with 45 CFR §§ 164.502(E)(1)(ii) and 164.308(b)(2), if applicable, ensure that any agents and contractors that create, receive, maintain, or transmit Protected Health Information received from DHHS, or created by or received from the Subrecipient on behalf of DHHS, agree in writing to the same restrictions, conditions, and requirements relating to the confidentiality, care, custody, and minimum use of Protected Health Information that apply to the Subrecipient with respect to such information.
   e. Obtain reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Subrecipient of any instances of which it is aware that the confidentiality of the information has been breached.
   f. Within fifteen (15) days:
      i. Make available Protected Health Information to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.524;
      ii. Make any amendment(s) to Protected Health Information as directed or agreed to by DHHS pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy DHHS' obligations under 45 CFR § 164.526;
      iii. Maintain and make available the information required to provide an accounting of disclosures to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.528.
   g. Make its internal practices, books, and records relating to the use and disclosure of Protected Heath Information received from, or created or received by the Subrecipient on behalf of the DHHS available to the Secretary for purposes of determining compliance with the HIPAA rules. Subrecipient shall provide DHHS with copies of the information it has made available to the Secretary.
   h. Report to DHHS within fifteen (15) days, any unauthorized use or disclosure of Protected Health Information made in violation of this subaward, or the HIPAA rules, including any security incident that may put electronic Protected Health Information at risk. Subrecipient shall, as instructed by DHHS, take immediate steps to mitigate any harmful effect of such unauthorized disclosure of

Protected Health Information pursuant to the conditions of this subaward through the preparation and completion of a written Corrective Action Plan subject to the review and approval by DHHS. The Subrecipient shall report any breach to the individuals affected and to the Secretary as required by the HIPAA rules.

3. TERMINATION.
   a. DHHS may immediately terminate this subaward and any and all associated subawards if DHHS determines that the Subrecipient has violated a material term of this subaward.
   b. Within thirty (30) days of expiration or termination of this subaward, or as agreed, unless Subrecipient requests and DHHS authorizes a longer period of time, Subrecipient shall return or at the written direction of DHHS destroy all Protected Health Information received from DHHS (or created or received by Subrecipient on behalf of DHHS) that Subrecipient still maintains in any form and retain no copies of such Protected Health Information. Subrecipient shall provide a written certification to DHHS that all such Protected Health Information has been returned or destroyed (if so instructed), whichever is deemed appropriate. If such return or destruction is determined by the DHHS be infeasible, Subrecipient shall use such Protected Health Information only for purposes that makes such return or destruction infeasible and the provisions of this subaward shall survive with respect to such Protected Health Information.
   c. The obligations of the Subrecipient under the Termination Section shall survive the termination of this subaward.

This Addendum and any attachments hereto will become part of the Contract. Except as set forth in this Addendum, the Contract is unaffected and shall continue in full force and effect in accordance with its terms.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the date of execution by both parties below.

State of Nebraska

By: ______________________________

Name: ______________________________

Title: Materiel Administrator_____________

Date: ______________________________

Contractor: ______________________________

By: ______________________________

Name: ______________________________

Title:______________________________

Date:______________________________

State of Nebraska
Department of Health and Human Services

By: ______________________________

Name: ______________________________

Title: ______________________________

Date: ______________________________

ATTACHMENT FIVE

Foster Care Reimbursement Rate Committee
Eighth Meeting
May 16, 2014
1:00 PM – 4:00 PM
Country Inn and Suites, Omaha Room
5353 N. 27th Street, Lincoln, NE

I. Call to Order (Harriott)
   a. Announcement of the placement of the Open Meetings Act
II. Roll Call (Sorensen)
III. Review and Approval of the Agenda (Harriott)
IV. Review and Approval of April 1, 2014 Minutes
V. Review and Approval of May 6, 2014 Minutes

VI. Chair's Report (Harriott)

VII. Public Comment (Harriott)
   a. Public comment will be limited to three minutes per person and fifteen minutes total unless otherwise announced by the chairperson at the beginning of the public comment period. Persons wishing to offer public comment will be asked to provide name and address.

VIII. Agency Support and Services Rate Discussion Group Report (Temple-Plotz)
   a. Rate Approval – action item

IX. Standardized Level of Care Work Group Report
   a. Work Group Report(Temple-Plotz)
   b. Recommendations – action item

X. DHHS Update(Pristow)

XI. Recommendations to Children's Commission – action item

XII. New Business

XIII. Next Meeting Date - tentative
   a. June 3, 2014 1-4PM – Platte Room,
      Airport Country Inn & Suites
      1301 West Bond Circle
      Lincoln, NE 68521

XIV. Adjourn (Harriott)

Agency Support and Services Rate Discussion

DHHS, Level of Care Workgroup, Agency Representatives
May 12, 2014

DHHS Representatives: Thomas Pristow, Lindy Bryceson, Doug Kreifels, Jodi Allen, Nanette Simmons, Nathan Busch, Mindi Alley

Level of Care Workgroup Members and Agency Representatives: Lana Temple-Plotz (LOC WG), Ryan Suhr (LOC WG), Barb Nissen (LOC WG), Julie Harmon (Boys Town), Stacy Giebler (NFC), Randy Ptacek (Boys Town), Cindy Rudolph (CEDARS), Dick Henrichs (LFS), Traci Taylor (Building Blocks), Rachel Kallhoff (Building Blocks), Gregg Nicklas (Christian Heritage), Kent Klute and Gary Pohlmann (Christian Heritage Finance), Jodie Austin (KVC), Susan Henrie (LOC WG)

Minutes:

The group discussed the administrative/support rate outlined by DHHS at the Reimbursement Rate Committee meeting on May 6, 2014 and reworked the numbers using the following salaries, ratios, and assumptions:

Salaries:

Provided by DHHS at May 6, 2014 meeting -

Foster Care Specialist

	Hourly	Annual	Benefits	# of Positions	Total Costs
Essential	$17.00	$35,360.00	$12,022.40	48	$2,274,355.20
Enhanced	$18.02	$37,481.60	$12,743.74	57	$2,862,844.61
Intensive	$18.53	$38,542.40	$13,104.42	72	$3,718,570.75

Foster Care Specialist Supervisor (CFS Specialist Supervisor)

	Hourly	Annual	Benefits	# of Positions	Total Costs
Essential	$21.37	$44,453.76	$15,114.28	6	$357,408.23
Enhanced	$22.65	$47,120.99	$16,021.14	7	$449,887.61
Intensive	$23.30	$48,454.60	$16,474.56	9	$584,362.46

Licensing/Training/Recruitment Specialist per 75 Homes

	Hourly	Annual	Benefits	# of Positions	Total Costs	per Day
All	$15.00	$31,200.00	$10,608.00	23	$952,664.96	$2.27

Ratios:

Level of Care	FC Specialist to Child	Supervisor to Staff
Essential	1:18	1:8
Enhanced	1:14	1:8
Intensive	1:10	1:8

Formulas used to Calculate Rates:

FC Specialist Salary & Benefits ÷ 365 ÷ case load ratio (1:18, 1:14, 1:10) = Rate per day

FC Specialist Supervisor Salary & Benefits ÷ 365 ÷ case load ratio (1:18, 1:14, 1:10) ÷ supervision ratio (8:1) = Rate per day

Licensing/Training/Recruitment Specialist = $2.27 per day (see above)

For each level, the following were added:

FC Specialist rate per day
+ Supervisor rate per day
+ Licensing/Training/Recruitment (LTR) Specialist Rate per day
Total Rate per day for Specialist, Supervisor and LTR

Total Rate per day for Specialist, Supervisor and LTR
× 50% (Other Direct Costs)
Total Other Direct Costs

Total Rate per day for Specialist, Supervisor and LTR
+ Total Other Direct Costs
Total Direct Operating Costs

Total Direct Operating Costs
× 20% (Indirect Cost)
Total Indirect Cost

Total Direct Operating Costs + Total Indirect Cost = Rate per day

Rates:

Level	100% Capacity	85% Capacity	Rural* (80% of 85% Capacity)
Essential	$19.11	$21.76	$26.18
Enhanced	$24.56	$28.17	$34.19
Intensive	$33.56	$38.76	$47.43

*rural was defined as 50 miles or more from FC Program Site of Agency Approved Satellite Office

85% Capacity - group agreed to 85% capacity rates as this is more realistic than a program being at 100% capacity 100% of the time.

Pre-Assessment - group agreed to accept the enhanced rate of $28.17 as the pre-assessment rate.

Respite - group agreed that respite rates are included in the maintenance payment to foster parents.

The meeting adjourned with all workgroup members and providers agreeing to the rates outlined above.

DHHS' Response to Agreed Upon Rates Following Their Financial Analysis:

Director Pristow contacted Lana Temple-Plotz on May 13, 2014. DHHS reviewed the rates providers developed on May 12, 2014 and analyzed their impact on the budget.

Director Pristow proposed the following:

1. Accept the 85% capacity rates (Essential $21.76, Enhanced $28.17, Intensive $38.76) and advance to the Reimbursement Rate Committee.

2. In place of a different daily rate for rural placements, utilize the same rate for all placements (Essential $21.76, Enhanced $28.17, Intensive $38.76). To compensate for the additional mileage and travel time by agency providers, implement a payment of $0.56/mile for distances over 50 miles roundtrip from the agency satellite office or foster care program site to the ASFC home and a payment of $18.00/hr windshield/travel time.

3. Modify the pre-assessment rate to $21.76 (essential).

On May 13, 2014 Lana Temple-Plotz sent an e-mail to all providers at the meeting on May 12, 2014 and they agreed to the modifications outlined by the Director.

respectfully submitted by Lana Temple-Plotz

Attachment Six
Business Requirements Traceability Matrix
Request for Proposal Number 5995 Z1 ESA RFP

Bidders are instructed to complete a Business Requirements Traceability Matrix for Full Service Case Management. Bidders are required to describe in detail how their proposed solution meets the conformance specification outlined within each Business Requirement.

The traceability matrix is used to document and track the business requirements from the proposal through subaward completion to verify that the requirement has been completely fulfilled. The Subrecipient will be responsible for maintaining the contract set of Baseline Requirements.

The traceability matrix should indicate how the bidder intends to comply with the requirement and the effort required to achieve that compliance. It is not sufficient for the bidder to simply state that it intends to meet the requirements of the RFP. DHHS will consider any such response to the requirements in this RFP to be non-responsive and the bid may be rejected. The narrative should provide DHHS with sufficient information to differentiate the bidder's business solution from other bidders' solutions.

The bidder must ensure that the original requirement identifier and requirement description are maintained in the traceability matrix as provided by DHHS. Failure to maintain these elements may render the bid non-responsive and result in for rejection of the bidder.

How to complete the traceability matrix:

Column Description	Bidder Responsibility
Req #	The unique identifier for the requirement as assigned by DHHS, followed by the specific requirement number. This column is dictated by this RFP and must not be modified by the bidder.
Requirement	The statement of the requirement to which the bidder must respond. This column is dictated by the RFP and must not be modified by the bidder.
Comply	The bidder should insert an "X" if the bidder's proposed solution complies with the requirement. The bidder should leave blank if the bidder's proposed solution does not comply with the requirement. If left blank, the bidder must also address the following: • Capability does not currently exist in the proposed system, but is planned in the near future (within four months from the date of submission of the bid) • Capability not available, is not planned, or requires extensive source-code design and customization to be considered part of the bidder's standard capability • Requires an extensive integration effort of more than 500 hours

REQ #	Requirement	Comply
	CORPORATE OVERVIEW	
CO-1	The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization. If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference. The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.	
		Comply
CO-2	The bidder should provide a summary matrix listing the bidder's previous projects similar to this RFP in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.	
		Comply
CO-3	The bidder should present a detailed description of its proposed approach to the management of the project. The bidder should identify the specific professionals who will work on the State's project if their company is awarded the subaward resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified. The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.	
	TRANSITION AND IMPLIMENTATION	Comply
TI-1	The bidder should submit a preliminary implementation plan with its proposal. The plan must describe the Subrecipient's plan to comply with all the provisions of the RFP. The plan must also address staffing, facilities, and other operational issues as identified in the RFP, including tasks, deliverables and milestones necessary to implement the program.	

FINANCIAL REQUIREMENTS

Req #	Requirement	Comply
FIN-1	The bidder must submit a draft Cost Allocation Plan that summarizes the methods and procedures that the bidder will use to allocate costs to various programs, services, subcontracts and agreements. The draft Cost Allocation Plan will, at a minimum, include cost pools; allocation methodologies; and benefitting programs.	
	Bidder's Response:	
		Comply
FIN - 2	The bidder should describe a plan of how it will implement a Random Moment Time Study or other time tracking method consistent with 45 CFR §§75 et seq. with employees in order to maximize Title IV-E Funding.	
	Bidder's Response:	
		Comply
FIN- 3	The bidder should describe how it will comply with the requirements of the governing board and financial liquidity as described in Neb. Rev. Stat. § 43-4204.	
	Bidder's Response:	

INFORMATION SYSTEM REQUIREMENTS

Req #	Requirement	Comply
IST- 1	The Subrecipient must describe a plan of how it will adopt and use the state-provided case management system to perform all case management activities for services provided under this subaward. Connection to the state case management system must only be accomplished through state authorized connection and encryption methodology. Subrecipient employees are granted access to information systems and information created, collected, processed and stored on behalf of DHHS under the terms and conditions of this subaward, including but not limited to the Business Associate Provisions (Attachment Four). The bidder should describe their plan to comply with these requirements.	
	Bidder's Response:	

TECHNICAL APPROACH

Req #	Requirement	Comply
	Case Management:	
CSM-1	The bidder should describe its philosophy on case management and the on-going case management model that it plans to utilize to effectively serve all populations involved with child protection cases. The description shall include any Well-Supported, Supported or evidence-based models that are used. The bidder should describe its understanding of statutory requirements related to the provision of case management. The bidder should describe its knowledge of and ability to coordinate services across various state and community programs available to children/families.	
	Bidder's Response:	
		Comply
CSM-2	The bidder should describe its philosophy and approach to maintaining sibling connections and visitation, and parental visitation.	
	Bidder's Response:	
		Comply
CSM-3	The bidder should describe how it will engage non-custodial parents and relatives in order to strengthen and preserve connections for the child. The description shall include any Well-Supported, Supported, or promising practice evidence-based models that are used.	
	Bidder's Response:	
		Comply
CSM-4	The bidder should describe a plan on how it will promote and enhance communication and support between foster parents and biological-parents, legal parents, adoptive parents, relative caregivers, guardians, etc. The description should include any and all Well-Supported, Supported, or promising practice evidence-based models used.	
	Bidder's Response:	

Req #	Requirement	Comply
	Workforce:	
WRK-1	The bidder should describe its plan to develop and sustain a stable case management workforce, to include: i. Hiring process to determine knowledge, skills and abilities for the workforce; ii. Training: including ensuring staff are trained in trauma-informed care and to be culturally humble; and, iii. Plan and process how to address the turnover rate and retention practices.	
	Bidder's Response:	
	Continuum of services:	Comply
CNT- 1	The bidder should describe a plan of how it will develop, implement, manage, and deliver a continuum of evidence-based models used in the context of the service continuum that will be available for children and families, in both court and non-court cases, in order to achieve the permanency goals identified while delivering ongoing case management.	
	Bidder's Response:	
		Comply
CNT- 2	The bidder should describe a plan to ensure at least 30% of prevention services will meet the criteria for Well-Supported, Supported, or promising practice evidence-based services, as outlined in FFPSA, in its service continuum for the first year, at least 40% of prevention services will meet the criteria for Well-Supported, Supported or promising practice evidence-based services, as outlined in FFPSA, in the second year, and 50% or more of prevention services will meet the criteria for Well-Supported, Supported or promising practice evidence-based services as outlined in the FFPSA, in years following.	
	Bidder's Response:	
		Comply
CNT- 3	The bidder should describe a plan of how it will prevent children from being removed from the family home by developing, implementing, managing, and delivering a continuum of evidence-based services, including all Well-Supported services, as outlined in the FFPSA, as well as supports, that will be available for children and families, 24 hours a day, 7 days a week, 365 days a year, during the time that DHHS is conducting the Initial Assessment of safety and risk.	

Req #	Requirement	Comply
	Bidder's Response:	
		Comply
CNT- 4	The bidder should demonstrate how it will ensure delivery of Well-Supported, Supported, or promising practice evidence-based services to the following populations:	
	a) Children ages birth to five (5).	
	Bidder's Response a):	
	b) Infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from pre-natal drug exposure, or a Fetal Alcohol Spectrum Disorder.	
	Bidder's Response b):	
	c) Children who have an intellectual disability, Autism Spectrum Disorder, or who demonstrate behaviors consistent with children who have an intellectual disability.	
	Bidder's Response c):	
	d) Children who have been exposed to domestic violence.	
	Bidder's Response d):	
	e) Children who have extensive histories of trauma.	
	Bidder's Response e):	
	f) Children who have limited connections with supportive adults.	
	Bidder's Response f):	
	g) Youth that intersect both the child welfare and juvenile justice systems.	
	Bidder's Response g):	
	h) Youth identified as survivors of sex trafficking.	
	Bidder's Response h):	

Req #	Requirement	Comply
	i) Youth who are near the age of majority and preparing to transition to adulthood.	
	Bidder's Response i):	

Req #	Requirement	Comply
CNT- 5	The bidder should describe a plan on how it will assess gaps in service array for the populations served and said plan shall include how it proposes to fill these gaps in services. Gaps in service means that needed services for families are not available due to capacity issues or there are no Second Tier Subrecipients or subcontractors in the area that provide needed services	
	Bidder's Response:	
	Placement Capacity:	Comply
PLC- 1	The bidder should outline a detailed plan that describes how it will ensure that a sufficient capacity of trained resource families are available to foster and adopt children in the Eastern Service Area, to include developing and implementing specific strategies to recruit resource families for historically difficult to place children.	
	Bidder's Response:	
		Comply
PLC- 2	The bidder should describe a plan of how it will recruit and retain licensed foster parents in the Eastern Service Area who will meet the unique and special needs of children and children's caretakers under this subaward.	
	Bidder's Response:	
		Comply
PLC- 3	The bidder should describe a plan of how it will support relative and kinship homes in the Eastern Service Area.	
	Bidder's Response:	

Req #	Requirement	Comply
	Community Engagement:	
ENG-1	The bidder should provide a draft Community Engagement Plan. This plan should describe how the bidder will engage community partners who connect children and families to all available programs and resources, including food pantries and other non-government resources.The plan should include engagement with, but not limited to, the following stakeholders:	
	a) Families and Children	
	Bidder's Response a):	
	b) Attorneys, guardian ad litems, and other legal stakeholders	
	Bidder's Response b):	
	c) Law Enforcement (including juvenile justice agencies)	
	Bidder's Response c):	
	d) Local School Districts	
	Bidder's Response d):	
	e) Faith Based Organizations	
	Bidder's Response e):	
	f) Foster Parents	
	Bidder's Response f):	
	g) Residential Child Care Providers	
	Bidder's Response g):	
	h) Purchased Service Providers	
	Bidder's Response h):	
	i) Local Community Service Providers	
	Bidder's Response i):	

Req #	Requirement	Comply
	j) Managed Care Organizations	
	Bidder's Response j):	
	k) Non-traditional community resources and leaders	
	Bidder's Response k):	
	l) Other county and/or community stakeholders	
	Bidder's Response l):	
	Engagement of Recognized Tribes:	Comply
ENG- 2	The bidder should include a plan of how it will engage in meaningful consultation, collaboration and coordination with federally recognized tribes to support children and families with tribal affiliations.	
	Bidder's Response:	
	Transition Planning:	Comply
T&T- 1	The bidder should describe a plan of how it will collaborate with DHHS to ensure that families experience a smooth and non-disruptive transition from initial assessment to ongoing case management.	
	Bidder's Response:	
T&T- 2	**Turnover Planning:** The bidder should describe a plan of transition of case management services that includes but is not limited to:	
	i. An outline and implementation plan that prepares for a successor agency;	
	Bidder's Response i.:	

Req #	Requirement	Comply
	ii. An outline of service model components that will clearly explain service structure and evidence-based practices implemented at or during subaward execution.	
	Bidder's Response ii.:	
	iii. An outline and implementation plan that addresses: a) Staffing; b) Use and transition of equipment; c) Transition of case management to successor agency; d) Migration of any data owned by DHHS; e) Dispute resolution between DHHS and Subrecipient in regards to cases, case loads, and reimbursement for services.	
	a) Staffing	
	Bidder's Response iii. a):	
	b) Use and transition of equipment	
	Bidder's Response iii. b):	
	c) Transition of case management to successor agency	
	Bidder's Response iii. c):	
	d) Migration of any data owned by DHHS	
	Bidder's Response iii. d):	
	e) Dispute resolution between DHHS and Subrecipient in regards to cases, case loads, and reimbursement for services.	
	Bidder's Response iii. e):	

Req #	Requirement	Comply
	Title IV-E and Eligibility:	Comply
IVE- 1	The bidder should describe its knowledge of federal statutes and regulations related to funding for child welfare and a plan of how it will comply with current federal statutes and regulations, and maximize the availability of Title IV-E funding.	
	Bidder's Response:	
		Comply
IVE- 2	The bidder should describe a plan of how it will collect, validate and submit eligibility-related documentation.	
	Bidder's Response:	
	Maximizing Public and Private Funding:	Comply
PPF- 1	The bidder should describe its knowledge of public and private funding options available for the population served including program rules and the application process and a plan to maximize public and private funding operations.	
	Bidder's Response:	
		Comply
PPF- 2	The bidder should describe a plan of how it will assist eligible families with accessing the services and supports offered through DHHS's Division of Children and Family Services Economic Assistance Programs such as SNAP; LIHEAP; Medicaid, TANF, and EA.	
	Bidder's Response:	
		Comply
PPF- 3	The bidder should describe a plan to ensure an application is made through ACCESSNebraska for both public assistance and Medicaid prior to discharge of a child or family.	
	Bidder's Response:	

Req #	Requirement	Comply
PPF- 4	The bidder should describe a plan to ensure a complete and accurate application is made to Social Security and the DHHS Division of Developmental Disabilities for children or adults who are disabled.	
	Bidder's Response:	
		Comply
PPF- 5	The bidder should identify strategies for raising private dollars and / or grants to support its operations. As part of its explanation, the bidder should specify if it is recognized as a Title IV-E recipient in any other States or within any other tribes.	
	Bidder's Response:	

Req #	Requirement	Comply
	Youth Services:	
YTH- 1	The bidder should describe the specific strategies and interventions it will utilize to ensure young people nearing the age of majority (age 16 and above) are prepared to transition to adulthood, including but not limited to:	
	a) Exposure to employment opportunities;	
	Bidder's Response a):	
	b) Driving and obtaining a driver's license;	
	Bidder's Response b):	
	c) Laundry, cooking, hygiene;	
	Bidder's Response c):	
	d) Instruction on banking, checking, debt, and general financial capability knowledge;	
	Bidder's Response d):	

Req #	Requirement	Comply
	e) Housing;	
	Bidder’s Response e):	
	f) Contact information for relatives and supportive adults;	
	Bidder’s Response f):	
	g) Physical and mental health;	
	Bidder’s Response g):	
	h) Opportunities to visit colleges, explore certificate or trade programs, and complete the FAFSA.	
	Bidder’s Response h):	
YTH- 2	The bidder should describe a plan of how it will administer and report on the National Youth in Transition Data (NYTD) Survey.	Comply
	Bidder’s Response:	

Req #	Requirement	Comply
YTH- 3	The bidder should describe a plan of how it will develop, implement and manage data for youth who are being provided independent living services.	
	Bidder’s Response:	

Req #	Requirement	Comply
YTH- 4	The bidder should describe its understanding of normalcy activities, the activities' importance, and strategies that promote normalcy for youth in its care through the use of the Reasonable and Prudent Parent Standard [Preventing Sex Trafficking and Strengthening Families Act, at 5 U.S.C. §§ 552, 20 U.S.C. § 1001, 25 U.S.C. § 450b, 28 U.S.C. § 1738B and 534, 42 U.S.C. §§ 1301, 1315] when making decisions involving the participation of the youth in age or developmentally-appropriate activities that provide opportunities for youth to grow emotionally, socially, and developmentally and to have the most family-like experience possible.	
	Bidder's Response:	
	Educational Outcomes:	
EDO- 1	The bidder should describe a plan in detail of how it will maintain and achieve educational outcomes for children it serves.	
	Bidder's Response:	
		Comply
EDO- 2	The bidder should describe its knowledge of the Every Student Succeeds Act. and how it will meet the requirements of this act.	
	Bidder's Response:	
	Continuous Quality Improvement:	Comply
CQI- 1	The bidder should describe its understanding of continuous quality improvement principles and its Continuous Quality Improvement approach to monitor and evaluate the quality of services, including services provided by subcontractors.	
	Bidder's Response:	

Req #	Requirement	Comply
CQI- 2	The bidder should describe how Continuous Quality Improvement will be used to meet or exceed state and federal performance indicators and outcomes that are detailed in Section V, subsection L of this RFP.	
	Bidder's Response:	
	Utilization Management:	Comply
UTZ- 1	The bidder should describe its understanding of Utilization Management and its approach to building a utilization management system within its organization.	
	Bidder's Response:	

Req #	Requirement	Comply
	Complaint/Grievance Process:	
C&G- 1	The bidder should describe its complaint/grievance process.	
	Bidder's Response:	
	Performance-Based Contracting:	Comply
PBC- 1	The bidder should provide a plan on how it will enter into performance-based contracts with subcontractors to incentivize improved performance outcomes. The bidder must state a percent of the expenditures that will be performance-based.	
	Bidder's Response:	

5995 Z1 Attachment Seven Est. Mileage 2018			
PromiseShip **Mileage State FY 2018**			
			MILES
Out of State Total			49,363
Out of town/service area Total			95,786
Recruiting Total			828
In town/service area Total			1,113,671
Grand Total			**1,259,648**

ATTACHMENT EIGHT - FFPSA INFORMATION

Executive Summary: Interventions with Special Relevance for the Family First Prevention Services Act (FFPSA) (Second Edition)

CASEY FAMILY PROGRAMS COPYRIGHT ©November 10, 2018 Casey Family Programs. All rights reserved. No part of this catalog may be reproduced, stored in a retrieval system or transmitted in any form or by any means, mechanical, electronic, photocopying, or otherwise without the prior written permission of Casey Family Programs.

Executive Summary

Family First Prevention Services Act

The passage of a new federal law, *the Family First Prevention Services Act (P.L. 115-123),* affords opportunities to use research-based interventions to help children safely avoid placement in foster care by meeting key service and treatment needs of children and their parents. Three major categories of services are eligible for reimbursement for up to 12 months under the new law:

1. Mental health services for children and parents
2. Substance abuse prevention and treatment services for children and parents
3. In-home parent skill-based programs:
   - Parenting skills training
   - Parent education
   - Individual and family counseling

The law includes Kinship Navigator programs, but as a separate provision with its own timeline.

FFPSA supports funding for services "directly related to the safety, well-being or permanence of the child or to prevent the child from entering foster care" (p. 170) that can be provided to:

- Infants, children, youth, pregnant and parenting youth, birth parents, kinship caregivers providing temporary or permanent care for children
- Children who are at risk of entering out-of-home care but who can stay safely with parents or kinship caregivers. This also includes children whose adoption or guardianship is at risk of disruption/dissolution.
- Children multiple times if they are identified as a "candidate"/at risk of out of home multiple times.
- Families regardless of their income (in contrast to current requirements).[1]

Evidence Standards

The levels of evidence for interventions (Promising, Supported and Well-supported) are currently being clarified by the Federal government but are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with three major exceptions: (1) an RCT study is *not* required; (2) publication in a peer review journal is *not* required (at least at this time); and (3) a book, program manual or some other form of documentation is required.[2] See Table E1 for a comparison of the current evidence criteria for FFPSA and CEBC.

[1] FFPSA law, pp. 170-173. Retrieved from https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[2] For example, the language in the FFPSA uses the CEBC's language but allows for other available writings: "The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice." The CEBC uses the concept of "other available writings" to include programs that do not have a formal book or manual, but have written training materials available that specify the components of the practice protocol and describe how to administer the practice (Personal Communication, Jennifer A. Rolls Reutz, May 15, 2018). See: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

Table E1. A Comparison of the Criteria for FFPSA and CEBC

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
General Requirements: In order for an intervention to be reimbursed by FFPSA it must: (i) have a book, manual or other available writings that specify the components of the practice protocol, and describe how to administer the practice. (ii) there is no empirical basis is suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. (iii) if multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice (iv) outcome measures are reliable and valid, and are administered consistently and accurately across all those receiving the practice. (v) there are no case data suggesting a risk of harm that was probably caused by the treatment that was severe or frequent. (p. 171) (vi) been published in "government reports and peer-reviewed journal articles that assess effectiveness (i.e., impact) using quantitative methods." (See https://www.federalregister.gov/d/2018-13420, p. 9.) FFPSA also requires that ▪ The practice be provided in an agency context and with a "trauma-informed approach and trauma-specific interventions" (p. 171) ▪ Study must be rated by some kind of "an independent systematic review" (p. 172) ▪ Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia; and published/prepared in English during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.) ▪ The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)	**General Requirements:** In order for an intervention to be rated by CEBC it must: a. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. b. If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice. c. There are no case data suggesting a risk of harm that: (a) was probably caused by the treatment and (b) the harm was severe or frequent. d. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. e. The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it. (See http://www.cebc4cw.org/ratings/)
Well-Supported: A practice shall be considered to be a 'well- supported practice' if: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that— (aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and (cc) were carried out in a usual care or practice setting; and (II) at least one of the studies described in sub clause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment. (pp. 172-173) [I.e. at least one 12 month follow-up study is required.]	**Well-Supported:** • At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. • In at least one of these RCTs, the practice has shown to have a sustained effect of at least one year beyond the end of treatment, when compared to a control group.

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
Supported: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that— (aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and (cc) was carried out in a usual care or practice setting; and (II) the study described in sub-clause (I) established that the practice has a sustained effect (when com-pared to a control group) for at least 6 months beyond the end of the treatment (p. 172) [I.e. at least one 6 month follow-up study is required.]	**Supported:** • At least one rigorous RCT in a usual care or practice setting has found the practice to be superior to an appropriate comparison practice. • In that RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
Promising: The practice is superior to a comparison practice "using conventional standards of statistical significance in terms of demonstrated meaningful improvements in validated measure of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being, as established by the results or outcomes of at least one study that: (I) that was rated by an independent systematic review for the quality of the study design and execution, and determined to be well-designed and well-executed; and (II) utilized some form of control (e.g., untreated group, placebo group, wait list study) (III) the evaluation was carried out in a "usual care or practice setting." (p. 172)	**Promising:**[c] • At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the comparison, or found it to be equal to or better than an appropriate comparison practice.

[a] See the final FFPSA bill at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[b] The CEBC criteria are described here: http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf CEBC uses two rating scales – one for strength of the research evidence supporting a practice or program; and a second rating of the tools used for screening or assessment. See http://www.cebc4cw.org/ratings/

[c] Note that the research support for the CEBC "promising" level varies substantially. For example, some interventions have high quality comparison-group studies that are not randomized or have RCTs with no follow-up, while others barely meet the "control group" requirement (Personal Communication, Jennifer A. Rolls Reutz, May 30, 2018)

Interventions Reviewed and Sources

Based on a review of the literature, the following interventions are highlighted as effective or relevant for potential reimbursement under FFPSA. For each intervention, the following information is provided (when available): intervention summary, consumer age range, problem areas addressed, number of sessions, duration of treatment, cost, cost savings, benefit-cost ratio, and the availability of a manual. Due to the importance of the Title IV-E Waiver program, we also designate which of these interventions were being implemented by a jurisdiction as part of their Waiver, as of 2015,[3] and how each of these interventions was

[3] Pecora, P.J., O'Brien, K. & Maher, E. (2015). *Levels of research evidence and benefit-cost data for Title IV-E waiver interventions: A Casey research brief. (Third Edition)* Seattle: Casey Family Programs. Available at: http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf

rated according to the established criteria of the California Evidence-Based Clearinghouse for Child Welfare (CEBC), using the three levels of effectiveness for the CEBC classification system as described in the table above:[4]

1. Well-supported by Research Evidence
2. Supported by Research Evidence
3. Promising Research Evidence

As noted in the table above, in order for an intervention to be rated by the CEBC for any level, it must (a) Have a book or manual that describes how to administer it; (b) Meet the requirements for inclusion in one of the CEBC topic areas; (c) Outcomes of the research must be published in a peer review journal; and (d) Outcome measures are reliable/valid and administered consistently and accurately.[5]

Interventions listed on the CEBC were included if: they were rated 1, 2 or 3; there was a response and details provided by the developer; there was a book or manual; and, in the case of substance abuse and mental health treatment, the treatment provided was delivered by a qualified clinician in either individual or group format; and, in the case of *in-home* parenting services, the intervention did not require a group component. Parent training or skill-building interventions, even if they were group-based, were included in the mental health treatment FFPSA program category if they helped improve some aspect of a caregiver's emotional or behavioral health. While most evidence-based interventions last 6-8 months, a number last longer than 12 months. Strictly applying the 12 month time limit in the FFPSA legislation would result in well-researched programs like Nurse Family Partnership and promising programs such as Parents as Teachers being excluded from the catalog. However, while FFPSA may pay for up to 12 months of a longer term intervention, states can likely elect to use Medicaid, state or other funding to continue the service beyond 12 months; hence, we have included interventions that extend beyond 12 months in the catalog. The duration information then indicates if the FFPSA funding would "time out" before that intervention was fully delivered.

Some relevant interventions were not included in the CEBC, but were selected for inclusion here based on ratings from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), which uses a four level system (where the quality of research studies is rated on a 4-point scale)[6], the "BLUEPRINTS" intervention registry (which uses a three level system of promising, model and model plus),[7] or the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide (which uses a three level system of harmful, promising and effective).[8] For some of the interventions included in these sources, the information was not obtained directly from the developer but from published manuals, reports, journal articles or book chapters. With this exception, all the other criteria used to select interventions from the CEBC were applied to these clearinghouses.

Interventions that were not able to be rated due to a lack of evaluation data are listed in a companion document, as some of these interventions warrant further evaluation so that they might qualify. In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse. In this case we rely on the research evidence indicating that the intervention is effective for a particular problem, or area of functioning that children and

---

[4] See http://www.cebc4cw.org/. For more complete definitions, see http://www.cebc4cw.org/ratings/scientific-rating-scale/.
[5] See http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf
[6] Note that the NREPP contractor and review criteria/process may be undergoing change. See https://nrepp.samhsa.gov/landing.aspx
[7] See Center for the Study and Prevention of Violence's http://www.blueprintsprograms.com/
[8] See OJJDP's https://www.ojjdp.gov/mpg/

their caregivers typically have in child welfare, and various meta-analyses that have reported intervention effect sizes.[9] In addition, to help describe the evidence base or other aspects of the interventions with scant material, a wide range of other websites were reviewed. Note that Multisystemic Therapy for Substance Abuse (MST-SA), Structural Family Therapy (SFT) and Trauma Systems Therapy (TST), despite their use by child welfare programs in New York City and elsewhere, were not included in this catalog as these interventions are not rated by the CEBC or Blueprints; and the NREPP site was taken down at the time this catalog was being revised. We will rate these interventions in a later edition of this catalog.

In addition, in contrast to Family Spirit and some other culturally competent interventions, the in-home and group-based versions of the Positive Indian Parenting Program have not been evaluated sufficiently to be rated by one of the Clearinghouses. Until more evaluation data can be gathered by NICWA, the law allows for a request to be made to the Secretary of HHS to waive those aspects of the law, via guidance, per the provision allowing for cultural and tribal specific needs.

Interventions Summary

On pages xii-xv, we provide a condensed table that lists each of the interventions in the catalog by program category and level of evidence (Table E4). In order for states, counties, and tribal nations to make well-informed intervention-selection decisions, better understanding where and how these interventions have been tested, used, spread, or discontinued across child-serving and family-serving systems is also important. In the months ahead, we will also be adding effect-size data for more interventions because of its value in estimating the expected impact of the intervention outcomes of interest.

In examining that summary table, even without applying the less stringent FFPSA criteria to the interventions, we see that there are sizable numbers of interventions that meet the standards for each level for each program area. There are not, however, as many interventions that are rated by the CEBC or other ranking system at a *Well-supported* level. (See Table E2 below.) This highest evidence level is important because 50 percent of the state intervention funding for FFPSA-eligible interventions must be spent on *Well-supported* interventions, but using criteria that is slightly less stringent than CEBC, as discussed earlier.

[9] For examples of meta-analyses reporting intervention effect sizes, see Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243 Leenarts, L.E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P., & Lindauer, R.J.L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child Adolesc Psychiatry* 22:269-283.

Table E2. Summary Table of Interventions Classified as Well-Supported in Terms of Evidence Level (N=40)

FFPSA Intervention Areas	Number of Interventions Ranked as Well-supported According to the CEBC or Other Ranking System
▪ Mental health services for children and parents	29
▪ Substance abuse prevention and treatment services for children and parents	4
▪ In-home parent skill-based programs: ▪ Parenting skills training and Parent education[a] ▪ Individual and family counseling	 5 2

[a] A clear definition of each program type and how they differ from each other has not yet been issued by the Federal Government in relation to FFPSA. Therefore, we grouped interventions that might qualify for one or both these program types together.

Table E2 needs to be viewed with caution as Casey Family Programs, the CEBC staff, Abt Associates (the organization that ACYF has contracted with to act as the FFPSA Clearinghouse), and others are just now beginning to review the research literature for interventions to see how they would be rated if the current FFPSA research evidence criteria remain unchanged. Many experts are reluctant to devote a large amount of staff time or other resources to that effort since we need to know what kinds of research reports or data summaries can be used to determine what rating the intervention should receive. FFPSA does *not* require a Randomized Control Trial (RCT) or publication in a peer-review journal, which should result in a larger number of interventions qualifying for the upper evidence levels than what we show in this catalog. For example, in a special review described next, 26 interventions which are currently classified at a lower level using the CEBC, NREPP, or BLUEPRINTS rating criteria should be determined to be at the *Well-supported* level using FFPSA criteria (see Table E3.) ***Combining Tables E2 and E3, a total of 66 interventions relevant to child welfare should be classified as Well-Supported.***

Interventions that Should be Rated as Well-Supported Under the Most Recent FFPSA Standards

The levels of evidence that will be used to rate interventions for reimbursement under Family First as Promising, Supported and Well-supported are currently being clarified by the Federal government, and new parameters were recently released for comment by ACYF. All the FFPSA evidence criteria released thus far are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with six major exceptions:

1. A RCT study is *not* required
2. Publication in a peer review journal is *not* necessary
3. Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia;
4. The study report must have been published in English
5. The study conducted or summarized during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.)
6. The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)

Review Process

The Casey Family Programs review team from Research Services examined all 45 "Supported" interventions in the first edition of the Catalog in relation to all the specific rating criteria published to date about the FFPSA interventions. We also paid special attention to the following:

- Study sample size.
- The drop-out/attrition rates as the study proceeded, including the response rate for the follow-up studies. The study might be disqualified if these drop-out/attrition rates are too high – especially if there was differential attrition across the treatment and comparison groups.
- Use of valid assessment measures.

If the information gathered showed that the intervention had evidence that would qualify it for the *Well-Supported level,* that was recorded, along with a brief summary of why – along with the articles supporting that evidence level. We also confirmed that there were at least two qualifying studies for every outcome highlighted for that intervention (as distinct from a situation where each study found a different outcome).

If the initial set of evidence was insufficient to qualify for *Well-Supported*, we contacted the intervention developer for additional studies and technical reports that might help their intervention qualify for the highest level possible. The 27 interventions with evidence that should qualify them for the *Well-Supported* level under FFPSA are listed in Table E.2, along with their target outcomes. The studies that provided the most direct evidence are footnoted for each intervention.

Conclusions

In sum, although further direction from the Children's Bureau is forthcoming, the information in this document provides a conservative approach regarding interventions that may be covered under FFPSA. In other words, if an intervention is designated as promising, supported, or well-supported in this document, it is likely to have the same or higher evidence standard under FFPSA. Until further direction is provided, this catalog offers a rough estimate as to what interventions are likely to be covered under FFPSA.

Table E3. Relevant Interventions Rated as Supported Using CEBC Criteria that Could Be Classified as Well-Supported Under FFPSA Rating Criteria
(N = 26)[10]

Mental Health Services for Children and Parents
1. **Blues Program**[1] (Depressive symptoms, lower risk for onset of major depression - i.e. risk of future depressive episodes)
2. **Building Confidence**[2] (Child and adolescent anxiety)
3. **Chicago Parent Program**[3] (Parent self-efficacy, corporal punishment, consistent discipline, positive parenting, and child behavior problems)
4. **Cognitive Behavioral Therapy (CBT) for Child & Adolescent Depression**[4] (Child and adolescent depression)
5. **Cognitive Behavioral Therapy (CBT) - Group Therapy for Children with Anxiety**[5] (Child anxiety)
6. **Cognitive Behavioral Therapy (CBT) - Parent Counseling for Young Children with Anxiety**[6] (Child anxiety)
7. **Dialectical Behavior Therapy (DBT)**[7] (Reducing self-harm; suicide attempts in highly suicidal self-harming adolescents; non-suicidal self-injury; depression; and improved general functioning among people with borderline personality disorder)
8. **Families and Schools Together (FAST)**[8] (Youth aggressive/externalizing behavior, academic performance)
9. **Family-Focused Treatment for Adolescents (FFT-A)**[9] (Manic symptoms in youth with bipolar disorder)
10. **Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST)**[10] (Child and adolescent depression, overall functioning)
11. **Wraparound Services**[11] **(**Reduced recidivism in terms of juvenile justice offenses, improved overall youth functioning, placement in least restrictive settings, including achieving legal permanency)
Substance Abuse Prevention and Treatment Services for Children and Parents

[10] *Source*: Compiled by Olivia Thai, Danielle Roy, Jessica Elm and Peter J. Pecora, Research Services, Casey Family Programs. Note that the table lists target outcomes where 2 or more separate studies found positive effects for that outcome, with at least one study finding positive results at a 12 month or longer follow-up.

12. **Buprenorphine Maintenance Treatment for Opioid Use Disorder**[12] (Opioid use)
13. **Assertive Continuing Care (ACC)**[13] (Substance abuse)
14. **Adolescent Community Reinforcement Approach (A-CRA)**[14] (Substance abuse)
15. **Adolescent Coping with Depression (CWD-A)**[15] (Depression)
16. **Brief Marijuana Dependence Counseling (BMDC)**[16] (Marijuana use)
17. **Ecologically Based Family Therapy (EBFT)**[17] (Substance abuse)
18. **Functional Family Therapy (FFT) for adolescents with SUDs**[18] (Substance abuse)
19. **Helping Women Recover & Beyond Trauma (HWR/BT)**[19] (Substance abuse among women)
20. **Interim Methadone Maintenance (IM) for opioid use**[20] (Opioid use)
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education
21. **Family Spirit (for American Indian/Alaskan Native parents)**[21] (Mothers' knowledge of and involvement in child care, maternal parenting skills)
22. **Home Instruction for Parents of Preschool Youngsters (HIPPY)**[22] (Child school performance)
23. **SafeCare**[23] (Re-referral to CPS for child neglect or physical abuse)
In-Home Parent Skill-Based Programs: Individual and Family Counseling
24. **Child-Parent Psychotherapy**[24] (Secure and disorganized attachment)
25. **Functional Family Therapy (FFT)**[25] (Family functioning, youth emotional and behavior improvement, child out-of-home placement prevention, and delinquent behavior recidivism/arrests)
26. **Homebuilders**[26] (Family functioning improvement to prevent child out-of-home placement)
27. **Parenting with Love and Limits**[27] (Child emotional and behavior health problems)

In Table E.4 the interventions in the catalog are listed by their FFPSA program area and evidence level.

Table E.4: Interventions Summary by Program Areas Listed in P.L. 115-123

Mental Health Services for Children and Parents (Total: 81)		
Well-supported (sub-total: 29):	*Supported (sub-total: 23):*	*Promising (sub-total: 29):*
▪ Acceptance and Commitment Therapy (ACT) for Adults ▪ Acceptance and Commitment Therapy (ACT) for adults with anxiety ▪ Acceptance and Commitment Therapy (ACT) for adults with schizophrenia and psychosis ▪ Acceptance and Commitment Therapy (ACT) for children with anxiety ▪ Acceptance and Commitment Therapy (ACT) for children with depression ▪ Aggression Replacement Training® (ART) ▪ Attachment and Biobehavioral Catch Up (ABC) ▪ Child and Family Traumatic Stress Intervention (CFTSI) ▪ Cognitive Behavioral Therapy (CBT) ▪ Cognitive Behavioral Therapy (CBT) for Adult Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Adult Depression ▪ Cognitive Behavioral Therapy (CBT) for Adult Posttraumatic Stress Disorder (PTSD) ▪ Cognitive Behavioral Therapy (CBT) for Adult Schizophrenia and Psychosis ▪ Cognitive Behavioral Therapy (CBT) for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Children with Trauma	▪ Accelerated Resolution Therapy ▪ Blues Program ▪ Building Confidence ▪ Chicago Parent Program (CPP) ▪ Childhaven Childhood Trauma Treatment ▪ Cognitive Behavioral Therapy (CBT) for Child and Adolescent Depression ▪ Cognitive Behavioral Therapy (CBT) – Group Therapy for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) – Parent counseling for young children with anxiety ▪ Collaborative & Proactive Solutions ▪ Collaborative Problem-Solving ▪ Common Sense Parenting (CSP) ▪ Community Reinforcement + Vouchers Approach (CRA + Vouchers) ▪ Dialectical Behavior Therapy (DBT) ▪ Dialectical Behavior Therapy (DBT) for Adolescent Self-Harming Behavior ▪ Families and Schools Together (FAST) ▪ Family-Focused Treatment for Adolescents (FFT-A) ▪ Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST) ▪ Multi-Family Psychoeducational Psychotherapy (MF-PEP) ▪ New Beginnings (for children of divorce)	▪ 1-2-3 Magic ▪ ACTION (youth group treatment for depression) ▪ Adolescent Coping with Depression (CWD-A) ▪ Behavioral Activation Treatment for Depression (BATD) ▪ Brief Eclectic Psychotherapy for PTSD (BEPP) ▪ C.A.T. Project ▪ Child-Centered Play Therapy (CCPT) ▪ *CICC's Effective Black Parenting Program (EBPP)* ▪ Cognitive Behavioral Analysis System of Psychotherapy (CBASP) ▪ Cognitive-Behavioral Coping-Skills Training ▪ Cognitive Processing Therapy (CPT) ▪ Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT) ▪ Cool Kids ▪ Defiant Children: A Clinician's Manual for Assessment and Parent Training (The Barkley Method of Behavioral Parent Training) ▪ Exchange Parent Aide ▪ Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach) ▪ Family Connections ▪ Helping the Noncompliant Child ▪ Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) ▪ Life Space Crisis Intervention (LSCI)

Mental Health Services for Children and Parents (Total: 81)		
Well-supported (sub-total: 29):	***Supported (sub-total: 23):***	***Promising (sub-total: 29):***
▪ Cognitive Behavioral Therapy (CBT) – Individual Therapy for Children with Anxiety ▪ Cognitive Therapy (CT) ▪ Coping Cat ▪ Coping Power Program ▪ Eye movement desensitization and reprocessing (EMDR) for Adult PTSD ▪ Eye movement desensitization and reprocessing (EMDR) for Children ▪ GenerationPMTO (Group Delivery Format) ▪ Mindfulness-Based Cognitive Therapy (MBCT) for Adults ▪ Multidimensional Family Therapy (MDFT) ▪ Parent Child Interaction Therapy (PCIT) ▪ Problem Solving Skills Training for Children ▪ Prolonged Exposure Therapy for Adolescents (PE-A) ▪ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) ▪ Triple P – Positive Parenting Program – Level 4 Individual for Child Disruptive Behavior	▪ Positive Peer Culture (PPC) ▪ Primary and Secondary Control Enhancement Training (PASCET) ▪ Problematic Sexual Behavior- (PSB-CBT-S)- for School Age Children ▪ Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) for Sexual Behavior Problems in Children	▪ Mindfulness-Based Cognitive Therapy for Children (MBCT-C) ▪ Nurturing Parenting Program for Parents and their School-age Children 5 to 12 Years ▪ Parents Anonymous ▪ Play and Learning Strategies–Infant Program ▪ Solution-Based Casework (SBC) ▪ Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) ▪ Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP-ART) ▪ Trauma and Grief Component Therapy for Adolescents (TGCT-A) ▪ Wraparound

<table>
<tr><td colspan="3">Substance Abuse Prevention and Treatment for Children and Parents (Total: 26)</td></tr>
<tr><td>Well-supported (sub-total: 4):
▪ Communities that Care for Substance Abuse Prevention
▪ Motivational Interviewing
▪ Multidimensional Family Therapy (MDFT)
▪ PROSPER</td><td>Supported (sub-total: 15):
▪ Adaptive Stepped Care
▪ Adolescent Community Reinforcement
▪ Approach/Assertive Continuing Care (A-CRA/ACC)
▪ Adolescent Coping with Depression (CWD-A)
▪ Adolescent-focused Family Behavior Therapy
▪ Adult-focused Family Behavior Therapy
▪ Brief Marijuana Dependence Counseling (BMDC)
▪ Brief Strategic Family Therapy
▪ Buprenorphine (or buprenorphine/naloxone) maintenance treatment for opioid use disorder
▪ Ecologically Based Family Therapy
▪ Families Facing the Future
▪ Functional Family Therapy (FFT) for adolescents with substance use disorder
▪ Helping Women Recover & Beyond Trauma (HWR/BT) [Substance Abuse Treatment (Adult)]
▪ Injectable naltrexone for opiates
▪ Intermittent methadone maintenance</td><td>Promising (sub-total: 7):
▪ Alcohol Behavioral Couple Therapy
▪ C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support)
▪ Cognitive-Behavioral Coping-Skills Therapy for alcohol or drug use disorders
▪ Matrix Model Intensive Outpatient program
▪ Seeking Safety
▪ Sobriety Treatment and Recovery Teams (START)
▪ 12-Step Facilitation Therapy for Substance Abuse (TSF)</td></tr>
<tr><td colspan="3">In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education (Total: 17)</td></tr>
<tr><td>Well-supported (sub-total: 5):
▪ Family Connects
▪ Healthy Families America (HFA)
▪ Minding the Baby® (MTB)
▪ Nurse Family Partnership (NFP)
▪ The Incredible Years</td><td>Supported (sub-total: 5):
▪ AVANCE Parent-Child Education Program
▪ Home Instruction for Parents of Preschool Youngsters (HIPPY)
▪ SafeCare
▪ Tuning In To Kids (TIK)
▪ Tuning In To Teens (TINT)</td><td>Promising (sub-total: 7):
▪ All Babies Cry (ABC)
▪ Circle of Security-Home Visiting-4 (COS-HV4)
▪ Collaborative Problem Solving (CPS)
▪ Early Head Start-Home Visiting (EHS-HV)
▪ GenerationPMTO (individual delivery format)
▪ Infant Health and Development Program (IHDP)
▪ Parents as Teachers (PAT)</td></tr>
</table>

In-Home Parent Skill-Based Programs: Individual and Family Counseling (Total: 23)		
Well-supported (sub-total: 2): ▪ Attachment-Based Family Therapy (ABFT) ▪ The Family Check-up (FCU)	***Supported (sub-total: 7):*** ▪ Child-Parent Psychotherapy (CPP) ▪ Child Parent Relationship Therapy (CPRT) ▪ Functional Family Therapy (FFT) ▪ Intensive Family Preservation Services (HOMEBUILDERS®) ▪ Multisystemic Therapy (MST) ▪ Parenting with Love and Limits (PLL) ▪ Strengthening Families for Parents and Youth 10–14	***Promising (sub-total: 14):*** ▪ Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) ▪ Child FIRST (Child and Family Interagency, Resource, Support, and Training) ▪ Cue-Centered Treatment (CCT) ▪ Domestic Abuse Intervention Project - The Duluth Model (DAIP) ▪ Early Pathways Program (EPP) ▪ Families First ▪ Family Centered Treatment ▪ Multisystemic Therapy Building Stronger Families (MST-BSF) ▪ Parent Child Assistance Program (PCAP) ▪ Promoting First Relationships (PFR) ▪ Risk Reduction through Family Therapy (RRFT) ▪ Step-by-Step Parenting Program© ▪ Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) ▪ Wraparound (in-home parent support focus)

[1] Studies that help Blues Program meet FFPSA evidence criteria include:

- Stice, E., Rohde, P., Seeley, J. R., & Gau, J. M. (2008). Brief cognitive-behavioral depression prevention program for high-risk adolescents outperforms two alternative interventions: A randomized efficacy trial. Journal of Consulting and Clinical Psychology, 76(4), 595-606.
- Rohde, P., Stice, E., Shaw, H., & Briere, F. N. (2014). Indicated cognitive behavioral group depression prevention compared to bibliotherapy and brochure control: Acute effects of an effectiveness trial with adolescents. Journal of Consulting and Clinical Psychology, 82 (1), 65-74.
- Stice, E., Rohde, P., Gau, J. M., & Wade, E. (2010). Efficacy trial of a brief cognitive-behavioral depression prevention program for high-risk adolescents: Effects at 1- and 2-year follow-up. Journal of Consulting and Clinical Psychology, 78(6), 856-867.
- Rohde, P., Stice, E., Shaw, H., & Gau, J. M. (2015). Effectiveness Trial of an Indicated Cognitive-Behavioral Group Adolescent Depression Prevention Program versus Bibliotherapy and Brochure Control at 1- and 2-Year Follow-Up. Journal of Consulting and Clinical Psychology, 83(4), 736–747. http://doi.org/10.1037/ccp0000022

[2] Studies that help Building Confidence meet FFPSA evidence criteria include two main studies with sample sizes less than 50 but with 40 or more children:

- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B. C., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry,* 45(3), 314-321.
- Chiu, Angela W., Langer, David A., McLeod, Bryce D., Har, Kim, Drahota, Amy, Galla, Brian M., . . . Wood, Jeffrey J. (2013). Effectiveness of Modular CBT for Child anxiety in elementary schools. *School Psychology Quarterl*y, 28(2), 141-153.
- Wood, Jeffrey J., McLeod, Bryce D., Piacentini, John C., & Sigman, Marian. (2009). One-year follow-up of family versus child cbt for anxiety disorders: exploring the roles of child age and parental intrusiveness. *Child Psychiatry and Human Development,* 40(2), 301-316.
- Galla, Brian M., Wood, Jeffrey J., Chiu, Angela W., Langer, David A., Jacobs, Jeffrey, Ifekwunigwe, Muriel, & Larkins, Clare. (2012). One year follow-up to modular cognitive behavioral therapy for the treatment of pediatric anxiety disorders in an elementary school setting. *Child Psychiatry and Human Development,* 43(2), 219-226.

[3] Studies that help Chicago Parent Program meet FFPSA evidence criteria include:

- Gross, D., Garvey, C., Julion, W., Fogg, L., Tucker, S., & Mokros, H. (2009). Efficacy of the Chicago Parent Program with Low-Income African American and Latino parents of young children. *Prevention Science: The Official Journal of the Society for Prevention Research,* 10(1), 54–65. http://doi.org/10.1007/s11121-008-0116-7
- Breitenstein, S. M., Gross, D., Fogg, L., Ridge, A., Garvey, C., Julion, W., & Tucker, S. (2012). The Chicago Parent Program: Comparing 1-Year outcomes for African American and Latino parents of young children. *Research in Nursing & Health*, 35(5), 475–489. http://doi.org/10.1002/nur.21489
- Additional research may be found at: http://www.chicagoparentprogram.org/our-research

[4] Studies that help CBT for Child & Adolescent Depression meet FFPSA evidence criteria include:

- Brent, D., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., . . . Johnson, B. (1997). A Clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, 54(9), 877-885.
- Clarke, Gregory, DeBar, Lynn L., Pearson, John A., Dickerson, John F., Lynch, Frances L., Gullion, Christina M., & Leo, Michael C. (2016). Cognitive behavioral therapy in primary care for youth declining antidepressants: A randomized trial. *Pediatrics*, 137(5), 1.
- Brent, Kolko, Birmaher, Baugher, Bridge, Roth, & Holder. (1998). Predictors of Treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(9), 906-914.
- Reinecke, Ryan, & Dubois. (1998). Cognitive-Behavioral Therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(1), 26-34.
- A cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/542

[5] Studies that help CBT Group Therapy for Children with Anxiety meet FFPSA evidence criteria include:

- Barrett, P. (1998). Evaluation of cognitive-behavioral group treatments for childhood anxiety disorders. *Journal of Clinical Child Psychology*, 27(4), 459-468.
- Wergeland, Fjermestad, Marin, Haugland, Bjaastad, Oeding, . . . Heiervang. (2014). An effectiveness study of individual vs. group cognitive behavioral therapy for anxiety disorders in youth. *Behaviour Research and Therapy*, 57(1), 1-12.
- Hudson, Rapee, Deveney, Schniering, Lyneham, & Bovopoulos. (2009). Cognitive-behavioral treatment versus an active control for children and adolescents with anxiety disorders: A randomized trial. Journal of the American Academy of Child & Adolescent Psychiatry, 48(5), 533-544.
- Lau, Chan, Li, & Au. (2010). Effectiveness of group cognitive-behavioral treatment for childhood anxiety in community clinics. *Behaviour Research and Therapy*, 48(11), 1067-1077.
- A cost-benefit analysis conducted by the Washington State Institute of Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/66

[6] Studies that help CBT Parent Counseling for Young Children with Anxiety meet FFPSA evidence criteria include:

- Waters, Ford, Wharton, & Cobham. (2009). Cognitive-behavioural therapy for young children with anxiety disorders: Comparison of a Child   Parent condition versus a Parent Only condition. *Behaviour Research and Therapy*, 47(8), 654-662.
- Rapee, R., Kennedy, S., Ingram, M., Edwards, S., & Sweeney, L. (2010). Altering the trajectory of anxiety in at-risk young children. *American Journal of Psychiatry*, 167(12), 1518-1525.
- Kennedy, Rapee, & Edwards. (2009). A selective intervention program for inhibited preschool-aged children of parents with an anxiety disorder: effects on current anxiety disorders and temperament. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(6), 602-609.

[7] Studies that help Dialectical Behavior Therapy (DBT) meet FFPSA evidence criteria include:

- Mccauley, E., Berk, M., Asarnow, J., Adrian, M., Cohen, J., Korslund, K., . . . Linehan, M. (2018). Efficacy of Dialectical Behavior Therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry*, 20 June 2018.
- Linehan, M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., . . . Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757-766.
- Neacsiu, Lungu, Harned, Rizvi, & Linehan. (2014). Impact of dialectical behavior therapy versus community treatment by experts on emotional experience, expression, and acceptance in borderline personality disorder. *Behaviour Research and Therapy*, 53(1), 47-54.
- Linehan, M., Armstrong, H., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatr*y, 48(12), 1060-1064.
- Additional research on Dialectical Behavior Therapy may be found here: https://behavioraltech.org/research/evidence/#domains

[8] Studies that help Families and Schools Together (FAST) meet FFPSA evidence criteria include:

- Kratochwill, T.R., McDonald, L., Levin, J.R., Young Bear-Tibbetts, H., & Demaray, M.K. (2004). Families and Schools Together: An Experimental analysis of a parent-mediated multi-family group program for american Indian children. *Journal of School Psychology*, 42(5), 359-383.
- McDonald, Lynn, Moberg, D. Paul, Brown, Roger, Rodriguez-Espiricueta, Ismael, Flores, Nydia I., Burke, Melissa P., & Coover, Gail. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools,* 28(1), 25-34.
- Kratochwill, Mcdonald, Levin, Scalia, & Coover. (2009). Families And Schools Together: An experimental study of multi-family support groups for children at risk. *Journal of School Psychology,* 47(4), 245-265.
- Additional research on FAST may be found here: https://www.familiesandschools.org/why-fast-works/ And a cost-benefit analysis from the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/150/Families-and-Schools-Together-FAST

[9] Studies that help Family-Focused Treatment for Adolescents (FFT-A) meet FFPSA evidence criteria include:

- Miklowitz, D., Schneck, C., George, E., Taylor, D., Sugar, C., Birmaher, B., . . . Axelson, D. (2014). Pharmacotherapy and Family-Focused Treatment for Adolescents With Bipolar I and II Disorders: A 2-Year Randomized Trial. American Journal of Psychiatry, 171(6), 658-667.
- Miklowitz, Axelson, George, Taylor, Schneck, Sullivan, . . . Birmaher. (2009). Expressed Emotion Moderates the Effects of Family-Focused Treatment for Bipolar Adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 48(6), 643-651.
- Miklowitz, George, Axelson, Kim, Birmaher, Schneck, . . . Brent. (2004). Family-focused treatment for adolescents with bipolar disorder. Journal of Affective Disorders, 82(S), S113-S128.

[10] Studies that help Interpersonal Psychotherapy-Adolescent Skills Training (IPA-AST) meet FFPSA evidence criteria include:

- Young, J., Jones, J., Sbrilli, M., Benas, J., Spiro, C., Haimm, C., . . . Gillham, J. (2018). Long-term effects from a school-based trial comparing Interpersonal Psychotherapy-Adolescent Skills Training to group counseling. *Journal of Clinical Child & Adolescent Psychology,* 1-10.
- Young, Jami F., Mufson, Laura, & Davies, Mark. (2006). Efficacy of Interpersonal Psychotherapy-Adolescent Skills Training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry,* 47(12), 1254-1262.
- Young, J., Mufson, L., & Gallop, R. (2010). Preventing depression: A randomized trial of interpersonal psychotherapy-adolescent skills training. *Depression and Anxiety*, 27(5), 426-433.
- Mufson, & Fairbanks. (1996). Interpersonal Psychotherapy for Depressed Adolescents: A one-year naturalistic follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry,* 35(9), 1145-1155.
- Mufson, L., Weissman, M., Moreau, D., & Garfinkel, R. (1999). Efficacy of Interpersonal Psychotherapy for depressed adolescents. *Archives of General Psychiatry*, 56(6), 573-579.

[11] Studies that help Wraparound meet FFPSA evidence criteria include:

1. Carney, M. M., & Butell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice, 13*(5), 551-568. doi:10.1177/1049731503253364

2. Clark, H. B., Lee, B., Prange, M. E., & McDonald, B. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies, 5*(1), 39-54. doi:10.1007/BF02234677
3. Grimes, K.E., Schulz, M.F., Cohen, S.A., Mullin, B.O., Lehar, S.E., & Tien, S. (2011) Pursuing cost-effectiveness in mental health service delivery for youth with complex needs. *J Ment Health Policy Econ.*14(2):73-83. PMID: 21881163.
4. Jeong, S., Lee, B. H., & Martin, J. H. (2014). Evaluating the effectiveness of a special needs diversionary program in reducing reoffending among mentally ill youthful offenders. *International Journal of Offender Therapy and Comparative Criminology*, 58(9), 1058–1080. doi:10.1177/0306624x13492403
5. Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of Wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice, 19,* 678-685. doi:10.1177/1049731508329385
6. Pullman, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using Wraparound. *Crime and Delinquency, 52*(3), 375-397. doi:10.1177/0011128705278632
7. Rast, J., Bruns, E. J., Brown, E. C., Peterson, C. R., & Mears, S. L. (2008). *Outcomes of the wraparound process for children involved in the child welfare system: Results of a matched comparison study.* Manuscript submitted for publication.

[12] Studies that help Buprenorphine Maintenance Treatment for Opioid Use Disorder meet the FFPSA evidence criteria include:

- Johnson, R., Jaffe, J., & Fudala, P. (1992). A Controlled Trial of Buprenorphine Treatment for Opioid Dependence. JAMA, 267(20), 2750-2755.
- D′Onofrio, G., Chawarski, M., O′Connor, C., Pantalon, P., Busch, G., Owens, M., . . . Fiellin, H. (2017). Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. Journal of General Internal Medicine, 32(6), 660-666.
- O′connor, Oliveto, Shi, Triffleman, Carroll, Kosten, . . . Schottenfeld. (1998). A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone clinic. The American Journal of Medicine, 105(2), 100-105.
- Johnson, Eissenberg, Stitzer, Strain, Liebson, & Bigelow. (1995). A placebo controlled clinical trial of buprenorphine as a treatment for opioid dependence. Drug and Alcohol Dependence, 40(1), 17-25.
- Knudsen, Ducharme, & Roman. (2006). Early adoption of buprenorphine in substance abuse treatment centers: Data from the private and public sectors. Journal of Substance Abuse Treatment, 30(4), 363-373.

[13] Studies that help Assertive Continuing Care (ACC) meet FFPSA evidence criteria include:

- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., Passetti, Lora L., Petry, Nancy M., & Nezu, Arthur M. (2014). A Randomized Trial of Assertive Continuing Care and Contingency Management for Adolescents With Substance Use Disorders. Journal of Consulting and Clinical Psychology, 82(1), 40-51.
- Garner, Bryan R., Godley, Mark D., Funk, Rodney R., Dennis, Michael L., Godley, Susan H., & Shaffer, Howard J. (2007). The Impact of Continuing Care Adherence on Environmental Risks, Substance Use, and Substance-Related Problems Following Adolescent Residential Treatment. Psychology of Addictive Behaviors, 21(4), 488-497.
- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., & Passetti, Lora L. (2007). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. Addiction, 102(1), 81-93.

[14] Studies that help Adolescent Community Reinforcement Approach (A-CRA) meet FFPSA evidence criteria include:

- Dennis, Godley, Diamond, Tims, Babor, Donaldson, . . . Funk. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. Journal of Substance Abuse Treatment, 27(3), 197-213.
- Hunter, B. D., Godley, S. H., Hesson-McInnis, M. S., & Roozen, H. G. (2014). Longitudinal change mechanisms for substance use and illegal activity for adolescents in treatment. Psychology of Addictive Behaviors, 28(2), 507-515.
- Slesnick, Prestopnik, Meyers, & Glassman. (2007). Treatment outcome for street-living, homeless youth. Addictive Behaviors, 32(6), 1237-1251.

[15] Studies that help Adolescent Coping with Depression (CWD-A) meet FFPSA evidence criteria include:

- Lewinsohn, Clarke, Hops, & Andrews. (1990). Cognitive-behavioral treatment for depressed adolescents. Behavior Therapy, 21(4), 385-401.

- Clarke, Rohde, Lewinsohn, Hops, & Seeley. (1999). Cognitive-Behavioral Treatment of Adolescent Depression: Efficacy of Acute Group Treatment and Booster Sessions. Journal of the American Academy of Child & Adolescent Psychiatry, 38(3), 272-279.
- Clarke, G., Hornbrook, Lynch, Polen, Gale, Beardslee, . . . Seeley. (2001). A Randomized Trial of a Group Cognitive Intervention for Preventing Depression in Adolescent Offspring of Depressed Parents. Archives of General Psychiatry, 58(12), 1127-1134.
- Clarke, Hornbrook, Lynch, Polen, Gale, O'connor, . . . Debar. (2002). Group Cognitive-Behavioral Treatment for Depressed Adolescent Offspring of Depressed Parents in a Health Maintenance Organization. Journal of the American Academy of Child & Adolescent Psychiatry, 41(3), 305-313.

[16] Studies that help Brief Marijuana Dependence Counseling (BMDC) meet FFPSA evidence criteria include:

- Babor, Thomas F. (2004). Brief treatments for cannabis dependence: Findings from a randomized multisite trial. *Journal of Consulting and Clinical Psycholo*gy, 72(3), 455-466.
- Litt, M., Kadden, R., Kabela-Cormier, E., & Petry, N. (2008). Coping skills training and contingency management treatments for marijuana dependence: Exploring mechanisms of behavior change. *Addiction*, 103(4), 638-648.
- The BMDC program manual may be found here: https://www.integration.samhsa.gov/clinical-practice/sbirt/brief_counseling_for_marijuana_dependence.pdf and a cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/306/Brief-Marijuana-Dependence-Counseling

[17] Studies that help Ecologically Based Family Therapy (EBFT) meet FFPSA evidence criteria include:

- Slesnick, & Prestopnik. (2005). Ecologically based family therapy outcome with substance abusing runaway adolescents. *Journal of Adolescence,* 28(2), 277-298.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy*, 35(3), 255-277.

[18] Studies that help Functional Family Therapy (FFT) for adolescents with SUDs meet the FFPSA evidence criteria include:

- Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments, *Journal of Consulting and Clinical Psychology, 69*(5), 802-813.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital & Family Therapy, 35*(3), 255-277.
- Slesnick, N., & Prestopnik, J. (2004). Office versus home-based family therapy for runaway, alcohol abusing adolescents: Examination of factors associated with treatment attendance. *Alcoholism Treatment Quarterly, 22*(2), 3-19.
- Alexander J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*(3), 219-225.
- Parsons, B., & Alexander, J. (1973). Short-term family intervention: A therapy outcome study. *Journal of Consulting and Clinical Psychology, 41*(2), 195-201.
- Alexander, J., Barton, C., Schiavo, R., & Parsons, B. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology, 44*(4), 656-664.
- Klein, N., Alexander, J., & Parsons, B. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*(3), 469-474.
- Friedman, A. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy, 17*(4), 335-347.
- Rohde, P., Waldron, H. B., Turner, C. W., Brody, J., & Jorgensen, J. (2014). Sequenced Versus Coordinated Treatment for Adolescents With Comorbid Depressive and Substance Use Disorders. *Journal Of Consulting & Clinical Psychology, 82*(2), 342-348. doi:10.1037/a0035808

[19] Studies that help Helping Women Recover & Beyond Trauma (HWR/BT) for substance abuse treatment in women meet the FFPSA evidence criteria include:

- Messina, N., Grella, C. E., Cartier, J., & Torres, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of Substance Abuse Treatment, 38*(2), 97–107.
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender responsive drug court treatment: A randomized controlled trial. *Criminal Justice and Behavior, 9*(12), 1539-1558.
- Covington, S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, SARC Supplement 5,* 387-398.

- Saxena, P., Messina, N., & Grella, C. E., (2014). Who benefits from gender responsive treatment. Accounting for abuse history on longitudinal outcomes for women in prison. *Criminal Justice and Behavior, 41*(4), 417–432.

[20] Studies that help Interim Methadone Maintenance for Opioid use (IMM) meet the FFPSA evidence criteria include:

- Schwartz, R. P., Highfield, D. A., Jaffe, J. H., Brady, J. V., Butler, C. B., Rouse, C. O., ... & Breteler, M. M. (2006). A randomized controlled trial of interim methadone maintenance. *Archives of General Psychiatry*, *63*(1), 102-109.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Schwartz, R. P., Kelly, S. M., O'Grady, K. E., Gandhi, D., & Jaffe, J. H. (2011). Interim methadone treatment compared to standard methadone treatment: 4-month findings. *Journal of substance abuse treatment*, *41*(1), 21-29.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Gruber, V. A., Delucchi, K. L., Kielstein, A., & Batki, S. L. (2008). A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. *Drug and alcohol dependence*, *94*(1-3), 199-206.
- Schwartz, R. P., Jaffe, J. H., O'Grady, K. E., Kinlock, T. W., Gordon, M. S., Kelly, S. M., ... & Ahmed, A. (2009). Interim methadone treatment: impact on arrests. *Drug and Alcohol Dependence*, *103*(3), 148-154.
- Schwartz, R. P., Kelly, S. M., Mitchell, S. G., Gryczynski, J., O'Grady, K. E., Gandhi, D., & ... Jaffe, J. H. (2017). Patient-centered methadone treatment: a randomized clinical trial. *Addiction*, *112*(3), 454-464. doi:10.1111/add.13622
- Yancovitz, S. K., Des Jarlais, D. C., Peskoe Peyser, N., Drew, E., Friedmann, P., Trigg, H. L., & Robinson, J. W. (1991). A Randomized Trial of an Interim Methadone Maintenance Clinic. *American Journal Of Public Health*, *81*(9), 1185-1191.
- Gryczynski, J., Schwartz, R., O'Grady, K., & Jaffe, J. (2009). Treatment Entry among Individuals on a Waiting List for Methadone Maintenance. *American Journal Of Drug & Alcohol Abuse*, *35*(5), 290-294. doi:10.1080/00952990902968577
- Interim methadone maintenance therapy makes a difference. (2006). *Inpharma Weekly*, (1529), 8.

[21]Studies that help Family Spirit meet the FFPSA evidence criteria include these below:

- Barlow A, Varipatis-Baker E, Speakman K, et al. Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. *Arch Pediatr Adolesc Med*. 2006; 160(11):1101-1107.
- Barlow, A., Mullany, B., Neault, N., et al. (2015). Paraprofessional Delivered, Home-Visiting Intervention for American Indian Teen Mothers and Children: Three-Year Outcomes from a Randomized Controlled Trial. *American Journal of Psychiatry*, 172(2), 154-162. doi: 10.1176/appi.ajp.2014.14030332.
- Walkup J.T., Barlow, A., Mullany, B.C., et al. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *J Am Acad Child Adolesc Psychiatry*, 48(6), 591-601.

[22] Studies that help Home Instruction for Parents of Preschool Youngsters (HIPPY) meet the FFPSA evidence criteria include:

- Baker, A. J. L., Piotrkowski, C. S., & Brooks-Gunn, J. (1998). The effects of the Home Instruction Program for Preschool Youngsters (HIPPY) on children's school performance at the end of the program and one year later. *Early Childhood Research Quarterly, 13*(4), 571-588.
- Brown, A., & Lee, J. (2014). School performance in elementary, middle, and high school: A comparison of children based on HIPPY participation during the preschool years. *School Community, 24*(2), 83-106.
- Nievar, M. A., Jacobson, A., Chen, Q., Johnson, U., & Dier, S. (2011). Impact of HIPPY on home learning environments of Latino families. *Early Childhood Research Quarterly, 26,* 268-277.
- Barhava-Monteith, G., Harre, N., & Field, J. (1999). A promising start: An evaluation of the HIPPY program in New Zealand. *Early Child Development and Care*, *159*, 145-157.
- Bradley, R. H., & Gilkey, B. (2002). The impact of the Home Instructional Program for Preschool Youngsters (HIPPY) on school performance in 3rd and 6th Grades. *Early Education and Development, 13*(3), 301-311.

- Brown, A. L. (2013). The impact of early intervention on the school readiness of children born to teenage mothers. *Journal of Early Childhood Research*. Advance online publication. doi: 10.1177/1476718X13479048

[23]Studies that help SafeCare meet the FFPSA evidence criteria:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,
- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.

[24] Studies that help Child-Parent Psychotherapy (CPP) meet the FFPSA evidence criteria include:

- Cicchetti, D., Rogosh, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*, 623-649.
- Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of Toddler-Parent psychotherapy to increase attachment security in off-spring of depressed mothers. *Attachment & Human Development, 1*(1), 34-66.
- Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-Parent Psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913-918. doi:10.1097.01.chi.0000222784.03735.92
- Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005**).** Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241-1448.
- Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive interaction and outcome with anxiously attached dyads. *Child Development, 62,* 199-209.

[25] Studies that help Functional Family Therapy (FFT) meet the FFPSA evidence criteria for the outcomes listed in the table include those below. Also see https://www.fftllc.com/documents/FFT-CW-Model-Effectiveness.pdf

- Baglivio, M. T., Jackowski, K., Greenwald, M. A. and Howell, J. C. (2014), Serious, Violent, and Chronic Juvenile Offenders. Criminology & Public Policy, 13: 83-116. doi:10.1111/1745-9133.12064
- Barnoski, R. (2004, January). *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders* (Document No. 04-01-1201). Olympia: Washington State Institute for Public Policy.
- Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. American Journal of Family Therapy, 13(3), 16–26.
- Darnell, A.J., & Schuler, M.S. (2015). Quasi-experimental study of Functional Family Therapy effectiveness for juvenile justice aftercare in a racially and ethnically diverse community sample. *Children and Youth Services Review, 50*, 75-82.
- Gordon, D. A., Graves, K., & Arbuthnot, J. (1995). The effect of Functional Family Therapy for delinquents on adult criminal behavior. Criminal Justice and Behavior, 22(1), 60–73.
- Hansson, K., Cederblad, M., & Hook, B. (2000). Functional family therapy: A method for treating juvenile delinquents. Socialvetenskaplig tidskrift, 3, 231-243. [Being translated into English.]
- Hansson, K., Johansson, Drott-Englén, & Benderix (2004). Functional Family Therapy in child psychiatric practice. *Nordisk Psykologi*, 56, 4, 304–320. [Being translated into English.]
- Kerig, P. K., & Alexander, J. F. (2012). Family Matters: Integrating Trauma Treatment into Functional Family Therapy for Traumatized Delinquent Youth. *Journal of Child & Adolescent Trauma*, *5*(3), 205-223. doi:10.1080/19361521.2012.697103
- Rohde, P., Waldron, H., Turner, C., Brody, J., & Jorgensen, J. (2014). Sequenced versus coordinated treatment for adolescents with comorbid depressive and substance use disorders. *Journal Of Consulting And Clinical Psychology,* 82(2):342-8. doi: 10.1037/a0035808
- Sexton, T., & Turner, C. W. (2010). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Journal Of Family Psychology*, *24*(3), 339-348. doi:10.1037/a0019406

- Stanton, M.D., & Shadish, W.R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin*.122, 170–191.
- Stout, B.D & Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. *Journal of Child and Family Studies*, 22:311–321 DOI 10.1007/s10826-012-9580-6
- Waldron, H. B., Slesnick, N., Brody, J. L., Turner, C. W., & Peterson, T. R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7- month assessments. *Journal of Consulting and Clinical Psychology*, 69, 802-813.

[26] Studies that help HOMEBUILDERS meet the FFPSA evidence criteria are documented in these two meta-analyses:

- Walton, E. (1998). In-home family focused reunification: A six-year follow-up of a successful experiment. *Social Work Research, 22*(4), 205-214.
- Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review, 18*(4/5), 335-361.
- Forrester, D., Copello, A., Waissbein, C., & Pokhrel, S. (2008). Evaluation of an intensive family preservation service for families affected by parental substance misuse. *Child Abuse Review*, *17*(6), 410-426.
- Department for Community Based Services. (2008) Kentucky's Family Preservation Program: Comprehensive Program Evaluation. (DCBS).
- Stuva, D., Ringle, J. L., Thompson, R. W., Chmelka, B., Juliano, N., & Bohn, K. (2016). In-Home Family Services: Providing Lasting Results to Crisis Helpline Callers. *American Journal Of Family Therapy*, *44*(5), 245-254. doi:10.1080/01926187.2016.1223566
- Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & van der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review*, *34*(8), 1472–1479. doi:10.1016/j.childyouth.2012.04.002
- Schweitzer, D. D., Pecora, P. J., Nelson, K., Walters, B., & Blythe, B. J. (2015). Building the evidence base for intensive family preservation services. *Journal of Public Child Welfare*, *9*(5), 423–443. doi:10.1080/15548732.2015.1090363

[27] Studies that help Building Confidence meet FFPSA evidence criteria include:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,
- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs . *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.
- Winokur-Early, K, Chapman, S. F., & Hand, G. A. (2013). Family-focused juvenile reentry services: A quasi-experimental design evaluation of recidivism outcomes. *Journal of Juvenile Justice, 2*(2), 1–22.

Interventions with Special Relevance for the Family First Prevention Services Act (FFPSA) (Second Edition)

CASEY FAMILY PROGRAMS ©November 10, 2018 Casey Family Programs. All rights reserved. No part of this catalog may be reproduced, stored in a retrieval system or transmitted in any form or by any means, mechanical, electronic, photocopying, or otherwise without the prior written permission of Casey Family Programs

EXECUTIVE SUMMARY **iii**
Family First Prevention Services Act ... iii
Interventions Reviewed and Sources ... v
Interventions Summary ... vii
Table E.4: Interventions Summary by Program Areas Listed in P.L. 115-123 ... xi

INTERVENTIONS WITH SPECIAL RELEVANCE FOR THE FAMILY FIRST PREVENTION SERVICES ACT (FFPSA) **1**

INTRODUCTION **1**
Family First Prevention Services Act ... 1
Interventions Reviewed and Sources ... 2
Intervention Cost and Cost Savings ... 7
Cautions and Limitations: What this Document Does Not Include or Address ... 8
Next Steps ... 9

INTERVENTIONS CATALOG **10**

Section I: Interventions that Appear to Qualify Under the FFPSA Criteria of *Well-supported* ... 10
Mental Health for Caregivers or Children ... 10
Substance Abuse Prevention and Treatment ... 20
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education ... 22

Section II: Interventions that Appear to Qualify Under the FFPSA Criteria of *Supported* ... 25
Mental Health ... 25
Substance Abuse Prevention and Treatment ... 34
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education ... 41
In-Home Parent Skill-Based Programs: Individual and Family Counseling ... 44

Section III: Interventions that Appear to Qualify Under the FFPSA Criteria of *Promising* ... 47
Mental Health ... 47
Substance Abuse Prevention and Treatment ... 60
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education ... 64

Executive Summary

Family First Prevention Services Act

The passage of a new federal law, *the Family First Prevention Services Act (P.L. 115-123)*, affords opportunities to use research-based interventions to help children safely avoid placement in foster care by meeting key service and treatment needs of children and their parents. Three major categories of services are eligible for reimbursement for up to 12 months under the new law:

1. Mental health services for children and parents
2. Substance abuse prevention and treatment services for children and parents
3. In-home parent skill-based programs:
   - Parenting skills training
   - Parent education
   - Individual and family counseling

The law includes Kinship Navigator programs, but as a separate provision with its own timeline.

FFPSA supports funding for services "directly related to the safety, well-being or permanence of the child or to prevent the child from entering foster care" (p. 170) that can be provided to:

- Infants, children, youth, pregnant and parenting youth, birth parents, kinship caregivers providing temporary or permanent care for children
- Children who are at risk of entering out-of-home care but who can stay safely with parents or kinship caregivers. This also includes children whose adoption or guardianship is at risk of disruption/dissolution.
- Children multiple times if they are identified as a "candidate"/at risk of out of home multiple times.
- Families regardless of their income (in contrast to current requirements).[1]

Evidence Standards

The levels of evidence for interventions (Promising, Supported and Well-supported) are currently being clarified by the Federal government but are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with three major exceptions: (1) an RCT study is *not* required; (2) publication in a peer review journal is *not* required (at this time); and (3) a book, program manual or some other form of documentation is required.[2] See Table E1 for a comparison of the current evidence criteria for FFPSA and CEBC.

[1] FFPSA law, pp. 170-173. Retrieved from https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[2] For example, the language in the FFPSA uses the CEBC's language but allows for other available writings: "The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice." The CEBC uses the concept of "other available writings" to include programs that do not have a formal book or manual, but have written training materials available that specify the components of the practice protocol and describe how to administer the practice (Personal Communication, Jennifer A. Rolls Reutz, May 15, 2018). See: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

Table E1. A Comparison of the Criteria for FFPSA and CEBC

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
General Requirements: In order for an intervention to be reimbursed by FFPSA it must: (i) have a book, manual or other available writings that specify the components of the practice protocol, and describe how to administer the practice. (ii) there is no empirical basis is suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. (iii) if multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice (iv) outcome measures are reliable and valid, and are administered consistently and accurately across all those receiving the practice. (v) there are no case data suggesting a risk of harm that was probably caused by the treatment that was severe or frequent. (p. 171) (vi) been published in "government reports and peer-reviewed journal articles that assess effectiveness (i.e., impact) using quantitative methods." (See https://www.federalregister.gov/d/2018-13420, p. 9.) FFPSA also requires that ▪ The practice be provided in an agency context and with a "trauma-informed approach and trauma-specific interventions" (p. 171) ▪ Study must be rated by some kind of "an independent systematic review" (p. 172) ▪ Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia; and published/prepared in English during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.) ▪ The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)	**General Requirements:** In order for an intervention to be rated by CEBC it must: a. Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects. b. If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice. c. There are no case data suggesting a risk of harm that: (a) was probably caused by the treatment and (b) the harm was severe or frequent. d. There is no legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it. e. The practice has a book, manual, and/or other available writings that specify the components of the practice protocol and describe how to administer it. (See http://www.cebc4cw.org/ratings/)
Well-Supported: A practice shall be considered to be a 'well- supported practice' if: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least two studies that— (aa) were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design); and (cc) were carried out in a usual care or practice setting; and (II) at least one of the studies described in sub clause (I) established that the practice has a sustained effect (when compared to a control group) for at least 1 year beyond the end of treatment. (pp. 172-173) [I.e. at least one 12 month follow-up study is required.]	**Well-Supported:** • At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. • In at least one of these RCTs, the practice has shown to have a sustained effect of at least one year beyond the end of treatment, when compared to a control group.

Family First Prevention Services Act (FFPSA)[a]	California Evidence-Based Clearinghouse (CEBC)[b]
Supported: (I) the practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that— (aa) was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed; (bb) was a rigorous random-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design); and (cc) was carried out in a usual care or practice setting; and (II) the study described in sub-clause (I) established that the practice has a sustained effect (when com-pared to a control group) for at least 6 months beyond the end of the treatment (p. 172) [I.e. at least one 6 month follow-up study is required.]	**Supported:** • At least one rigorous RCT in a usual care or practice setting has found the practice to be superior to an appropriate comparison practice. • In that RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
Promising: The practice is superior to a comparison practice "using conventional standards of statistical significance in terms of demonstrated meaningful improvements in validated measure of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being, as established by the results or outcomes of at least one study that: (I) that was rated by an independent systematic review for the quality of the study design and execution, and determined to be well-designed and well-executed; and (II) utilized some form of control (e.g., untreated group, placebo group, wait list study) (III) the evaluation was carried out in a "usual care or practice setting." (p. 172)	**Promising:**[c] • At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the comparison, or found it to be equal to or better than an appropriate comparison practice.

[a] See the final FFPSA bill at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[b] The CEBC criteria are described here: http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf CEBC uses two rating scales – one for strength of the research evidence supporting a practice or program; and a second rating of the tools used for screening or assessment. See http://www.cebc4cw.org/ratings/

[c] Note that the research support for the CEBC "promising" level varies substantially. For example, some interventions have high quality comparison-group studies that are not randomized or have RCTs with no follow-up, while others barely meet the "control group" requirement (Personal Communication, Jennifer A. Rolls Reutz, May 30, 2018)

Interventions Reviewed and Sources

Based on a review of the literature, the following interventions are highlighted as effective or relevant for potential reimbursement under FFPSA. For each intervention, the following information is provided (when available): intervention summary, consumer age range, problem areas addressed, number of sessions, duration of treatment, cost, cost savings, benefit-cost ratio, and the availability of a manual. Due to the importance of the Title IV-E Waiver program, we also designate which of these interventions were being implemented by a jurisdiction as part of their Waiver, as of 2015,[3] and how each of these interventions was rated according to the established criteria of the California Evidence-Based Clearinghouse for Child Welfare (CEBC), using the three levels of effectiveness for the CEBC classification system as described in the table above:[4]

1. Well-supported by Research Evidence

[3] Pecora, P.J., O'Brien, K. & Maher, E. (2015). *Levels of research evidence and benefit-cost data for Title IV-E waiver interventions: A Casey research brief. (Third Edition)* Seattle: Casey Family Programs. Available at: http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf

[4] See http://www.cebc4cw.org/. For more complete definitions, see http://www.cebc4cw.org/ratings/scientific-rating-scale/.

2. Supported by Research Evidence
3. Promising Research Evidence

As noted in the table above, in order for an intervention to be rated by the CEBC for any level, it must (a) Have a book or manual that describes how to administer it; (b) Meet the requirements for inclusion in one of the CEBC topic areas; (c) Outcomes of the research must be published in a peer review journal; and (d) Outcome measures are reliable/valid and administered consistently and accurately.[5]

Interventions listed on the CEBC were included if: they were rated 1, 2 or 3; there was a response and details provided by the developer; there was a book or manual; and, in the case of substance abuse and mental health treatment, the treatment provided was delivered by a qualified clinician in either individual or group format; and, in the case of *in-home* parenting services, the intervention did not require a group component. Parent training or skill-building interventions, even if they were group-based, were included in the mental health treatment FFPSA program category if they helped improve some aspect of a caregiver's emotional or behavioral health. While most evidence-based interventions last 6-8 months, a number last longer than 12 months. Strictly applying the 12 month time limit in the FFPSA legislation would result in well-researched programs like Nurse Family Partnership and promising programs such as Parents as Teachers being excluded from the catalog. However, while FFPSA may pay for up to 12 months of a longer term intervention, states can likely elect to use Medicaid, state or other funding to continue the service beyond 12 months; hence, we have included interventions that extend beyond 12 months in the catalog. The duration information then indicates if the FFPSA funding would "time out" before that intervention was fully delivered.

Some relevant interventions were not included in the CEBC, but were selected for inclusion here based on ratings from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), which uses a four level system (where the quality of research studies is rated on a 4-point scale)[6], the "BLUEPRINTS" intervention registry (which uses a three level system of promising, model and model plus),[7] or the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide (which uses a three level system of harmful, promising and effective).[8] For some of the interventions included in these sources, the information was not obtained directly from the developer but from published manuals, reports, journal articles or book chapters. With this exception, all the other criteria used to select interventions from the CEBC were applied to these clearinghouses.

Interventions that were not able to be rated due to a lack of evaluation data are listed in a companion document, as some of these interventions warrant further evaluation so that they might qualify. In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse. In this case we rely on the research evidence indicating that the intervention is effective for a particular problem, or area of functioning that children and their caregivers typically have in child welfare, and various meta-analyses that have reported intervention effect sizes.[9] In addition, to help describe the evidence base or other aspects of the interventions with scant material, a wide range of other websites were reviewed. Note that Multisystemic Therapy for Substance Abuse (MST-SA), Structural Family Therapy (SFT) and Trauma Systems Therapy (TST), despite their use by child welfare programs in New York City and

[5] See http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf
[6] Note that the NREPP contractor and review criteria/process may be undergoing change. See https://nrepp.samhsa.gov/landing.aspx
[7] See Center for the Study and Prevention of Violence's http://www.blueprintsprograms.com/
[8] See OJJDP's https://www.ojjdp.gov/mpg/
[9] For examples of meta-analyses reporting intervention effect sizes, see Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243 Leenarts, L.E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P., & Lindauer, R.J.L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child Adolesc Psychiatry* 22:269-283.

elsewhere, were not included in this catalog as these interventions are not rated by the CEBC or Blueprints; and the NREPP site was taken down at the time this catalog was being revised. We will rate these interventions in a later edition of this catalog.

In addition, in contrast to Family Spirit and some other culturally competent interventions, the in-home and group-based versions of the Positive Indian Parenting Program have not been evaluated sufficiently to be rated by one of the Clearinghouses. Until more evaluation data can be gathered by NICWA, the law allows for a request to be made to the Secretary of HHS to waive those aspects of the law, via guidance, per the provision allowing for cultural and tribal specific needs.

Interventions Summary

On pages xii-xv, we provide a condensed table that lists each of the interventions in the catalog by program category and level of evidence (Table E4). In order for states, counties, and tribal nations to make well-informed intervention-selection decisions, better understanding where and how these interventions have been tested, used, spread, or discontinued across child-serving and family-serving systems is also important. In the months ahead, we will also be adding effect-size data for more interventions because of its value in estimating the expected impact of the intervention outcomes of interest.

In examining that summary table, even without applying the less stringent FFPSA criteria to the interventions, we see that there are sizable numbers of interventions that meet the standards for each level for each program area. There are not, however, as many interventions that are rated by the CEBC or other ranking system at a *Well-supported* level. (See Table E2 below.) This highest evidence level is important because 50 percent of the state intervention funding for FFPSA-eligible interventions must be spent on *Well-supported* interventions, but using criteria that is slightly less stringent than CEBC, as discussed earlier.

Table E2. Summary Table of Interventions Classified as Well-Supported in Terms of Evidence Level (N=40)

FFPSA Intervention Areas	Number of Interventions Ranked as Well-supported According to the CEBC or Other Ranking System
▪ Mental health services for children and parents	29
▪ Substance abuse prevention and treatment services for children and parents	4
▪ In-home parent skill-based programs: ▪ Parenting skills training and Parent education[a] ▪ Individual and family counseling	 5 2

[a] A clear definition of each program type and how they differ from each other has not yet been issued by the Federal Government in relation to FFPSA. Therefore, we grouped interventions that might qualify for one or both these program types together.

Table E2 needs to be viewed with caution as Casey Family Programs, the CEBC staff, Abt Associates (the organization that ACYF has contracted with to act as the FFPSA Clearinghouse), and others are just now beginning to review the research literature for interventions to see how they would be rated if the current FFPSA research evidence criteria remain unchanged. Many experts are reluctant to devote a large amount of staff time or other resources to that effort since we need to know what kinds of research reports or data summaries can be used to determine what rating the intervention should receive. FFPSA does *not* require a Randomized Control Trial (RCT) or publication in a peer-review journal, which should result in a larger number of interventions qualifying for the upper evidence

levels than what we show in this catalog. For example, in a special review described next, 26 interventions which are currently classified at a lower level using the CEBC, NREPP, or BLUEPRINTS rating criteria should be determined to be at the *Well-supported* level using FFPSA criteria (see Table E3.) ***Combining Tables E2 and E3, a total of 67 interventions relevant to child welfare should be classified as Well-Supported.***

Interventions that Should be Rated as Well-Supported Under the Most Recent FFPSA Standards

The levels of evidence that will be used to rate interventions for reimbursement under Family First as Promising, Supported and Well-supported are currently being clarified by the Federal government, and new parameters were recently released for comment by ACYF. All the FFPSA evidence criteria released thus far are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with six major exceptions:

1. A RCT study is *not* required
2. Publication in a peer review journal is *not* necessary
3. Study must have targeted one of the FFPSA "target outcomes;" conducted in the U.S., U.K., Canada, New Zealand, or Australia;
4. The study report must have been published in English
5. The study conducted or summarized during or after 1990. (See https://www.federalregister.gov/d/2018-13420, pp. 9.-10.)
6. The "meaningful positive significant effect" on the study FFPSA target outcome "…will be defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of p<.05)." (See https://www.federalregister.gov/d/2018-13420, p. 11.)

Review Process

The Casey Family Programs review team from Research Services examined all 45 "Supported" interventions in the first edition of the Catalog in relation to all the specific rating criteria published to date about the FFPSA interventions. We also paid special attention to the following:

- Study sample size.
- The drop-out/attrition rates as the study proceeded, including the response rate for the follow-up studies. The study might be disqualified if these drop-out/attrition rates are too high – especially if there was differential attrition across the treatment and comparison groups.
- Use of valid assessment measures.

If the information gathered showed that the intervention had evidence that would qualify it for the *Well-Supported level,* that was recorded, along with a brief summary of why – along with the articles supporting that evidence level. We also confirmed that there were at least two qualifying studies for every outcome highlighted for that intervention (as distinct from a situation where each study found a different outcome).

If the initial set of evidence was insufficient to qualify for *Well-Supported*, we contacted the intervention developer for additional studies and technical reports that might help their intervention qualify for the highest level possible. The 27 interventions with evidence that should qualify them for the *Well-Supported* level under FFPSA are listed in Table E.2, along with their target outcomes. The studies that provided the most direct evidence are footnoted for each intervention.

Conclusions

In sum, although further direction from the Children's Bureau is forthcoming, the information in this document provides a conservative approach regarding interventions that may be covered under FFPSA. In other words, if an intervention is designated as promising, supported, or well-supported in this document, it is

likely to have the same or higher evidence standard under FFPSA. Until further direction is provided, this catalog offers a rough estimate as to what interventions are likely to be covered under FFPSA.

Table E3. Relevant Interventions Rated as Supported Using CEBC Criteria that Could Be Classified as Well-Supported Under FFPSA Rating Criteria
(N = 27)[10]

Mental Health Services for Children and Parents
1. **Blues Program**[1] (Depressive symptoms, lower risk for onset of major depression - i.e. risk of future depressive episodes)
2. **Building Confidence**[2] (Child and adolescent anxiety)
3. **Chicago Parent Program**[3] (Parent self-efficacy, corporal punishment, consistent discipline, positive parenting, and child behavior problems)
4. **Cognitive Behavioral Therapy (CBT) for Child & Adolescent Depression**[4] (Child and adolescent depression)
5. **Cognitive Behavioral Therapy (CBT) - Group Therapy for Children with Anxiety**[5] (Child anxiety)
6. **Cognitive Behavioral Therapy (CBT) - Parent Counseling for Young Children with Anxiety**[6] (Child anxiety)
7. **Dialectical Behavior Therapy (DBT)**[7] (Reducing self-harm; suicide attempts in highly suicidal self-harming adolescents; non-suicidal self-injury; depression; and improved general functioning among people with borderline personality disorder)
8. **Families and Schools Together (FAST)**[8] (Youth aggressive/externalizing behavior, academic performance)
9. **Family-Focused Treatment for Adolescents (FFT-A)**[9] (Manic symptoms in youth with bipolar disorder)
10. **Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST)**[10] (Child and adolescent depression, overall functioning)
11. Wraparound[11] **(**Reduced recidivism in terms of juvenile justice offenses, improved overall youth functioning, placement in least restrictive settings, including achieving legal permanency)
Substance Abuse Prevention and Treatment Services for Children and Parents
12. **Buprenorphine Maintenance Treatment for Opioid Use Disorder**[12] (Opioid use)

[10] *Source*: Compiled by Olivia Thai, Danielle Roy, Jessica Elm and Peter J. Pecora, Research Services, Casey Family Programs. Note that the table lists target outcomes where 2 or more separate studies found positive effects for that outcome, with at least one study finding positive results at a 12 month or longer follow-up.

13. **Assertive Continuing Care (ACC)**[13] (Substance abuse)
14. **Adolescent Community Reinforcement Approach (A-CRA)**[14] (Substance abuse)
15. **Adolescent Coping with Depression (CWD-A)**[15] (Depression)
16. **Brief Marijuana Dependence Counseling (BMDC)**[16] (Marijuana use)
17. **Ecologically Based Family Therapy (EBFT)**[17] (Substance abuse)
18. **Functional Family Therapy (FFT) for adolescents with SUDs**[18] (Substance abuse)
19. **Helping Women Recover & Beyond Trauma (HWR/BT)**[19] (Substance abuse among women)
20. **Interim Methadone Maintenance (IM) for opioid use**[20] (Opioid use)
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education
21. **Family Spirit (for American Indian/Alaskan Native parents)**[21] (Mothers' knowledge of and involvement in child care, maternal parenting skills)
22. **Home Instruction for Parents of Preschool Youngsters (HIPPY)**[22] (Child school performance)
23. **SafeCare**[23] (Re-referral to CPS for child neglect or physical abuse)
In-Home Parent Skill-Based Programs: Individual and Family Counseling
24. **Child-Parent Psychotherapy**[24] (Secure and disorganized attachment)
25. **Functional Family Therapy (FFT)**[25] (Family functioning, youth emotional and behavior improvement, child out-of-home placement prevention, and delinquent behavior recidivism/arrests)
26. **Homebuilders**[26] (Family functioning improvement to prevent child out-of-home placement)
27. **Parenting with Love and Limits**[27] (Child emotional and behavior health problems)

In Table E.4 the interventions in the catalog are listed by their FFPSA program area and evidence level.

Table E.4: Interventions Summary by Program Areas Listed in P.L. 115-123

Mental Health Services for Children and Parents (Total: 80)		
Well-supported (sub-total: 29):	*Supported (sub-total: 22):*	*Promising (sub-total: 29):*
▪ Acceptance and Commitment Therapy (ACT) for Adults ▪ Acceptance and Commitment Therapy (ACT) for adults with anxiety ▪ Acceptance and Commitment Therapy (ACT) for adults with schizophrenia and psychosis ▪ Acceptance and Commitment Therapy (ACT) for children with anxiety ▪ Acceptance and Commitment Therapy (ACT) for children with depression ▪ Aggression Replacement Training® (ART) ▪ Attachment and Biobehavioral Catch Up (ABC) ▪ Child and Family Traumatic Stress Intervention (CFTSI) ▪ Cognitive Behavioral Therapy (CBT) ▪ Cognitive Behavioral Therapy (CBT) for Adult Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Adult Depression ▪ Cognitive Behavioral Therapy (CBT) for Adult Posttraumatic Stress Disorder (PTSD) ▪ Cognitive Behavioral Therapy (CBT) for Adult Schizophrenia and Psychosis ▪ Cognitive Behavioral Therapy (CBT) for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) for Children with Trauma ▪ Cognitive Behavioral Therapy (CBT) – Individual Therapy for Children with Anxiety	▪ Accelerated Resolution Therapy ▪ Blues Program ▪ Building Confidence ▪ Chicago Parent Program (CPP) ▪ Childhaven Childhood Trauma Treatment ▪ Cognitive Behavioral Therapy (CBT) for Child and Adolescent Depression ▪ Cognitive Behavioral Therapy (CBT) – Group Therapy for Children with Anxiety ▪ Cognitive Behavioral Therapy (CBT) – Parent counseling for young children with anxiety ▪ Collaborative & Proactive Solutions ▪ Common Sense Parenting (CSP) ▪ Community Reinforcement + Vouchers Approach (CRA + Vouchers) ▪ Dialectical Behavior Therapy (DBT) ▪ Dialectical Behavior Therapy (DBT) for Adolescent Self-Harming Behavior ▪ Families and Schools Together (FAST) ▪ Family-Focused Treatment for Adolescents (FFT-A) ▪ Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST) ▪ Multi-Family Psychoeducational Psychotherapy (MF-PEP) ▪ New Beginnings (for children of divorce) ▪ Positive Peer Culture (PPC) ▪ Primary and Secondary Control Enhancement Training (PASCET)	▪ 1-2-3 Magic ▪ ACTION (youth group treatment for depression) ▪ Adolescent Coping with Depression (CWD-A) ▪ Behavioral Activation Treatment for Depression (BATD) ▪ Brief Eclectic Psychotherapy for PTSD (BEPP) ▪ C.A.T. Project ▪ Child-Centered Play Therapy (CCPT) ▪ *CICC's Effective Black Parenting Program (EBPP)* ▪ Cognitive Behavioral Analysis System of Psychotherapy (CBASP) ▪ Cognitive-Behavioral Coping-Skills Training ▪ Cognitive Processing Therapy (CPT) ▪ Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT) ▪ Cool Kids ▪ Defiant Children: A Clinician's Manual for Assessment and Parent Training (The Barkley Method of Behavioral Parent Training) ▪ Exchange Parent Aide ▪ Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach) ▪ Family Connections ▪ Helping the Noncompliant Child ▪ Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) ▪ Life Space Crisis Intervention (LSCI) ▪ Mindfulness-Based Cognitive Therapy for Children (MBCT-C)

Mental Health Services for Children and Parents (Total: 80)		
Well-supported (sub-total: 29):	*Supported (sub-total: 22):*	*Promising (sub-total: 29):*
▪ Cognitive Therapy (CT) ▪ Coping Cat ▪ Coping Power Program ▪ Eye movement desensitization and reprocessing (EMDR) for Adult PTSD ▪ Eye movement desensitization and reprocessing (EMDR) for Children ▪ GenerationPMTO (Group Delivery Format) ▪ Mindfulness-Based Cognitive Therapy (MBCT) for Adults ▪ Multidimensional Family Therapy (MDFT) ▪ Parent Child Interaction Therapy (PCIT) ▪ Problem Solving Skills Training for Children ▪ Prolonged Exposure Therapy for Adolescents (PE-A) ▪ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) ▪ Triple P – Positive Parenting Program – Level 4 Individual for Child Disruptive Behavior	▪ Problematic Sexual Behavior- (PSB-CBT-S)- for School Age Children ▪ Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) for Sexual Behavior Problems in Children	▪ Nurturing Parenting Program for Parents and their School-age Children 5 to 12 Years ▪ Parents Anonymous ▪ Play and Learning Strategies–Infant Program ▪ Solution-Based Casework (SBC) ▪ Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) ▪ Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP-ART) ▪ Trauma and Grief Component Therapy for Adolescents (TGCT-A) ▪ Wraparound

Substance Abuse Prevention and Treatment for Children and Parents (Total: 26)		
Well-supported (sub-total: 4): ▪ Communities that Care for Substance Abuse Prevention ▪ Motivational Interviewing ▪ Multidimensional Family Therapy (MDFT) ▪ PROSPER	*Supported (sub-total: 15):* ▪ Adaptive Stepped Care ▪ Adolescent Community Reinforcement ▪ Approach/Assertive Continuing Care (A-CRA/ACC) ▪ Adolescent Coping with Depression (CWD-A) ▪ Adolescent-focused Family Behavior Therapy ▪ Adult-focused Family Behavior Therapy ▪ Brief Marijuana Dependence Counseling (BMDC) ▪ Brief Strategic Family Therapy ▪ Buprenorphine (or buprenorphine/naloxone) maintenance treatment for opioid use disorder ▪ Ecologically Based Family Therapy ▪ Families Facing the Future ▪ Functional Family Therapy (FFT) for adolescents with substance use disorder ▪ Helping Women Recover & Beyond Trauma (HWR/BT) [Substance Abuse Treatment (Adult)] ▪ Injectable naltrexone for opiates ▪ Intermittent methadone maintenance	*Promising (sub-total: 7):* ▪ Alcohol Behavioral Couple Therapy ▪ C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support) ▪ Cognitive-Behavioral Coping-Skills Therapy for alcohol or drug use disorders ▪ Matrix Model Intensive Outpatient program ▪ Seeking Safety ▪ Sobriety Treatment and Recovery Teams (START) ▪ 12-Step Facilitation Therapy for Substance Abuse (TSF)

In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education (Total: 17)		
Well-supported (sub-total: 5): ▪ Family Connects ▪ Healthy Families America (HFA) ▪ Minding the Baby® (MTB) ▪ Nurse Family Partnership (NFP) ▪ The Incredible Years	*Supported (sub-total: 5):* ▪ AVANCE Parent-Child Education Program ▪ Home Instruction for Parents of Preschool Youngsters (HIPPY) ▪ SafeCare ▪ Tuning In To Kids (TIK) ▪ Tuning In To Teens (TINT)	*Promising (sub-total: 7):* ▪ All Babies Cry (ABC) ▪ Circle of Security-Home Visiting-4 (COS-HV4) ▪ Collaborative Problem Solving (CPS) ▪ Early Head Start-Home Visiting (EHS-HV) ▪ GenerationPMTO (individual delivery format) ▪ Infant Health and Development Program (IHDP) ▪ Parents as Teachers (PAT)

In-Home Parent Skill-Based Programs: Individual and Family Counseling (Total: 23)		
Well-supported (sub-total: 2): ▪ Attachment-Based Family Therapy (ABFT) ▪ The Family Check-up (FCU)	*Supported (sub-total: 7):* ▪ Child-Parent Psychotherapy (CPP) ▪ Child Parent Relationship Therapy (CPRT) ▪ Functional Family Therapy (FFT) ▪ Intensive Family Preservation Services (HOMEBUILDERS®) ▪ Multisystemic Therapy (MST) ▪ Parenting with Love and Limits (PLL) ▪ Strengthening Families for Parents and Youth 10–14	*Promising (sub-total: 14):* ▪ Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) ▪ Child FIRST (Child and Family Interagency, Resource, Support, and Training) ▪ Cue-Centered Treatment (CCT) ▪ Domestic Abuse Intervention Project - The Duluth Model (DAIP) ▪ Early Pathways Program (EPP) ▪ Families First ▪ Family Centered Treatment ▪ Multisystemic Therapy Building Stronger Families (MST-BSF) ▪ Parent Child Assistance Program (PCAP) ▪ Promoting First Relationships (PFR) ▪ Risk Reduction through Family Therapy (RRFT) ▪ Step-by-Step Parenting Program© ▪ Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) ▪ Wraparound (in-home parent support focus)

Interventions with Special Relevance for the Family First Prevention Services Act (FFPSA)[11]

Introduction

Family First Prevention Services Act

The passage of a new federal law, *the Family First Prevention Services Act (P.L. 115-123)*, affords opportunities to use research-based interventions to help children safely avoid placement in foster care by meeting key service and treatment needs of children and their parents. Three major categories of services are eligible for reimbursement for up to 12 months under the new law:

- Mental health services for children and parents
- Substance abuse prevention and treatment services for children and parent
- In-home parent skill-based programs:
  - Parenting skills training
  - Parent education
  - Individual and family counseling

FFPSA provides federal funds for up to 12 months of services to prevent children from entering or re-entering foster care. Many aspects of the new law are being clarified but described below are some of the reasons why children and their families would be covered:

- Infants, children, youth, pregnant and parenting youth, other birth parents, kinship caregivers providing temporary or permanent care for children
- Services "directly related to the safety, well-being or permanence of the child or to prevent the child from entering foster care" (p. 170)
- Children who are at risk of entering out-of-home care but who can stay safely with parents or kinship caregivers. This also includes children whose adoption or guardianship is at risk of disruption/dissolution.
- Can receive services more than once if child is again identified as a "candidate"/at risk of out of home care but for the services.
- Not dependent upon family income like federal foster care is.[12]

The levels of evidence for interventions (Promising, Supported and Well-supported) are being clarified by the Federal government but are similar in many ways to the California Evidence Based Clearinghouse for Child Welfare (CEBC) criteria, with three major exceptions: (1) an RCT study is *not* required, (2) publication in a peer review journal is *not* necessary (at least at this time); and (3) a program manual *is* required.[13] To receive federal funding for these areas, FFPSA will require 50 percent of interventions to be evidence-based. To facilitate this a ranking system a clearinghouse will be established. An important requirement for the interventions relates to having evidence of their ability to achieve certain kinds of child welfare outcomes:

---

[11] Compiled by the Casey Family Programs Research Services and Knowledge Management teams as part of a project to help public child welfare agencies and their community partners' better match child and family needs with effective services. For more information, please contact Research Services at ResearchTeam@casey.org or Knowledge Management at KMresources@casey.org. This interventions catalog builds on material compiled from English, D., Pecora, P.J., Goodman, D., Wackerman, J. & Rebbe, R. (2018). *Interventions with special relevance for child welfare, with age range, treatment duration, effect sizes and cost data.* Seattle, WA: Casey Family Programs. We thank the staff of the California Evidence Based Clearinghouse for Child Welfare and the Washington State Institute for Public Policy for their excellent and timely work in reviewing numerous interventions.

[12] FFPSA law, pp. 170-173. Retrieved from https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[13] See: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

HHS must, directly or through grants, contracts or interagency agreements, evaluate research on the promising, supported, or Well-supported practices and programs, including culturally specific, or location- or population-based adaptations, to identify and establish a public clearinghouse of the promising, supported, or Well-supported practices. The clearinghouse must include specific information on whether the promising, supported, or Well-supported practice has been shown to prevent child abuse and neglect or reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children.[14]

Interventions Reviewed and Sources

Based on a review of the literature and selected conversations with experts from the U.S. and overseas, the following interventions are highlighted as effective or relevant for potential reimbursement under FFPSA. For each intervention, the following information is provided: summary of the intervention, client age range, problem areas addressed, number of sessions, the length of treatment, effect sizes, cost, cost savings, benefit cost ratio, and availability of a manual. Because of the importance of the Title IV-E Waiver program, we also designate which of these interventions were being implemented by a jurisdiction as part of their Waiver, as of 2015,[15] and how each of these interventions was rated according to the established criteria of the California Evidence-Based Clearinghouse for Child Welfare (CEBC), using the three highest levels of effectiveness for the CEBC classification system:[16]

1. ***Well-supported by Research Evidence:*** At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. In at least one of these RCTs, the practice has shown to have a sustained effect of at least one year beyond the end of treatment, when compared to a control group.
2. ***Supported by Research Evidence***: At least one RCT in usual care or a practice setting that has found the practice to be superior to an appropriate comparison practice. In that RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.
3. ***Promising Research Evidence:*** At least one study utilizing some form of comparison (e.g., untreated group, placebo group, matched wait list) [that has] established the practice's benefit over the control, or found it to be comparable to a practice rated 3 or higher on the CEBC, or superior to an appropriate comparison practice.

Note that In order for an intervention to be rated by the CEBC for any level, it must (a) Have a book or manual that describes how to administer it; (b) Meet the requirements for inclusion in one of the CEBC topic areas; (c) Outcomes of the research must be published in a peer review journal; and (d) Outcome measures are reliable/valid and administered consistently and accurately.[17]

---

[14] U.S. DHHS. (April 12, 2018*). INFORMATION MEMORANDUM: NEW LEGISLATION – Public Law 115-123, the Family First Prevention Services Act within Division E, Title VII of the Bipartisan Budget Act of 2018.* Log No: ACYF-CB-IM-18-02. Attachment B: Time-Limited Foster Care Prevention Program and Services. Washington, D.C.: Author, p. 6.

[15] Pecora, P.J., O'Brien, K. & Maher, E. (2015). *Levels of research evidence and benefit-cost data for Title IV-E waiver interventions: A Casey research brief. (Third Edition)* Seattle: Casey Family Programs. Available at: http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf http://www.casey.org/media/Title-IV_E-Waiver-Interventions-Research-Brief.pdf

[16]See http://www.cebc4cw.org/. And for more complete definitions, see http://www.cebc4cw.org/ratings/scientific-rating-scale/.

[17] See http://www.cebc4cw.org/files/OverviewOfTheCEBCScientificRatingScale.pdf

Interventions listed on the CEBC were included if: they were rated 1, 2 or 3; there was a response and details provided by the developer; there was a book or manual; and, in the case of substance abuse and mental health treatment, the treatment provided was delivered by a qualified clinician in either individual or group format; and, in the case of in-home parenting services, the intervention did not require a group component. Parent training or skill-building interventions, even if they were group-based, were included in the mental health treatment FFPSA program category if they helped improve some aspect of a caregiver's emotional or behavioral health. Strictly applying the 12 month time limit in the FFPSA legislation would result in well-researched programs like Nurse Family Partnership and promising programs such as Parents as Teachers being excluded from the catalog. Because we believe that FFPSA will pay for up to 12 months of a longer term intervention and states can then elect to use Medicaid, state or other funding to continue the service, we have included interventions that often do extend beyond 12 months in the catalog. The duration information then indicates if the FFPSA funding would "time out" before that intervention was fully delivered.

When not rated by the CEBC, for some interventions we based our selection on ratings from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), which uses a four level system (where the quality of research studies is rated on a 4-point scale,[18] the "BLUEPRINTS" intervention registry (which uses a three level system of promising, model and model plus),[19] or the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide (which uses a three level system of harmful, promising and effective).[20] The NREPP site lists over 560 programs, so we prioritized including the 215 *"effective"* programs in the "newly reviewed group" (reviewed since 2015 with new criteria), rather than the programs in the legacy group. All of the interventions rated as *Promising* or above on the Blueprints site were included if they fit one of the FFPSA program categories. For the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide we focused on FFPSA-relevant interventions among those rated as *Effective*.

In addition, where multiple studies of the intervention have been reviewed as part of either the Cochrane or Campbell reviews to examine their overall effectiveness (e.g., effect sizes), the summary results for those reviews are reported.[21] For some interventions in these sources, the information was not obtained directly from the developer but from published manuals, reports and journal articles or book chapters. With this exception, all the other criteria used to selected interventions from the CEBC were applied with these clearinghouses. Interventions that were not able to be rated due to a lack of evaluation data are listed in a companion document as some of these deserve further evaluation so they might qualify.

In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse. In this case we rely on the research evidence indicating that the intervention is effective for a particular problem, or area of functioning that children and their caregivers typically have in child welfare, and various meta-analyses that have reported intervention effect sizes.[22] For example, many youth in out-of-home care suffer from depression[23]

---

[18] Note that the NREPP contractor and review criteria/process may be undergoing change. See https://nrepp.samhsa.gov/landing.aspx

[19] See Center for the Study and Prevention of Violence's http://www.blueprintsprograms.com/

[20] See OJJDP's https://www.ojjdp.gov/mpg/

[21] See https://www.campbellcollaboration.org/ and http://www.DBT
library.com/

[22] For examples of meta-analyses reporting intervention effect sizes, see Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243 Leenarts, L.E.W., Diehle, J., Doreleijers, T.A.H., Jansma, E.P., & Lindauer, R.J.L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: a systematic review. *European Child Adolesc Psychiatry* 22:269-283.

[23] Griffin, G., McClelland, G., Holzberg, M., Stolbach, B., Maj, N. & Kisiel, C. (2011). Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare,* 90, 69-89. Turney, K. & Wildeman, C. (2016). Mental and physical health of children in foster care. *Pediatrics*, 138(5), 1-11. e20161118

and yet relatively few intervention trials have focused on these youth. In addition, based on a 2016 Cochrane review of studies from around the world, the effects of Cognitive Behavioral Treatment (CBT), Interpersonal Therapy and Third Wave CBT were positive but more consistent results are needed:

> Overall the results show small positive benefits of depression prevention, for both the primary outcomes of self-rated depressive symptoms post-intervention and depression diagnosis up to 12 months (but not beyond). Estimates of numbers needed to treat to benefit (NNTB = 11) compare well with other public health interventions. However, the evidence was of moderate to low quality using the GRADE framework and the results were heterogeneous.[24]

Similarly, many youth in care also suffer from post-traumatic stress disorder (PTSD), and the evaluation research for common interventions for PTSD such as CBT, exposure-based, psychodynamic, narrative, supportive counselling, and Eye Movement Desensitization and Reprocessing (EMDR) needs to be bolstered, according to a 2012 Cochrane review of US and other literature:

> The psychological therapy for which there was the best evidence of effectiveness was CBT. Improvement was significantly better for up to a year following treatment…There is evidence for the effectiveness of psychological therapies, particularly CBT, for treating PTSD in children and adolescents for up to a month following treatment. [Overall] at this stage, there is no clear evidence for the effectiveness of one psychological therapy compared to others. There is also not enough evidence to conclude that children and adolescents with particular types of trauma are more or less likely to respond to psychological therapies than others. The findings of this review are limited by the potential for methodological biases, and the small number and generally small size of identified studies. In addition, there was evidence of substantial heterogeneity in some analyses which could not be explained by subgroup or sensitivity analyses.[25]

Similarly, many *caregivers* of youth in care also suffer from PTSD, and the evaluation research for common interventions for PTSD such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) for adults needs to be bolstered, according to a 2013 Cochrane review of US and other literature:

> The evidence for each of the comparisons made in this review was assessed as very low quality. This evidence showed that individual TFCBT and EMDR did better than waitlist/usual care in reducing clinician-assessed PTSD symptoms. There was evidence that individual TFCBT, EMDR and non-TFCBT are equally effective immediately post-treatment in the treatment of PTSD. There was some evidence that TFCBT and EMDR are superior to non-TFCBT between one to four months following treatment, and also that individual TFCBT, EMDR and non-TFCBT are more effective than other therapies. There was evidence of greater drop-out in active treatment groups. Although a substantial number of studies were included in the review, the conclusions are compromised by methodological issues evident in some. Sample sizes were small, and it is apparent that many of the studies were underpowered. There were limited follow-up data, which compromises conclusions regarding the long-term effects of psychological treatment.[26]

---

[24] http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD003380.pub4/epdf/standard, p. 4.

[25] Gillies D, Taylor F, Gray C, O'Brien L, D'Abrew N. (2012). *Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. Cochrane Database of Systematic Reviews 2012, Issue 12. Art. No.: CD006726. DOI: 10.1002/14651858.CD006726.pub2.* Retrieved from http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD006726.pub2/full, p. 1.

[26] Cochrane Database of Systematic Reviews Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults (Review) Bisson JI, Roberts NP, Andrew M, Cooper R, Lewis C Bisson JI, Roberts NP, Andrew M, Cooper R, & Lewis C. (2013). *Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults.* Cochrane Database of Systematic Reviews 2013, Issue 12. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub4. Retrieved from http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD003388.pub4/epdf/standard, p. 2.

Child welfare agencies have been criticized for over-prescribing group-based parenting programs or using programs with insufficient research evidence,[27] but for parents who truly need them, some high quality programs have significant positive effects according to a 2012 Campbell collaborative review:

> We included 48 studies that involved 4937 participants and covered three types of programmes: behavioural, cognitive-behavioural and multimodal. Overall, we found that group-based parenting programmes led to statistically significant short-term improvements in **depression** (standardised mean difference (SMD) -0.17, 95% confidence interval (CI) -0.28 to -0.07), **anxiety** (SMD -0.22, 95% CI -0.43 to -0.01), **stress** (SMD -0.29, 95% CI -0.42 to -0.15), **anger** (SMD -0.60, 95% CI -1.00 to -0.20), **guilt** (SMD -0.79, 95% CI -1.18 to -0.41), **confidence** (SMD -0.34, 95% CI -0.51 to -0.17) and **satisfaction with the partner relationship** (SMD -0.28, 95% CI -0.47 to -0.09). However, only stress and confidence continued to be statistically significant at six month follow-up, and none were significant at one year. There was no evidence of any effect on self-esteem (SMD -0.01, 95% CI -0.45 to 0.42). None of the trials reported on aggression or adverse effects. The limited data that explicitly focused on outcomes for fathers showed a statistically significant short-term improvement in paternal stress (SMD -0.43, 95% CI -0.79 to -0.06). We were unable to combine data for other outcomes and individual study results were inconclusive in terms of any effect on depressive symptoms, confidence or partner satisfaction.[28] [Bold formatting added.]

Some interventions were exclusively school-based and even though they were geared to prevent youth substance abuse or acting-out behavior, we did not include them until further federal guidance is issued [e.g., Adlerian Play Therapy, American Indian Life Skills (AILS), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Positive Action Project Towards No Drug Abuse, Promoting Alternative Thinking Strategies (PATHS)].

Listed below are the clearinghouses and intervention-focused websites we reviewed:

• Child Welfare: California Evidence Based Clearinghouse for Child Welfare • Children & Families: Promising Practices Network • Education: What Works Clearinghouse • Evidence-based Policy: Coalition for Evidence-Based Policy • Delinquency: OJJDP Model Programs Guide • Home Visiting: HomVEE - Home Visiting Evidence of Effectiveness	• Mental Health & Substance Abuse: National Registry of Evidence-Based Programs and Practices • State Implementation & Scaling up Evidence-based Practices Center: www.scalingup.org • Trauma: National Child Traumatic Stress Network • Youth Development, Youth Mental Health and Violence Prevention: Blueprints for Healthy Youth Development[29]

[27] Barth, R. P. (2012). Progress in developing responsive parenting programs for child welfare-involved infants: Commentary on Spieker, Oxford, Kelly, Nelson, and Fleming. *Child Maltreatment, 17*, 287-290. doi: 10.1177/1077559512466586.

[28] Barlow, J., Smailagic, N., Huband, N., Roloff, V., & Bennett, C. (2012). *Group-based parent training programmes for improving parental psychosocial health.* Campbell Systematic Reviews 2012:15 DOI: 10.4073/csr.2012.15, p. 7. Retrieved from https://www.campbellcollaboration.org/library/group-training-programmes-improving-parental-psychosocial-health.html

[29] This site includes 1,000 tested programs in the following areas: (1) Behavior, (2) Education, (3), Emotional Well-Being, (4) Physical Health, and (5) Positive Relationships. Also see: Blueprints Program Criteria for Selection

The table below describes the evidence rating of the primary clearinghouses used for this document (other than the CEBC).

SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) Criteria for Each Level	Blueprints for Healthy Youth Development Intervention Registry Criteria for Each Level[30]	Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide Criteria for Each Level
Inconclusive: Programs may be classified as inconclusive for two reasons. First, the evaluation evidence has insufficient methodological rigor to determine the impact of the program. Second, the size of the short-term effect could not be calculated. ***Ineffective:*** The evaluation evidence has sufficient methodological rigor, but there is little to no short-term effect. More specifically, the short-term effect does not favor the intervention group and the size of the effect is negligible. Occasionally, the evidence indicates that there is a *negative* short-term effect. In these cases, the short-term effect harms the intervention group and the size of the effect is substantial. ***Promising:*** The evaluation evidence has sufficient methodological rigor, and the short-term effect on this outcome is likely to be favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is likely to be substantial. ***Effective:*** The evaluation evidence has strong methodological rigor, and the short-term effect on this outcome is favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is substantial. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a	***Promising programs***: meet the following standards: • Intervention specificity: The program description clearly identifies the outcome the program is designed to change, the specific risk and/or protective factors targeted to produce this change in outcome, the population for which it is intended, and how the components of the intervention work to produce this change. • Evaluation quality: The evaluation trials produce valid and reliable findings. This requires a minimum of (a) one high quality randomized control trial or (b) two high quality quasi-experimental evaluations. • Intervention impact: The preponderance of evidence from the high quality evaluations indicates significant positive change in intended outcomes that can be attributed to the program and there is no evidence of harmful effects. • Dissemination readiness: The program is currently available for dissemination and has the necessary organizational capability, manuals, training, technical assistance and other support required for implementation with fidelity in communities and public service systems. European programs have not undergone the Blueprints certification process to determine dissemination readiness. ***Model programs***: meet these additional standards: • Evaluation Quality: A minimum of (a) two high quality randomized control trials or (b) one high quality randomized control trial plus one high quality quasi-experimental evaluation.	The Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Model Programs Guide (MPG) contains information about evidence-based juvenile justice and youth prevention, intervention, and reentry programs. It is a resource for practitioners and communities about what works, what is promising, and what does not work in juvenile justice, delinquency prevention, and child protection and safety. MPG uses expert study reviewers and CrimeSolutions.gov's program review process, scoring instrument, and evidence ratings. The two sites also share a common database of juvenile-related programs. Three levels are used: *Ineffective*, *Promising* and *Effective*.

[30] Blueprints criteria are defined here: http://www.blueprintsprograms.com/criteria

SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) Criteria for Each Level	Blueprints for Healthy Youth Development Intervention Registry Criteria for Each Level[30]	Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide Criteria for Each Level
program's conceptual framework. For more information on the ratings, see the review process. Beginning September 2015 and continuing through June 2019, NREPP staff will re-review programs that were reviewed under the previous criteria.[31] The re-reviewed programs can be found in the general registry of programs.	• Positive intervention impact is sustained for a minimum of 12 months after the program intervention ends. ***Model Plus programs***: meet one additional standard: • Independent Replication: In at least one high quality study demonstrating desired outcomes, authorship, data collection, and analysis has been conducted by a researcher who is neither a current or past member of the program developer's research team and who has no financial interest in the program.	

Intervention Cost and Cost Savings

We draw heavily from the Washington State Institute for Public Policy (WSIPP) for cost estimates around program costs, monetary benefits, and cost-benefit ratios, when available. [32] These costs are estimated and adjusted to be specific to Washington State, based on state wage, child welfare, and other state-specific data. Nonetheless, we believe these Washington State cost estimates provide a helpful guide to a program's effectiveness. The user of this information will need to determine how these costs and benefits may, or may not, apply in another state. Details on the three cost figures, as reported from WSIPP, can be found from WSIPP's technical documentation:[33]

When we cite the WSIPP cost figures we present them in this manner:

- Cost: $267
- Savings: $6,787
- B-C: $26.46

The program ***costs***, if derived from the WSIPP Cost-Benefit analyses, were calculated using a variety of methods. If available, average program costs were collected directly from the operating agency. If not, and program resource needs were available from the published evaluations, these were converted to unit costs with available data, such as relevant personnel salaries. Otherwise, when available, we obtained program costs directly from program Web sites or through personal communication. These costs are the direct costs of implementing the program per participant, family, or child.

[31] For the new SAMHSA NREPP review criteria, see: https://nrepp.samhsa.gov/reviews_open.aspx
[32] See http://www.wsipp.wa.gov/BenefitCost The information is drawn primarily from these reports:

- Washington State Institute for Public Policy (2017a). *Adult mental health.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health
- Washington State Institute for Public Policy (2017b). *Children's mental health.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health
- Washington State Institute for Public Policy (2017c*). Child welfare.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/3/WSIPP_BenefitCost_Child-Welfare
- Washington State Institute for Public Policy (2017d*). Substance use disorders.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[33] http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf

Cost savings or loss, if reported from WSIPP, are the life cycle benefits (direct and indirect) minus net program costs (program costs compared to the alternative) in present value. These are the expected returns over time per participant. If cost savings were derived from a source other than WSIPP, we recommend going to the original source document to see how the cost savings were calculated as there are different definitions and methodologies used. If reported as a loss (in red with accounting parentheses), it is because the costs, compared to the alternative, exceed any observed or anticipated benefits.

The ***benefit-to-cost ratio*** is the life cycle program benefits divided by the net program cost of producing the outcomes. This ratio is another way of presenting the same information and represents the monetary gain (or loss) for every dollar spent over the life cycle. Occasionally the costs for an intervention compared to the alternative will exceed the savings it generates, and those figures are presented in red font and in parentheses:

- Cost: $1,979
- Loss: ($4,046)
- B-C: ($0.17)

Note that in the example above, the B-C ratio is a negative $.17 cents. That means for every dollar spent, society will lose an additional .17 cents from the program investment. If, for example, the benefit cost ratio is not in red, as below, the B-C ratio would be interpreted as recouping $.16 cents for every dollar spent, because there were positive societal benefits, just not enough in relationship to the program costs relative to the alternative.

- Cost: $1,979
- Loss: $1,703
- B-C: $0.16

Please note, that the B-C ratio uses cost estimates NOT reported in our tables below to calculate the B-C ratio. That is, rather than using the per participant program cost, the B-C ratio uses the program cost, as compared to the alternative, which we do not report in these tables. We report the per participant program cost instead, because we believe this is more useful information to jurisdictions who want to know how much a program might cost to implement on a per person basis, regardless of the alternative. (To locate the per participant annual program cost in the WSIPP materials, after clicking on the program name in their benefit-cost results tables, scroll to the table titled, "Detailed Annual Cost Estimates Per Participant" and find the "Program costs" under the "Annual Cost" column. Please note the year for which the program cost is valid for.)

For some interventions, the developer websites were consulted and additional cost per client and cost-savings information is provided. If cost savings or benefit-to-cost ratios are reported from a source other than WSIPP, we recommend going to the original source document to see how the ratio was calculated as definitions and methodologies may vary. An important task for each jurisdiction is to distinguish which interventions could be paid for by Medicaid or behavioral health systems versus federal or state child welfare funds. In a few areas, we included what services or other supports might be needed to help a youth "step down" into a less restrictive form of care. For example, in juvenile probation in Los Angeles, Functional Family Therapy (FFT) is an important intervention while the youth is placed but also for helping the entire family when the youth returns home.

Cautions and Limitations: What this Document Does Not Include or Address

As mentioned earlier, there are a number of FFPSA areas where the federal government needs to issue more specific definitions and guidance. For example, we were not able to differentiate between *parenting skills training* and *parent education* interventions, so we included what are believed to be programs that qualified for one or both of these program types in the ***in-home parent skill-based programs*** category. What qualifies as a "manual" or adequate research

evidence in terms of a quasi-experimental design is not clear. Finally, effect size data for most interventions are limited and will be added in subsequent editions of this catalog. We also recommend the reader go to the registries or program website for more information.

To keep the document length and scope of the project manageable we were not able to present areas of information that other sites such as the CEBC, NREPP, NIRN and developer websites may provide, such as:

- Qualifications of staff required to provide program (e.g., paraprofessional, BA, undifferentiated master's degree, masters in psychology or social work)
- How staff are trained, certified and re-certified
- Implementation process, including time requirements
- Management information system requirements to store therapist fidelity data, if necessary
- Typical funding sources

We did not include interventions designed to prevent or treat domestic violence, although a 2016 Campbell review of US and international studies found two quality studies with 12 month follow-ups that showed significant effects for reduced minor physical abuse for brief but intensive advocacy interventions (less than 12 hours) with shelter services; and that an antenatal care program for pregnant women showed reduced emotional abuse at 12-month follow-up compared to no care or usual care.[34] We have included some but not all of the many group-based parenting interventions that are designed to improve parenting and reduce child behavior problems. Finally, as mentioned earlier, there are many interventions that are important for achieving good results in child welfare that do not meet the FFPSA funding criteria for some reason, including a lack of research evidence (e.g., Positive Indian Parenting Program). That does not mean that child welfare agencies should not invest in those programs.

Next Steps

In summary, although further direction from the Children's Bureau is forthcoming, the information in this document provides a conservative approach to what will be covered under FFPSA. In other words, if an intervention is designated as promising, supported or well-supported in this document, it is likely to have the same or higher evidence standard under FFPSA. Until further direction is provided, the summary provided here offers a rough-guide to what will be covered under FFPSA. In order for states, counties and tribes to make well-informed intervention selection decisions, better understanding of where and how these interventions have been tested, used, scaled up or discontinued across child and family-serving systems is also important. In addition, as the Children's Bureau research evidence standards and other aspects of the law are clarified further, and the ACYF FFPSA Interventions Clearinghouse contractor (Abt Associates) completes their intervention reviews, it will be possible to construct a catalog of programs that more precisely fit each of FFPSA evidence levels.

[34] Low to very low quality evidence from two intensive advocacy trials (12 hours plus duration) showed reduced severe physical abuse in women leaving a shelter at 24 months (OR 0.39, 95% CI 0.20 to 0.77; NNT = 8), but not at 12 or 36 months. See Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse, pp. 8-9.

Interventions Catalog

Section I: Interventions that Appear to Qualify Under the FFPSA Criteria of *Well-supported*

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Acceptance and Commitment Therapy (ACT) for Adults A contextually focused form of cognitive behavioral psychotherapy that uses mindfulness and behavioral activation to increase a client's psychological flexibility—his/her ability to engage in values-based, positive behaviors while experiencing difficult thoughts, emotions, or sensations. ACT establishes this through six core processes: Acceptance of private experiences; cognitive defusion (i.e., alter the undesirable functions of thoughts and other private events); being present, a perspective-taking sense of self; identification of values; and commitment to action.	Adults with depression; has also been used with adults with a variety of other mental health disorders and behavioral problems	Delivered to clients in one-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration of the intervention varies depending on the needs of the client or treatment provider.	**1** (Well-supported)	Cost: $367 Savings: $6,901 B-C: N/A[28],[29]	No official manual, but resources are available[30]	
Acceptance and Commitment Therapy (ACT) for children with anxiety ACT aims to increase client acceptance of negative thoughts and feelings and to reduce the negative behavioral impact of anxiety. Acceptance and Commitment Therapy relies on six core processes of change: (1) acceptance; (2) learning to view thoughts as hypotheses rather than facts, (3) being present, (4) viewing the self as context for experience, (5) identifying core values, and (6) acting based on those values. These core principles are applied through various exercises and through homework.	Children with anxiety	Delivered to clients in one-on-one sessions and in small groups. In the single study reported here, the treatment was delivered in 10 group sessions with parents present at all sessions.[31]	**1** (Well-supported)	Cost: $660 Savings: $6,901 B-C: N/A	No official manual, but resources are available[32]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Acceptance and Commitment Therapy (ACT) for adults with anxiety Aims to increase client acceptance of negative thoughts and feelings and to reduce the negative behavioral impact of anxiety. Acceptance and Commitment Therapy relies on six core processes of change: (1) acceptance; (2) learning to view thoughts as hypotheses rather than facts, (3) being present, (4) viewing the self as context for experience, (5) identifying core values, and (6) acting based on those values. These core principles are applied through various exercises and through homework.[33]	Adults with anxiety	One-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration varies.	**1** (Well-supported)	Cost: $1,319 (2015) Savings: $20,562 B-C: $48.55[34]	No official manual, but resources are available[35]	
Acceptance and Commitment Therapy (ACT) for adults with schizophrenia and psychosis Acceptance and Commitment Therapy for schizophrenia/psychosis aims to increase client acceptance of psychotic symptoms (such as hallucinations and delusions) and reduce the negative behavioral impact of psychosis. (See the catalog entry above for the six core processes of change.)[36]	Adults with schizophrenia and psychosis	One-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration varies.	**1** (Well-supported)	Cost: $693 Savings: $498 B-C: $1.71[37]	No official manual, but resources are available[38]	
Acceptance and Commitment Therapy (ACT) for children with depression Acceptance and Commitment Therapy (ACT) for depression aims to increase client acceptance of negative thoughts and feelings and to reduce the negative behavioral impact of depression. (See the catalog entry above for the six core processes of change.)	Children with depression	One-on-one sessions and in small groups. Number, frequency, and length of the sessions and overall duration varies.	**1** (Well-supported)	Cost: $1,417 Loss: ($755) B-C: ($0.26)[39]	No official manual, but resources are available[40]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Aggression Replacement Training® (ART®) This is a cognitive-behavioral intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents ages 12–17. The intervention training is divided into three components: social skills training, anger-control training, and training in moral reasoning. Clients attend a one-hour session in each of these components each week. Incremental learning, reinforcement techniques, and guided group discussions enhance skill acquisition, and reinforce the lessons in the curriculum.[41]	Ages 12–17. Chronic aggression	10 weeks (30 sessions)	**1** (Well-supported)	Cost: $1,449 (for youth in state juvenile justice institutions)[42] Savings: $4,865 B-C: $4.03[43]	Yes[44]	
Attachment and Biobehavioral Catch Up (ABC)[45] ABC intends to increase caregiver nurturance, sensitivity, and delight; child attachment security and child behavioral and biological regulation. It intends to decrease frightening behaviors and disorganized attachment. Utilizes parent coaches. This program is typically conducted in: Adoptive Homes, Birth Family Homes and Foster/Kinship Care	Ages 0–2 for children who have experienced early adversity	Ten weekly one-hour sessions Duration: 10 weeks	**1** (Well-supported)	$1,300-$1,600 per family. 2–3 day staff training is required.[46]	Yes	
Child and Family Traumatic Stress Intervention (CFTSI)[47] Focuses on 2 key risk factors (poor social or familial support, and poor coping skills in the aftermath of potentially traumatic events) with the primary goal of preventing the development of PTSD. CFTSI seeks to reduce these risks in two ways: (1) by increasing communication between the affected child and his caregivers about feelings, symptoms, and behaviors, with	Ages 7–18; both males and females; for parents and children who may have complex trauma histories	4 sessions within 30–45 days of a potentially traumatic event[48]	**1** (Well-supported)	N/A[49]	Yes[50]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
the aim of increasing the caregivers' support of the child; and (2) by teaching specific behavioral skills to both the caregiver and the child to enhance their ability to cope with traumatic stress reactions.						
Cognitive Behavioral Therapy (CBT) CBT is a time-limited, evidence-based psychotherapy for treating anxiety disorders and major depressive disorders. It is "an intervention for ameliorating distressing feelings, disturbing behavior, and the dysfunctional thoughts from which they spring. Improvements in target symptoms, such as anxiety and depression, are mediated through identifying and disputing the automatic thoughts that generate those feelings. Behavioral techniques, such as skills training and role-playing, are well-established ways of addressing phobias and posttraumatic reactions. These techniques also help patients develop coping mechanisms for managing the thoughts and feelings identified during the intervention."[51]	Ages 13–25 Anxiety, depression, dysfunctional thoughts	12 to 16 weekly sessions	**1** (Well-supported) 70% for depression (Cohen's d= .86)[52] Anxiety (Cohen's d= .65)[53] Post-traumatic stress (Cohen's d= .68)[54]	Cost: $1,661 (individual CBT for children with anxiety)[55]	Yes[56]	KY, NV
Cognitive Behavioral Therapy (CBT) for Adult Anxiety Cognitive-behavioral therapies (CBT) include various components, such as cognitive restructuring, behavioral activation, emotion regulation, exposure, communication skills, and problem-solving.	Adults ages 18 and older with anxiety	10–20 weekly sessions[57]	**1** (Well-supported)[58]	Cost: $1,458 (2015) Savings: $30,370 B-C: $54.01[59]	Yes[60]	
Cognitive Behavioral Therapy (CBT) for Adult Depression[61] Skills-based, present-focused, and goal-oriented treatment approach that targets the thinking styles and behavioral	Adults (18 and over) diagnosed with a mood disorder, including Unipolar	10–20 therapeutic hours per client[62]	**1** (Well-supported) Unadjusted random effects model: -	Cost: $1,231 (2014) Savings: $24,288 B-C: $49.09[63]	Yes[64]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
patterns that cause and maintain depression-like behavior and mood.	Major Depressive Disorder (MDD) not otherwise specified, and minor depression.		0.66; Adjusted effect size: -044			
Cognitive Behavioral Therapy (CBT) for Adult Posttraumatic Stress Disorder (PTSD) Treatments in this review include several components, such as psycho-education about posttraumatic stress disorder (PTSD), relaxation and other techniques for managing physiological and emotional stress, exposure (the gradual desensitization to memories of the traumatic event), and cognitive restructuring of inaccurate or unhelpful thoughts.	Adults (18 and over) diagnosed with PTSD	1–45 weekly sessions[65]	**1** (Well-supported)[66]	Cost: $1,444 (2014) Savings: $49,184 B-C: $88.11[67]	Yes[68]	
Cognitive Behavioral Therapy (CBT) for Adult Schizophrenia and Psychosis Cognitive behavioral therapy for psychosis (CBTp) includes the application of cognitive strategies focused on changing thoughts to improve feelings and behaviors as well as behavioral techniques most often used to address negative symptoms. CBTp involves teaching patients methods of coping with their symptoms and training in problem solving, social skills and strategies to reduce risk of relapse.	Adults (18 and over) diagnosed with Schizophrenia or Psychosis	12–20 sessions over 4–6 months[69]	**1** (Well-supported)[70]	Cost: $1,436 (2014) Savings: $12,221 B-C: $9.39[71]	Yes[72]	
Cognitive Behavioral Therapy (CBT) for Children with Anxiety	Children with anxiety	8–16 weekly sessions[73]	**1** (Well-supported)[74]	Cost: $217 (2010)[75]	Yes[76]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
These treatments utilize the same principles and techniques as those of other Cognitive Behavior Therapy (CBT) treatments for anxiety (e.g., strategies to control physiological responses to anxiety, cognitive restructuring and self-talk, exposure to feared stimuli, and positive reinforcement). However, they are unique insofar as clients have reduced (if any) face-to-face time with therapists. Clients are supported remotely via email or phone contact. A manual or online program helps to guide progress of the intervention.						
Cognitive Behavioral Therapy (CBT) for Children with Trauma CBT is a skills-based, present-focused, and goal-oriented treatment approach that targets the thinking styles and behavioral patterns that cause and maintain depression-like behavior and mood.[77]	Children ages 3–18[78]	12–18, 30–45 minute sessions[79] Duration: 12-18 weeks	**1** (Well-supported)	Cost: $1,037 (2016) Savings: 21,837 B-C: $N/A[80]	Yes	
Cognitive Therapy (CT) A form of psychotherapy proven in numerous clinical trials to be effective for a wide variety of disorders. The therapist and client work together as a team to identify and solve problems. Therapists help clients to overcome their difficulties by changing their thinking, behavior, and emotional responses. *CT* and Cognitive Behavioral Therapy are often used interchangeably. There are, however, numerous subsets of CBT that are narrower in scope than *CT*: e.g., problem-solving therapy, stress-inoculation therapy, motivational interviewing, dialectical behavior therapy, behavioral modification, exposure and response prevention, etc.	Children and adults with a wide range of problems	50-minute weekly sessions Duration: 12 weeks	**1** (Well-supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
Coping Cat Individual psychotherapy intervention for children with a range of anxiety difficulties. Includes psychoeducational, exposure therapy, somatic management, cognitive restructuring, problem solving.	Ages 7–13 with version for 13–17 year olds with anxiety	16 weekly group sessions Duration: about 16 weeks	**1** (Well-supported)	N/A	Yes[81]	CO
Coping Power Program For high-risk children, it addresses deficits in social cognition, self-regulation, peer relations, and positive parental involvement. The Coping Power Program, which has both a child and parent intervention component, is designed to be presented in an integrated manner. It was designed as a school-based program, but has been adapted for mental health settings.	Ages 7–14	34 group sessions	**1** (Well-supported)	Cost: $919 Savings: $1,016 B-C: $1.56[82]	Yes[83]	
Eye movement desensitization and reprocessing (EMDR) for Adult PTSD A psychological treatment commonly used to treat posttraumatic stress disorder. During treatment, clients focus on the traumatic memory for 30 seconds at a time while the therapist provides a stimulus.	Adults with posttraumatic stress disorder (PTSD)	One 50- or 90-minute session per week Duration: 3–12 weeks[84]	**1** (Well-supported)[85]	Cost: $974 (2014) Savings: $41,349 B-C: $598.49[86]	Yes[87]	CO
Eye movement desensitization and reprocessing (EMDR) for Children EMDR is based on Adaptive Information Processing theory and involves eight phases of psychotherapy that integrate psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies[88]	Ages 2–17. Anxiety, behavior problems, fear, phobias, posttraumatic stress and posttraumatic stress disorder (PTSD)	One 50- or 90-minute session per week Duration: 3–12 weeks[89]	**1** (Well-supported)[90]	Cost: $886 (2009) Savings: $8,810 B-C: N/A[91]	Yes[92]	CO

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
GenerationPMTO (Group Delivery Format) GenerationPMTO was formerly known as Parent Management Training - the Oregon Model (PMTO®). *GenerationPMTO (group delivery format)* is a parent training intervention		10-14 weeks	**1** (Well-supported)		Yes	
Mindfulness-Based Cognitive Therapy (MBCT) for Adults Based on Jon Kabat Zinn's Stress Reduction program at the University of Massachusetts Medical Center, which was developed to help people suffering with chronic physical pain and disease. It includes simple meditation techniques to help participants become more aware of their experience in the present moment, by tuning in to moment-to-moment changes in the mind and the body.[93]	Adults who have suffered three or more prior episodes of major depression	Weekly for 2 hours per week Duration: 9–10 weeks	**1** (Well-supported)	N/A	Yes	
Multidimensional Family Therapy (MDFT) *has been rated by the CEBC in the areas of Behavioral Management Programs for Adolescents in Child Welfare*.[94] See the Well-supported substance abuse section for more intervention details	Children and adolescents ages 11–18	Duration: 3–4 months for at-risk and early intervention youth and families. 5–6 months for youth with a substance abuse and/or conduct disorder diagnosis.	**1** (Well-supported)	Cost data are only available for its usage for treating substance abuse.	Yes[95]	CO
Parent Child Interaction Therapy (PCIT) PCIT has been used with child welfare populations has been successfully tested with the addition of a group	Ages 2–7 years old	Hour-long weekly sessions.	**1** (Well-supported)	Cost: $2,240 (2007) Savings: $22,994	Yes[97]	CO, MD, MT, NE, NV, WI

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
motivational component to increase engagement and success of the parent. As in standard PCIT, over the course of 12 to 14 sessions, a therapist directly observes a parent and child through a one-way mirror, and provides direct coaching to the parent through a radio earphone. The focus is building the skills of the parent to more positively interact with the child and manage his or her behavior.		Duration: Treatment length varies but averages about 14 weeks		B-C: $15[96]		
Problem Solving Skills Training (PSST) for Children Is aimed at decreasing inappropriate or disruptive behavior in children. The program teaches that problem behaviors arise because children lack constructive ways to deal with thoughts and feelings and instead resort to dysfunctional ones. It is designed to help children learn to slow down, stop and think, and generate multiple solutions to any given problem. The program uses a cognitive-behavioral approach to teach techniques in managing thoughts and feelings, and interacting appropriately with others. Specific techniques include modeling, role-playing, positive reinforcement of appropriate behavior, and teaching alternative behaviors.[98]	Children ages 7–14 with oppositional, aggressive, anti-social behavior	8–14 weekly sessions Duration: up to one year	**1** (Well-supported)	N/A	N/A	
Prolonged Exposure Therapy for Adolescents (PE-A) Promote the client's ability to emotionally process their traumatic experiences and consequently diminish posttraumatic stress disorder (PTSD) and other trauma-related symptoms. Clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through	Children, adolescents and adults who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc.).	8–15 sessions Duration: up to 17 months	**1** (Well-supported)	N/A (4-day on-site training costs $1500 per participant for PE Therapy for PTSD[100])	Yes[101]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health for Caregivers or Children						
retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment.[99]						
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) TF-CBT is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It has mostly been used and evaluated with youth who were sexually abused or exposed to domestic violence. TF-CBT can also benefit children with depression, anxiety, shame, and/or grief related to their trauma.[102] This psychotherapy model includes parent and child individual and joint sessions in several modules that combine trauma-sensitive interventions with CBT. TF-CBT aims to (1) improve child and parent knowledge and skills related to processing the trauma; (2) manage distressing thoughts, feelings, and behaviors; and (3) enhance safety, parenting skills, and family communication.[103]	Ages 4–18. Anxiety, depression, PTSD	Weekly 60- to 90-minute sessions Duration: 12–16 weeks	**1** (Well-supported)	$1,037 (CBT based models for child trauma)[104]	Yes[105]	AR, CO, IN, KY, MD, MT, NV, WI
Triple P – Positive Parenting Program – Level 4 Individual for Child Disruptive Behavior Triple P—Positive Parenting Program (Level 4, self-directed) is an intensive individual-based parenting program for families of children with challenging behavior problems. In the self-directed modality, parents receive a full Level 4 curriculum with a workbook and exercises to complete at their own pace. They are also offered support from a therapist by telephone on a regular basis.	Ages 0–12	10–16 sessions Duration:over 3–4 months[106]	**1** (Well-supported)	Cost: $1,792 Savings: $2339 B-C: $3.36[107]	Yes[108]	CO, ME, NE, TX, WA

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Communities that Care for Substance Abuse Prevention Communities that Care (CTC) is a coalition-based community prevention program that aims to prevent youth problem behaviors including underage drinking, tobacco use, violence, delinquency, school dropout, and substance abuse. CTC works through a community board to assess risk and protective factors among the youth in their community using a population-based survey of young people. The board works to implement tested and effective programs to address the issues and needs that are identified.	0–21[109]		**1** (Well-supported)[110]	Cost: $103 (2004) Savings: $2,555 B-C: $5.31[111]	Yes[112]	
Motivational Interviewing *MI* is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. *MI* can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities, including substance abuse treatment for adults.	Adults	1–3, 30–50 minute sessions	**1** (Well-supported) *Campbell 2011 Review:* Significant short-term effect for decreasing substance abuse at for 1-6 months and for the 7-12 month follow-up periods but not longer than that.[113]	Cost: $263 (2014) Savings: $5,572 B-C: $21.95[114]	Yes[115]	AR, CO, IN, NV
Multidimensional Family Therapy (MDFT) *MDFT* is a family-based treatment system for adolescent substance use, delinquency, and related behavioral and emotional problems. Therapists work simultaneously in four interdependent domains: the adolescent, parent, family, and community. Once a therapeutic alliance is established and	Children and adolescents, ages 11–18	1–3 sessions per week (average of 2) each lasting 45–90 minutes.[117] Duration: 5–6 months	**1** (Well-supported) *Campbell 2015 Review:* Small but significant short-term effect was found for decreasing	Cost: $6,168 (2001) Loss: ($5,827) B-C: $0.28[119]	Yes[120]	CO

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
youth and parent motivation is enhanced, the ***MDFT*** therapist focuses on facilitating behavioral and interactional change. The final stage of ***MDFT*** works to solidify behavioral and relational changes and launch the family successfully so that treatment gains are maintained.[116]			substance abuse at 6 month and 12 month follow-ups, but less so for the pooled effects across 4 studies.[118]			
PROSPER The PROSPER (PROmoting School-community-university Partnerships to Enhance Resilience) delivery system is a partnership-based prevention model designed to help communities implement effective programs to reduce substance use and problem behaviors in youth. In addition to supporting program delivery, the model includes needs assessments, quality monitoring, sustainability strategies, and evaluation. Communities participating in PROSPER form local teams consisting of staff from the Cooperative Extension System (CES); representatives from the public school system and service providers; youth and parents; and other community stakeholders. University researchers and CES staff partner with the local teams and provide a menu of effective programs, technical assistance, coordination, and other supports. Local teams select and implement a family-based program for students in 6th grade and a school-based program in 7th grade from the menu of effective practices.	10–14[121]		**1** (Well-supported)	Cost: $104 Savings: $469 B-C: $1.89[122]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Family Connects Family Connects® is a community-wide nurse home visiting program for parents of newborns residing in a given geographic area. It is based on the Durham Connects model piloted in Durham County, N.C.	Parent of children ages 0–2 years	3 to 7 contacts between 3 and 12 weeks after birth[123] Duration: about 8 weeks	**1** (Well-supported) Significant reduction in child maltreatment, measured by childhood injuries (*Cohen's d .48-.85*) and substantiated maltreatment reports (*Cohen's d .22-.62*).[124]	$700 per family[125] B/C ratio: $3.02[126]	N/A	
Healthy Families America (HFA) ***HFA*** is a home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues.[127]	Pregnant women and women with child ages Birth to 4 years+ ***HFA*** services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby).[128]	29–43 home visits Duration: about 16 months[129]	**1** (Well-supported)	Cost: $5,071 (2016) Loss: ($1,840) B-C: $0.64[130]	Yes[131]	DC
Nurse Family Partnership (NFP)[132] Program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday.	Ages 0-2 and their caregivers: Voluntary First time mothers Low income Enrolled early in pregnancy	Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits continue with	**1** (Well-supported)	Cost: $5,944 (2015) B-C: $0.81[134]	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
		varying frequency until the child is two years old.[133]				
Minding the Baby® (MTB) MTB is an intensive home visiting model for first-time young mothers and their families. The interdisciplinary intervention brings together a home visiting team including a pediatric nurse practitioner and a licensed clinical social worker to promote positive health, mental health, life course, and attachment outcomes in babies, mothers, and their families.[135]	Medically low-risk pregnant women age 14–25	27 months, beginning in second or third trimester of pregnancy.	**1** (Well-supported At least 2 RCTs and peer review journal articles. 5 year study underway.[136]	Approximately $10,000–$13,200 per year, per family[137]	Yes[138]	
The Incredible Years A series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations. In-home services delivery is one option.	Ages 4–8 Children with disruptive behavior and emotional problems	Basic Parent Training Program is 14 weeks and 18–20 weeks for treatment. Child Training Program is 18–22 weeks. Child Prevention Program is 20–30 weeks and may be spaced over two years.	**1** (Well-supported)	Cost: $2,215 (2013) Savings: $1,039C: 1.79[139]	Yes[140]	CO, WA

In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Attachment-Based Family Therapy (ABFT)[141] Designed to help families strengthen their relationships, solve problems, and regulate emotions. Consists of individual and joint meetings with depressed adolescents and their parents.	Ages 13–18 Depressed adolescents and their families	Weekly sessions Duration: Approximately 12 weeks	**1** (Well-supported) ABFT was found to have significant positive impacts on rates of change in adolescents' suicidal thoughts, clinical recovery for suicidal thoughts and depressive symptoms, and treatment retention.[142]	N/A	N/A	
The Family Check-up (FCU) A family-centered intervention that promotes positive family management and addresses child and adolescent adjustment problems. The ***FCU*** has two phases: (1) An initial assessment and feedback; (2) Parent management training (Everyday Parenting) which focuses on positive behavior support, healthy limit setting, and relationship building.[143]	Parents of children and adolescents	One-hour session every 1–2 weeks. Duration: 1–4 months depending on the individual needs of the family	**1** (Well-supported)	Cost: $164 (2013) Loss: ($399) B-C: $(0.20)[144]	Yes[145]	

Section II: Interventions that Appear to Qualify Under the FFPSA Criteria of *Supported*

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Accelerated Resolution Therapy A brief, exposure-based psychotherapy aimed at treating psychological trauma, depression, anxiety, phobias, obsessive–compulsive disorder, and substance use. The program incorporates specific visualization techniques enhanced through the use of rapid eye movements (similar to the rapid eye movement stage of sleep) and a directive approach that reduces physical and emotional reactions to distressing memories and images stored in the brain.[146]	Adults For psychological trauma, depression, anxiety, phobias, obsessive–compulsive disorder, and substance abuse.	One to five, 60–75 minute sessions. Duration: 2 weeks.	**2** (Supported)+ NREPP rating of effective	N/A	Yes	
Blues Program Actively engages high school students with depressive symptoms or at risk of onset of major depression, includes six weekly one-hour group sessions and home practice assignments. Weekly sessions focus on building group rapport and increasing participant involvement in pleasant activities (all sessions), learning and practicing cognitive restructuring techniques (sessions 2–4), and developing response plans to future life stressors (sessions 5–6). In-session exercises require participants to apply skills taught in the program. Home practice assignments are intended to reinforce the skills taught in the sessions and help participants learn how to apply these skills to their daily life.	Ages 15–18	6 weekly group sessions[147]	**2** (Supported)[148]	Cost: $114 (2014) Savings: $6144 B-C: $0.24[149]	Yes[150]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Building Confidence A cognitive-behavioral therapy (CBT) that is provided to school-aged children who demonstrate clinically significant symptoms of a range of anxiety disorders (e.g., separation anxiety disorder). The format consists of individual child therapy combined with parent-training and involvement. Both children and their parents are taught fundamental CBT principles and techniques as well as integrating ways to build confidence through graduated learning and practice of age-appropriate self-independence skills.[151]	**Ages:** 6 – 11 with anxiety disorder	Weekly 1.5-hour session Duration: 16 weeks	**2** (Supported)	N/A	Yes	
Chicago Parent Program (CPP) A parenting-skills training program that aims to prevent or reduce behavior problems in children, ages 2 to 5, by strengthening parenting skills, reducing reliance on harsh and inconsistent discipline methods, and improving parenting confidence. CPP is grounded in social learning theory and the belief that parents can shape their child's behavior and social–emotional well-being through the quality and consistency of their communications and behavioral interactions. Developed in collaboration with an advisory board of African American and Latino parents of young children, the CPP is designed to address the needs of a racially, ethnically, and economically diverse population of parents.	Ages 2–5 with behavior problems	Two trained group leaders deliver the program during weekly 2-hour sessions for 11 weeks, and at a booster session 4 weeks later Duration: 15 weeks	**2** (Supported)+ NREPP rating of effective	N/A	Yes (Manual and video vignettes)	
Childhaven Childhood Trauma Treatment Provides therapeutic child care and other optional specialized treatment services in a licensed child-care milieu) setting (therapeutic/treatment to abused,	Children ages 1–5 and their families to help improve relationships and	5.5 hours per day, five days a week, with a	**2** (Supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
neglected, at-risk, and/or drug-affected children. Children are referred by Child Protective Services, Child Welfare Services, Department of Health, or the TANF Program.[152]	parenting skills, enable children to be life-long learners	monthly home visit Duration: Variable				
Cognitive Behavioral Therapy (CBT) for Child and Adolescent Depression This is a developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. CBT emphasizes collaborative empiricism, the importance of socializing patients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions, and beliefs.[153]	Ages 13–25. Depression	12 to 16 weekly sessions	**2** (Supported) NREPP rating 3.4–3.7	Cost: $1,245 (2015) Savings: $566 B-C: $0.27[154]	Yes[155]	
Cognitive Behavioral Therapy (CBT) – Group Therapy for Children with Anxiety Treatments usually include multiple components, such as strategies to control physiological responses to anxiety, cognitive restructuring and self-talk, exposure to feared stimuli, and positive reinforcement. This brief therapy can be administered in individual, group, or family format; well-known examples include the Coping Cat and Coping Koala programs.	Children with anxiety	Not available	**2** (Supported) Effect size to decrease anxiety: between -.191 and -414 (WSIPP)[156] (CEBC rates non-group work based TF-CBT for children as "Well-Supported")	Cost: $559 (2010) Savings: $6,612 B-C: N/A[157]	N/A	
Cognitive Behavioral Therapy (CBT) – Individual Therapy for Children with Anxiety Treatments usually include multiple components, such as strategies to control physiological responses to anxiety, cognitive restructuring and self-talk, exposure to feared	Children with anxiety	N/A	**2** (Supported) Effect size to decrease anxiety: between -.191 and -414[158]	Cost: $1,661 (2010)[159] Savings: $3,554 B-C: $5.55[160]	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
stimuli, and positive reinforcement. This brief therapy can be administered in individual, group, or family format.						
Cognitive Behavioral Therapy (CBT) – Parent counseling for young children with anxiety Uses CBT techniques with a focus on anxiety.	Adults with children with anxiety	N/A	**2** (Supported)[161]	Cost: $648 Savings: $2,459 B-C: $ N/A [162]	N/A	
Collaborative & Proactive Solutions A treatment model that is designed to help parents/caregivers and children learn to collaboratively and proactively solve the problems that contribute to the children's challenging behaviors. It is made up of four modules that teach parents: (a) to identify lagging skills and unsolved problems that contribute to oppositional episodes; (b) to prioritize which unsolved problems to focus on first; (c) and how to resolve problems.[163]	Parents of children ages 4–14 to improve family communication, cohesion, and relationships	Weekly 60 minute sessions Duration: 11 weeks on average	**2** (Supported)	N/A	Yes	
Common Sense Parenting (CSP) A group-based class for parents led by a credentialed trainer who focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior. Each class is formatted to include a review of the prior session, instruction of the new skill, modeled examples, skill practice/feedback, and a summary. The goals of ***Common Sense Parenting (CSP)*** are to (a) Equip parents with a logical method for changing their children's behaviors through teaching positive behaviors, social skills, and methods to reduce stress in crisis situations; and (b)	Parents/caregivers of children ages 6 – 16 to increase children's positive behavior, decrease negative behavior, including delinquent and aggressive behavior	Six weekly, 2-hour sessions Duration: 6 weeks	**2** (Supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Provide parents with practical strategies for enhancing parent-child communication and building robust family relationships.						
Community Reinforcement + Vouchers Approach (CRA + Vouchers) It has two main components. The Community Reinforcement Approach (CRA) component is an intensive psychosocial therapy emphasizing changes in substance use; vocation; social and recreational practices; and coping skills. The Voucher Approach is a contingency- management intervention where clients earn material incentives for remaining in treatment and sustaining cocaine abstinence verified by urine toxicology testing.[164]	Adults 18+ with diagnosis of cocaine abuse or dependence	60 minute weekly sessions. Duration: for 24 weeks[165]	**2** (Supported)	Cost: $2,602 (2013) Savings: $4,165 B-C: $4.45[166]	No, but other instructional materials exist.	
Dialectical Behavior Therapy (DBT) DBT is a mindfulness- and acceptance-based cognitive-behavioral therapy adapted for treating people with severe, complex, hard-to-treat multi-diagnostic conditions, in particular borderline personality disorder (BPD). DBT for Substance Abusers was developed to treat individuals with co-occurring substance use disorders and BPD.[167] DBT was found effective as a precursor for treating trauma in sexually abused young women in TRTG,[168] and for reducing PTSD symptoms.[169]	Ages 13–25. Borderline personality disorder (BPD), self-harm, and substance abuse.[170]	About six months (15–20 sessions), but could be more intensive or as individualized therapy twice a week and group skills sessions five days a week.[171] This could total 52 individualized sessions and 104 group sessions. Duration: 6 or more months	**2** (Supported)+ Not CEBC[172]	Cost: $2,148 (2016)[173] $150/ individual session + $60/ group session = for full year intensive, cost could be $14,000. DBT for Youth In Juvenile Justice: B-C: N/A[174]	Yes[175]	KY

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Dialectical Behavior Therapy (DBT) for Adolescent Self-Harming Behavior A cognitive behavioral treatment originally developed for chronically parasuicidal adults. DBT involves both group skills training and individual psychotherapy and focuses on mindfulness, interpersonal, emotion-regulating, and self-management skills. In studies included in this meta-analysis, DBT was modified to treat adolescents by shortening the treatment length, streamlining and simplifying some lessons, and including parents in some sessions. Studies in this analysis include adolescents in both inpatient and outpatient treatment settings presenting with suicidal ideation, non-suicidal self-harm, and/or prior suicide attempts. Treatment duration ranges from 2–19 weeks, with multiple sessions per week.	Ages 13–21 Self-Harming behavior	2–19 weeks	2 (Supported)+ Not CEBC[176]	Cost: $151 Savings: ($5.00) B-C: $0.97[177]	Yes[178]	
Families and Schools Together (FAST) A 2-year, multifamily group intervention based on social ecological theory, family systems theory, and family stress theory. FAST is designed to build relationships between and within families, schools, and communities (particularly in low-income areas) to increase all children's well-being, especially as they transition into elementary school.[179]	Families with children 0-12 years	2.5 hours weekly for 8 weeks, then monthly for 2 years[180]	**2** (Supported)	Cost: $1,694 (2009)[181] Savings: $439 B-C: $1.23[182]	Yes[183]	
Family-Focused Treatment for Adolescents (FFT-A) *FFT-A* is a psychosocial treatment for youth with bipolar disorder, consisting of family psychoeducation, communication enhancement training, and problem-solving skills training. It is given alongside of medications in the period just after an episode of bipolar disorder. The	Ages 9–17	21, 1-hour sessions: 12 weekly, 6	**2** (Supported)	N/A	Yes[184]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
clients are the adolescent, mother/father, and where possible, siblings and extended relatives.		biweekly, 3 monthly Duration: 9 months				
Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST) The group focuses on psychoeducation and general skill-building that can be applied to different relationships within the framework of three interpersonal problem areas: interpersonal role disputes, role transitions, and interpersonal deficits. The psychoeducation component includes defining prevention, educating members about depression, and discussing the relationship between feelings and interpersonal interactions. The interpersonal skill-building component consists of two stages. First, communication and interpersonal strategies are taught through didactics, activities, and role-plays. Once group members understand the skills, they are asked to apply them to different people in their lives, practicing first in group and then at home.	Ages 12–18	Two initial individual sessions and eight weekly 90-minute group sessions. Duration: 10 weeks	**2** (Supported)	Not available	Yes[185]	
Multi-Family Psychoeducational Psychotherapy (MF-PEP) *MF-PEP* is a manual-based group treatment for children aged 8-12 with mood disorders (depressive and bipolar spectrum disorders). *MF-PEP* is based on a biopsychosocial framework and utilizes cognitive-behavioral and family-systems based interventions. *MF-PEP* treatment begins and ends with children and parents	Ages 8–12	Eight 90-minute weekly sessions Duration: 8 weeks	**2** (Supported)	N/A	Yes[186]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
together; the bulk of each session is run separately for parents and children.						
New Beginnings (for children of divorce) A group and individual Cognitive-Behavioral Treatment-based session program for divorced mothers and their children to promote resilience in children after parental divorce. Groups are led by two master's level clinicians. The intervention focuses on changing aspects of the child's environment that directly involve the child, including increasing effective discipline strategies, increasing mother-child relationship quality and decreasing exposure to interparental conflict. There are two individual phone sessions that are structured, but also allow for tailoring the program to specific needs. Program skills are taught through presentations, role-playing, and videotapes.[187]	Mothers of children 5–18 years Antisocial-aggressive Behavior Close Relationships with Parents Externalizing Internalizing Mental Health - Other Reciprocal Parent-Child Warmth Sexual Risk Behaviors	10 group and 2 individual sessions Duration: 10–15 weeks	**2** (Supported)+ Blueprints Model Program for the mother-only program as the mother and child program has not been replicated yet[188]	N/A	Yes	
Positive Peer Culture (PPC) *PPC* is a peer-helping model designed to improve social competence and cultivate strengths in youth. "Care and concern" for others (or "social interest") is the defining element of ***PPC***. Rather than demanding obedience to authority or peers, *PPC* demands responsibility, empowering youth to discover their greatness. Caring is made fashionable and any hurting behavior totally unacceptable. *PPC* assumes that as group members learn to trust, respect, and take responsibility for the actions of others, norms can be established. These norms not only extinguish antisocial conduct, but more	Ages 11–22 in private schools, groups homes and residential treatment centers Groups of 8–12	45–90-minute structured group meetings depending on the setting and the participants, ideally 5 times per week Duration: typically 6–9 months.	**2** (Supported)	N/A	Yes[190]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
importantly reinforce pro-social attitudes, beliefs, and behaviors. Positive values and behavioral change are achieved through the peer-helping process. Helping others increases self-worth. As one becomes more committed to caring for others, s/he abandons hurtful behaviors.[189]						
Primary and Secondary Control Enhancement Training (PASCET) Structured individual psychotherapy intervention for depression. Treatment sessions and take-home practice assignments are built on research findings concerning cognitive and behavioral features of depression in children and adolescents, and on the two-process model of perceived control and coping.	Ages 8–15 who are depressed	10–15 sessions, 2 individual, 8 group-up to 18 months.	**2** (Supported)	N/A	Yes[191]	
Problematic Sexual Behavior- (PSB-CBT-S)- for School Age Children A family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems	Ages 6–12 for children with problematic sexual behavior and who may or may not have a history of trauma	4–5 months	**2** (Supported)	N/A	Yes[192]	
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) for Sexual Behavior Problems in Children ***TF-CBT*** is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic	For parents and children ages 3–12 with sexual Behavior Problems	12–18 total 30- to 45-minute weekly sessions for child and parent separately plus 30-	**2** (Supported)	N/A	Yes[194]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.[193]		to 45-minute conjoint child-parent sessions towards end of treatment				

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Adaptive Stepped Care A program for adults with chronic substance use and addiction as an alternative to standard methadone maintenance treatment. It is based on a treatment model that integrates patient–service matching and patient–provider matching along with behavioral contingencies to reinforce treatment adherence within a four-step continuum of counseling treatment intensity. The program's three main components are medication, graded intensities of counseling care, and behavioral contingencies to reinforce the treatment plan. It is delivered by a team that includes a medical doctor, a clinical psychologist, a counseling supervisor, and counseling staff to groups of up to 50 clients. [195]	Adults with opioid, cocaine, sedative and general substance abuse disorders	Duration: TBD	**2** (Supported)+ NREP rating of effective	N/A	N/A	
Adolescent Community Reinforcement Approach/Assertive Continuing Care (A-CRA/ACC)	Youth and young adults ages 12 and	Generally includes ten,1-hour	**2** (Supported)+	N/A	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
An outpatient program for youths and young adults between the ages of 12 and 24 who have substance use and co-occurring mental health disorders. A-CRA uses both behavioral and cognitive–behavioral techniques to replace environmental settings and cues that have supported alcohol or drug use with prosocial activities and new social skills that support recovery. A-CRA is the main component within Assertive Continuing Care (ACC), which provides home, school, or other community visits to youths following residential treatment for substance use disorders.[196]	24 with substance use and co-occurring mental health disorders	individual sessions; two 1-hour sessions with parents/caregiver; and two 1-hour sessions with both adolescents and parents/caregivers together Duration: 12 to 14 weeks	NREPP rating of effective			
Adolescent Coping with Depression (CWD-A) A behavioral intervention that seeks to increase the family, social, and educational/vocational reinforcers of an adolescent to support recovery from substance abuse and dependence.	Adolescents aged 12 to 22 with substance abuse issues	3 types of sessions: adolescents alone, caregivers alone, and adolescents and caregivers together.	**2** (Supported)	Average cost is between $1,200 - $1,600 per person[197]	Yes[198]	
Adolescent-focused Family Behavior Therapy A comprehensive, outpatient program for managing problem behaviors such as adolescent substance misuse. FBT is based on elements of the community reinforcement approach to substance use, which posits that environmental elements and relationships have a significant role in encouraging and discouraging behaviors. Adolescent-focused FBT is aimed at replacing negative influences (people, places, situations) with positive influences to achieve patient goals. Cognitive and behavioral skills are developed through role play,	With substance abuse and non-cohesive family relations	Begins with 1- to 2-hour sessions twice a week, which are reduced as the adolescent progresses and achieves treatment goals. Duration: typically between 6–12 months.	**2** (Supported)+ NREPP rating of effective *Campbell 2015 Review:* Significant effect was found for family functioning but not non-opioid drug abuse at a 12 month follow-up.[200]	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
therapeutic assignments, and the use of family support systems. Parent participation is integral to treatment so parents attend sessions with their child.[199]						
Adult-focused Family Behavior Therapy Includes more than a dozen treatments including management of emergencies, treatment planning, home safety tours, behavioral goals and rewards, contingency management skills training, communication skills training, child management skills training, job-getting skills training, financial management, self-control, environmental control, home safety and aesthetics tours, and tele-therapy to improve session attendance.	Adults with drug abuse and dependence, as well as other co-existing problems such as depression, family dysfunction, trauma, child maltreatment, noncompliance, employment, HIV/STIs risk behavior, and poor communication skills	1 to 2-hour initial outpatient or home-based sessions once or twice in the first week then fades in frequency depending on multiple factors. Duration: 6–12 months	**2** (Supported)	N/A	Yes	
Brief Marijuana Dependence Counseling (BMDC) An intervention designed to treat adults with a diagnosis of cannabis dependence. Using a client-centered approach, BMDC targets a reduction in the frequency of marijuana use, thereby reducing marijuana-related problems and symptoms. BMDC is based on the research protocol used by counselors in the Center for Substance Abuse Treatment's (CSAT's) Marijuana Treatment Project, which was conducted in the late 1990s. BMDC is implemented as a 9-session, multicomponent therapy that includes elements of motivational enhancement therapy (MET), cognitive behavioral therapy (CBT), and case management.	Adults with cannabis dependence	9 sessions Duration: 12 weeks	**2** (Supported)+ NREPP rating of effective	Cost: $822 Savings: $7,611 B-C: $14.65[201]	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Brief Strategic Family Therapy *BSFT* is a brief intervention used to treat adolescent drug use that co-occurs with other problem behaviors. *BSFT* is based on three basic principles: First, *BSFT* is a family systems approach. Second, patterns of interaction in the family influence the behavior of each family member. The role of the *BSFT* counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors.[202]	Parents with adolescents 6-18 with drug use that co-occurs with other problem behaviors such as conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior.	12-17 weekly 60-90 minute sessions (range 8-24 sessions)[203]	**2** (Supported)[204]	Cost: $3,200[205]	Yes	
Ecologically Based Family Therapy Addresses multiple ecological systems and originated from the therapeutic work with substance-abusing adolescents who have run away from home. The treatment was developed to address immediate needs, to resolve the crisis of running away, and to facilitate emotional re-connection through communication and problem solving skills among family members. The intervention includes family systems techniques such as reframes, relabels, and relational interpretations; communication skills training; and conflict resolution, but also therapeutic case management in which systems outside the family are directly targeted.[206]	Ages 12–17 with substance abuse issues	12 home-based (or office-based) family therapy sessions and 2–4 individual HIV prevention sessions. Duration: 12-16 weeks	**2** (Supported)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Families Facing the Future for parents taking methadone The parent training format combines a peer support and skill training model to teach skills using the "guided participant modeling." Skills are modeled by trainers and other group members, then discussed and practiced by participants. Video-tape is frequently used in modeling the skills or during practice of the skills. The training focuses on affective and cognitive as well as behavioral aspects of performance.[207]	Adults and their children ages 5–14[208]	One, five-hour family retreat and 32 hour-and-a-half groups-based parent training sessions. Sessions are conducted twice a week.[209] Duration: 16 weeks	**2** (Supported)	N/A	Yes[210]	
Functional Family Therapy (FFT) for adolescents with substance use disorder FFT is a family intervention program for dysfunctional youth. ***FFT*** has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. While ***FFT*** targets youth aged 11–18, younger siblings of referred adolescents often become part of the intervention process. ***FFT*** has been conducted both in clinic settings as an outpatient therapy and as a home-based model.[211]	11–18 year olds with drug or alcohol abuse (but also for conduct disorder and violent acting-out)	8 to 12 one-hour sessions for mild cases and up to 30 sessions of direct service for more difficult situations. Duration: sessions are spread over a three-month period.	**2** (Supported) *Campbell 2015 Review:* Mixed effects were found in that cannabis use was reduced at a 4 month follow-up disappears in the longer term.[212]	Cost: $3,134 Savings and B-C: N/A [213]	Yes[214]	CA, MD, NY
Helping Women Recover & Beyond Trauma (HWR/BT) [Substance Abuse Treatment (Adult)] *HWR/BT* is a 29-session intervention that integrates three theories: a theory of addiction, a theory of women's psychological development, and a theory of trauma; and then adds a psychoeducational component that teaches women what trauma is, its process, and its impact. The program model is organized into seven modules. The first four: Self, Relationships, Sexuality, and Spirituality are	Adult women with addictive disorders and a trauma history Opioid drug abuse, positive parenting	1 or 2, 90-minute sessions of Helping Women Recover per week. 1 or 2, 2-hour sessions of Beyond Trauma per week	**2** (Supported)	N/A	Yes[216]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The last three: Violence, Abuse, and Trauma; The Impact of Trauma on Women's Lives; and Healing from Trauma; focus on the trauma with a major emphasis on coping skills, with specific exercises for developing emotional wellness. The program comes with facilitator's manuals, two participant workbooks (A Women's Journal and A Healing Journey), and 3 DVDs. The materials are designed to be user-friendly and self-instructive. A special edition for criminal justice settings has also been developed.[215]		Duration: 29 total sessions, over approximately 4–7 months				
Methadone maintenance for opioid use disorder Methadone is an opiate substitution treatment used to treat opioid dependence. It is a synthetic opioid that blocks the effects of opiates, reduces withdrawal symptoms, and relieves cravings. Methadone is a daily medication dispensed in outpatient clinics that specialize in methadone treatment and is often used in conjunction with behavioral counseling approaches.	Adults with opioid drug abuse	N/A	**2** (Supported)+ (Rated as effective by NREPP)[217]	Cost: $3,613 (2012) Savings: $4,488 B-C: $2.19[218]	N/A	
Buprenorphine (or buprenorphine/naloxone) maintenance treatment for opioid use disorder Buprenorphine/buprenorphine/naloxone is an opiate substitution treatment for opioid dependence. It is a daily medication generally provided in addition to counseling therapies. Buprenorphine/buprenorphine/naloxone is a partial agonist that suppresses withdrawal symptoms and blocks the effects of opioids. Two versions of buprenorphine are used in the treatment of opioid	Adults with opioid drug abuse	N/A	**2** (Supported)+ (Rated as effective by NREPP)[219]	Cost: $4,431 Loss: ($3,458) B-C: $1.75[220]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
dependence. Subutex consists of buprenorphine only while Suboxone is a version of buprenorphine that combines buprenorphine and naloxone. The addition of naloxone reduces the probability of overdose and reduces misuse by producing severe withdrawal effects if taken any way except sublingually. Suboxone is generally given during the maintenance phase and many clinics will only provide take-home doses of Suboxone. Buprenorphine and buprenorphine/naloxone are alternatives to methadone treatments and, unlike methadone, can be prescribed in office-based settings by physicians that have completed a special training.						
Injectable naltrexone for opiates Long-acting injectable naltrexone is used as an alcohol or opiate antagonist to treat alcohol or opiate dependence. Naltrexone is an antagonist that blocks the euphoric effects of alcohol or opiates, and patients do not develop tolerance or experience withdrawal symptoms when they stop taking the drug. It is intended to reduce cravings and prevent relapse.[221]	Adults with opioid drug abuse	N/A	**2** (Supported)+ (Not CEBC but reviewed by WSIPP: Effect size: -.566)[222]	Cost: $16,356 (2015) Loss: ($17,409) B-C: ($0.05)[223]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
AVANCE Parent-Child Education Program AVANCE's philosophy is based on the premise that education must begin in the home and that the parent is the child's first and most important teacher. The PCEP fosters parenting knowledge and skills through a nine-month, intensive bilingual parenting curriculum that aims to have a direct impact on a young child's physical, emotional, social, and cognitive development. Parents/primary caregivers are taught how to make toys out of common household materials and how to use them as tools to teach their children school readiness skills and concepts. Monthly home visits are also conducted to observe parent-child interactions and provide guidance in the home on learning through play. Along with the parenting education component, parents/primary caregivers are supported in meeting their personal growth, developmental and educational goals to foster economic stability. While parents/primary caregivers attend classes, their children under the age of three are provided with early childhood enrichment in a developmentally appropriate classroom setting which aims to build the academic, social, and physical foundation necessary for school readiness.[224] Note that this program appears to require a classroom component, and that portion of the cost may not be reimbursable by FFPSA.	Parents with children from birth to 3, pregnant women and/or partners of pregnant women, especially those with challenges such as poverty; illiteracy; teen parenthood; geographic and social marginalization; and toxic stress	Parent/primary caregiver contacts: Once per week for three hours - Child contacts: Once per week for three hours (early childhood education provided while parents are in class) Parent-Child contacts: Once per month for 30–45 minutes (minimum) in the home	**2** (Supported)	N/A	Yes[225]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Home Instruction for Parents of Preschool Youngsters (HIPPY) A home-based and parent-involved school readiness program that helps parents prepare their children ages three to five years old for success in school and beyond. The parent is provided with a set of carefully developed curriculum, books, and materials designed to strengthen their child's cognitive and early literacy skills, as well as their social, emotional, and physical development. The ***HIPPY*** Curriculum contains 30 weekly activity packets, a set of storybooks, and a set of 20 manipulative shapes for each year. In addition to these basic materials, supplies such as scissors and crayons are provided for each participating family. The program uses trained coordinators and community-based home visitors who go into the home. These coordinators and home visitors role-play the activities with the parents and support each family throughout.	3–5 years old Child development and school readiness, Positive parenting practices	Weekly home visits Duration: A minimum of 30 weeks of interaction with the home visitor-- up to three years total of home visiting services Duration: 30 weeks or more	**2** (Supported) Research outcomes: Child development and school readiness, Positive parenting practices	Cost: $2,050 (2016) Cost: $2,050 Loss: ($499) B-C: ($0.88)[226]	Yes[227]	
SafeCare A home-visiting program where parents are taught child behavior management, home safety, and child healthcare skills in order to avoid child maltreatment.	Parents of children under the age of 5 who are at risk of child maltreatment.	Weekly 60 minute home visits Duration:15–20 weeks	**2** (Supported)	Cost: $1,950 (2010) Savings: $3,563 B-C: $20.25[228]	Yes[229]	AR, MT, TX, WA

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Tuning In To Kids (TIK) Work with parents and caregivers of young children with disruptive behaviors, can be used as a preventative/early intervention strategy. A parenting program that focuses on emotions and emotion coaching. Note that this program appears to require a classroom component, and that portion of the cost may not be reimbursable by FFPSA.	Ages 1–18	6–10 sessions 2 day, 14 hour training to prepare staff	**2** (Supported)	N/A	Yes[230]	
Tuning In To Teens (TINT) Work with parents and caregivers of adolescents with disruptive behaviors, can be used as a preventative/early intervention strategy. A parenting program that focuses on emotions and emotion coaching. New Jersey modified TINT for overlays to help staff work with adoptive and guardian parents. Note that this program appears to require a classroom component, and that portion of the cost may not be reimbursable by FFPSA.	Ages 10–18	6–10 sessions Duration: 6-10 weeks	**2** (Supported)	N/A 2 day, 14 hour training to prepare staff	Yes[231]	NJ

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Child Parent Relationship Therapy (CPRT) A brief intervention used to treat adolescent drug use that occurs with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior.	Ages 12–18 with drug use and other problem behaviors.	12–16 sessions Duration: 12-16 weeks	**2** (Supported)	Cost: $545 Savings: -$192 B-C: $0.65[232]	Yes[233]	KY
Child-Parent Psychotherapy (CPP)[234] The aim of this intervention is to support and strengthen the relationship between a child and his or her parent (or caregiver) to help restore child's sense of safety, attachment, and appropriate affect and improve the child's cognitive, behavioral and social function. This program is typically conducted in a(n): Adoptive Home, Birth Family Home, Community Agency, Foster/Kinship Care, Outpatient Clinic or School	Ages 0–5 who have experienced a trauma, and their caregivers to improve secure attachment in the children.	1 to 1.5-hour sessions each week Duration: 52 weeks	**2** (Supported)	N/A Training costs available.[235]	Yes[236]	IL, IN, WI
Functional Family Therapy (FFT) FFT is a family counseling intervention targeted toward youth-family conflict areas. While FFT is increasingly being used in child welfare, the vast majority of FFT studies are based on programs targeted toward high risk youth who have had previous contact with the juvenile justice system or who are at risk of delinquency. A clinician meets in the home with the youth and his or her family to progressively build protective factors against delinquency while mitigating risk factors, or to improve parent and youth functioning in child welfare. The intermediate program goals focus on improving interpersonal relationships between family	Ages 11–18. Youth-family conflict areas, such as physical or verbal aggression, and other behavioral or emotional problems	12-14 sessions Duration: 3–4 months[238]	**2** (Supported)[239]	Cost: $3,134 Savings: A New Jersey study found cost savings over a multi-year period of FFT implementation.[240]	Yes[241]	CA, MD

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
members and then building those skills in extra-family relationships.[237]						
Intensive Family Preservation Services (HOMEBUILDERS®) A prevention intervention that consists of short term, in-home, intensive family-based services targeted at families facing child removal.	Parents of children ages 3–25 who are at risk of child maltreatment or foster care placement due to the behavior of the child.	Duration: 4–6 weeks	**2** (Supported)[242]	Cost: $3,547 (2008) Savings: $13,005 B-C: $4.73 [243]	Yes[244]	DC, KY, MD, WA
Multisystemic Therapy (MST)[245] An intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. The California Evidence Based Clearinghouse for Child Welfare lists three adaptations of MST that have high ratings for research support—MST Child Abuse and Neglect (MST-CAN), and MST for Youth with Problem Sexual Behavior (MST-YPSB).	Ages 12–17, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system	Weekly sessions, with multiple therapist-family contacts each week, that become less frequent as discharge approaches. Duration: 4 months	**2** (Supported) *Campbell 2015 Review:* No significant effects were found for decreasing the need for out-of-home placements.[246]	Cost: $7,076 Savings: $4,824 B-C: $1.62[247]	Yes[248]	CA, CO, MD, NY
Parenting with Love and Limits (PLL) An integrative group and family therapy approach that integrates parenting skills with in home trauma-informed family therapy and child behavioral management with the parents and their kinship network to prevent high risk youth from home removal or to accelerate permanency while preventing re-entry into foster care.	Parents of youth ages 10-18 Family conflict, unresolved trauma, and child behavioral or emotional	6- 20 individual/family counseling sessions (90 minutes on average).[249]	**2** (Supported)	Cost: $2,600 per youth[250] *Savings:* $1,197.39 to $2,268.33 per youth	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
	problems, juvenile delinquent behavior	Duration: 3-4 months				
Strengthening Families for Parents and Youth 10–14 A family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. It is theoretically based on several etiological and intervention models including the biopsychosocial vulnerability, resiliency, and family process models.	Parents and their children ages 10–14 with substance use, aggression and school success issues.	Seven 2-hour group sessions and four optional booster sessions Duration: 11 weeks	**2** (Supported)+ (Rated as effective by NREPP)	Cost: $754 (2009) Savings: $4,547 B-C: $6.45[251]	Yes	

Section III: Interventions that Appear to Qualify Under the FFPSA Criteria of *Promising*

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
1-2-3 Magic This is a group format discipline program for parents of children. The program can be used with children with and without cognitive impairments. 1-2-3 Magic divides the parenting responsibilities into three straightforward tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking.[252]	2–12 years of age Behavior problems	1–2, 1.5-hour sessions per week Duration: 4–8 weeks	**3** (Promising)	N/A	Yes (plus Spanish)[253]	
ACTION A developmentally sensitive group treatment program for depressed youth that follows a structured therapist's manual and workbook. Each of the 20 group and 2 individual meetings lasts approximately 60 minutes. The child treatment is designed to be fun and engaging while teaching the youngsters a variety of skills and therapeutic concepts that are applied to their depressive symptoms, interpersonal difficulties, and other stressors.	9 to 14-year olds who are depressed	2 one-hour sessions a week, but one session will work if time/transportation is an issue. 20 group meetings and 2 individual meetings Duration: 11 weeks	**3** (Promising)	N/A	Yes	
Adolescent Coping with Depression (CWD-A) A cognitive behavioral group intervention that targets specific problems typically experienced by depressed adolescents. Each participant receives a workbook that provides structured learning tasks, short quizzes, and homework forms. To encourage generalization of skills to everyday situations, adolescents are given homework	Ages 13–17. Anxiety, discomfort, irrational/negative thoughts, limited experiences of pleasant activities, poor social skills	16 two-hour sessions for mixed-gender groups of up to 10 adolescents Duration: 8 -16 weeks	**3** (Promising) (NREPP ratings: 3.6–3.8)	N/A[255]	Yes[256]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
assignments that are reviewed at the beginning of the subsequent session.[254]						
Behavioral Activation Treatment for Depression (BATD) The BATD program's primary goal is to reduce depressive symptoms. It is aimed at helping clients reconnect with their values across several life areas. It begins with behavioral monitoring of daily activities with an examination of the extent to which the client currently is living according to these values. In moving the client towards this more valued life, *BATD* uses a structured approach aimed at identifying activities that fit within the client's values on a daily basis. The program also uses contracts to recruit social support for these efforts. *BATD* can be conducted individually or in groups. It was designed to be a 10-12 session treatment, but has been shown to be efficacious in shorter durations.	Depressed adults including those with substance abuse problems	30–50-minute weekly sessions Duration: 10–12 weeks	**3** (Promising)	N/A	Yes	
Brief Eclectic Psychotherapy for PTSD (BEPP) The 16-session ***Brief Eclectic Psychotherapy for PTSD (BEPP)*** protocol starts with psychoeducation on posttraumatic stress disorder (PTSD). The patient and his/her partner learn to understand the symptoms of PTSD as dysfunctional, and caused by the traumatic event. The patient will then receive 4-6 sessions of relaxation and imaginary exposure, focused on the suppressed intense emotions of sorrow.	Adult patients suffering from posttraumatic stress disorder	45–60-minute weekly sessions Duration: 16 weeks	**3** (Promising)	N/A	Yes	
C.A.T. Project The program provides education about anxiety, skills for identifying and managing anxiety, and an approach to face	Youth ages 12–18	Duration: 16 weeks	**3** (Promising)	N/A	Yes[257]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Intervention
Mental Health						
one's fears and develop mastery. This requires exposure tasks.						
Child-Centered Play Therapy (CCPT) A developmentally responsive, play-based mental health intervention for children who are experiencing social, emotional, behavioral, or relational disorders. CCPT uses play and the therapeutic relationship to provide a safe, consistent therapeutic environment in which a child can experience full acceptance, empathy, and understanding from the counselor and process inner experiences and feelings through play and symbols. In CCPT, a child's experience within the counseling relationship is the factor that is most healing and meaningful in creating lasting, positive change. The goal of CCPT is to develop the child's potential to move toward integration and self-enhancing ways of being.[258]	Children ages 3–10 with problems in general functioning, anxiety and disruptive behavior disorders	16–20 weekly, 45-minute individual play sessions[259] Duration: 16–20 weeks	**3** (Promising)+ (NREPP rating)	N/A	Yes	
CICC's Effective Black Parenting Program (EBPP) *EBPP* is a parenting skill-building program created specifically for parents of African-American children. It was originally designed as a 15-session program to be used with small groups of parents. A one-day seminar version of the program for large numbers of parents has been created.[260]	For African-American parents/caregivers of children ages 0 – 17 where parental rejection, quality of family relationships, and child behavior outcomes may be present	Weekly three-hour sessions or a one-day 6.5 hours abbreviated seminar version Duration: 1-15 weeks	**3** (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Cognitive Behavioral Analysis System of Psychotherapy (CBASP) Developed solely for the treatment of the chronic depressive adults. Most patients present with maltreatment developmental histories that impede normal cognitive-emotive growth in the ability to related socially with others. Hence, patients begin treatment functioning in a primitive manner meaning their thought and feeling patterns are not very organized, self-centered, and prelogical, and they talk to therapists in a monologic manner. Chronic depression is essentially a chronic mood disorder and does not fit the typical description of major depression that comes and goes as a "thinking disorder."	Chronically depressed adults	Thirty 1-hour weekly sessions Duration: 7–8 months	**3** (Promising)	N/A	Yes	
Cognitive Processing Therapy (CPT) Developed originally for use with rape and crime victims, CPT begins with the trauma memory and focuses on feelings, beliefs, and thoughts that directly emanated from the traumatic event. The therapist then helps the clients examine whether the trauma appeared to disrupt or confirm beliefs prior to this experience, and how much the clients have over-generalized (over-accommodated) from the event to their beliefs about themselves and the world. Clients are then taught to challenge their own self-statements using a Socratic style of therapy (leading clients to understand their reasoning processes and beliefs through questions), and to modify their extreme beliefs to bring them into balance. CPT can be conducted individually or in groups where the written trauma account is completed in an individual session.[261]	Older adolescents and adults. Trauma symptoms, including depression, anxiety, guilt/shame, or anger	One-on-one: 1–2 sessions per week totaling 12 sessions (50 minutes per session), Group: weekly 90-minute sessions Duration: about 12 weeks	**3** (Promising)	N/A	Yes[262]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT) Helps the child heal from the trauma of the physical abuse, empowers and motivates parents to modulate their emotions and use effective non-coercive parenting strategies, and strengthens parent-child relationships while helping families stop the cycle of violence. Program is grounded in cognitive behavioral theory and incorporates elements (e.g., trauma narrative and processing, positive reinforcement, timeout, behavioral contracting) from CBT models for families who have experienced sexual abuse, physical abuse, and/or domestic violence, as well as elements from motivational, family systems, trauma, and developmental theories.	Children ages 3–17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies and children may present with PTSD symptoms, depression, behavioral problems and other difficulties	16 individual or group sessions Duration: 16–20 weeks	**3** (Promising)	N/A ($2k–$3k per day for training)[263]	Yes[264]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Defiant Children: A Clinician's Manual for Assessment and Parent Training (The Barkely Method of Behavioral Parent Training) A scientifically based behavioral paradigm and set of methods in which to train parents in the management of defiant/ oppositional defiant disorder (ODD) children. The program involves training parents in 10 steps through weekly sessions that have proven effectiveness in reducing defiance and ODD symptoms in children ages 4-12 years. The manual also provides information on the assessment of these children prior to intervention and with rating scales to use to monitor changes that occur during treatment. The manual further provides the parent handouts that are to be given by the therapist at each step. Therapists are granted limited permission to photocopy the assessment tools and rating scales as well as the parent handouts for use with families undergoing treatment in their practice.	Parents of children ages 4–12	1 hour (individual parent) or 2 hours (group parent) training per week Duration: 10 weeks	**3** (Promising)	N/A	Yes	
Exchange Parent Aide Program consists of trained, professionally supervised individuals (volunteer or paid) who provide supportive and educational in-home services to families at risk of child abuse and neglect. Agencies elect to use paid and/or volunteer Parent Aides to provide services based on their community needs and resources. Services are strength-based and family-centered. Auxiliary services enhance service delivery (e.g., group-based parenting classes).	Ages 0–12	1 or 2 home visits per week, lasting 1–2 hours each Duration: 9–12 months	**3** (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach) The Fairy Tale Model is a model of trauma-informed psychotherapy and is so named because it is taught with the telling of a fairy tale, in which each element of the story corresponds to one of the phases in treatment. Following the treatment manual, *Treating Problem Behaviors: A Trauma-Informed Approach*, this phase model of trauma-informed treatment calls for a given phase of treatment to be pursued until the client outcome specified for that phase has been achieved. The treatment manual has scripted interventions for working with teens individually.[265]	Ages 13–18	Varies by client/situation	**3** (Promising)	N/A	Yes	
Family Connections Multifaceted, community-based service program that works with families in their homes and in the context of their neighborhoods to help them meet the basic needs of their children and prevent child maltreatment. Individualized family intervention is geared to increase protective factors, decrease risk factors, and target child safety, well-being, and permanency outcomes.	Children 0–17 in families at risk of maltreatment	One hour once per week Duration: 3–4 months, with an optional 90-day extension if needed	**3** (Promising)[266]	N/A	Yes	CO, MD
Family Spirit[267] ▪ John's Hopkins Family Spirit Research Findings: https://www.jhsph.edu/research/affiliated-programs/family-spirit/proven-results/research-findings/ ▪ ChildTrends: https://www.childtrends.org/programs/family-spirit	Addresses maternal stress, substance use, depression and behavior problems, while promoting children's earliest social, emotional and behavioral development					

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
▪ Springer: https://link.springer.com/article/10.1007/s11121-012-0277-2						
Helping the Noncompliant Child A skills-training program aimed at teaching parents how to obtain compliance in their children ages 3 to 8 years old. The goal is to improve parent-child interactions in order to reduce the escalation of problems into more serious disorders (e.g., conduct disorder, juvenile delinquency).	Children ages 3–8 with disruptive behavior Together	60-to-90–minute sessions once or Two sessions per week, for a total of 5–14 sessions Duration: 7–14 weeks	**3** (Promising)[268]	Cost: $1,612 Savings: $857 B-C: $2.23[269]	Yes[270]	
Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) Interpersonal Psychotherapy (IPT) is a time-limited, manualized psychosocial treatment for depression in adolescents and adults. IPT for adults has been rated by the CEBC in the area of Depression Treatment (Adult). IPT identifies how interpersonal issues are related to the onset or maintenance of depressive symptoms while recognizing the contributions of genetic, biological, and personality factors to vulnerability for depression. Patients work to understand the effects of interpersonal events on their mood and to improve their communication and problem-solving skills in order to increase their effectiveness and satisfaction in current relationships.[271]	Ages 12–18	45–50-minute weekly sessions Duration: 12–16 weeks	**3** (Promising)	N/A	Yes	
Life Space Crisis Intervention (LSCI) *LSCI* is an interactive therapeutic strategy for turning crisis situations into learning opportunities for children and youth	Adults working and living with children and youth who	The intervention is intended to be used as needed	**3** (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
with chronic patterns of self-defeating behaviors. *LSCI* views problems or stressful incidents as opportunities for learning, growth, insight, and change.	escalate incidents into no-win power struggles, distort reality, are self-abusive, engage in destructive peer relationships, lack social skills, and show little conscience for aggressive behavior	when individuals are in crisis and display disruptive behaviors.				
Mindfulness-Based Cognitive Therapy for Children (MBCT-C) A psychotherapy for anxious or depressed children adapted from MBCT for adults which has been rated by the CEBC in the Depression Treatment (Adult) topic area. The adult and child programs both combine mindfulness-based theory and practices with cognitively oriented interventions. The aim is to improve affective self-regulation through development of mindful attention and decentering from thoughts and emotions. Unlike cognitive therapy, no effort is made to restructure or change existing thoughts and emotions. It includes simple meditation techniques to help participants become more aware of their experience in the present moment, by tuning in to moment-to-moment changes in the mind and the body.[272]	Children 8–12 years old	Weekly therapy sessions lasting 90-minutes, conducted individually or in small groups of 6–8 children Duration: 12 weeks	**3** (Promising)	N/A	Yes	
Multisystemic Therapy Building Stronger Families (MST-BSF)[273]	For co-occurring parental substance abuse and child	N/A	**3** (Promising) (Not CEBC)	N/A	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
MST-BSF is an integrated treatment model for the co-occurring problem of parental substance abuse and child maltreatment among CWS involved families.[274]	maltreatment among CWS-involved families.					
Nurturing Parenting Program for Parents and their School-age Children 5 to 12 Years A 15-session program that is group-based, and family-centered. Parents and their children attend separate groups that meet concurrently. Each session is scheduled for 2.5 hours with a 20-minute break in which parents and children get together and have fun. The lessons in the program are based on the known parenting behaviors that contribute to child maltreatment.[275]	Parents of children ages 5-12	2.5 hour sessions Duration: 15 weeks	**3** (Promising)	B-C:.87[276]	Yes	
Parents Anonymous A prevention and treatment program for stressed families at risk of becoming involved in the CW system. Addresses a comprehensive list of caregiver issues such as child development, communication skills, positive discipline, parent roles, age appropriate expectations, effecting parenting strategies anger management, mental health, drug/alcohol/safety and self-care through weekly adult support groups.	Ages 0–18. Child, parent, caregivers	Group treatment, groups meet 1.5–2 hour each week. Duration: at least 3–4 months. For CW-involved families, likely 12–18 months	**3** (Promising)[277]	N/A (Parent Leader certification = $3k; presume staff certification cost is similar; unable to find cost info for weekly groups)	Yes[278]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Play and Learning Strategies–Infant Program The *PALS I* curriculum was developed to facilitate parents' mastery of specific skills for interacting with their young children including paying attention to and correctly interpreting babies' signals, responding contingently to signals, and using rich language. It is designed as a preventive intervention program to strengthen the bond between parent and baby and to stimulate early language, cognitive, and social development.	Children 5–15 months and their families	Weekly 90-minute sessions Duration: 11 weeks	**3** (Promising)	N/A	Yes	
Solution-Based Casework (SBC) A case management approach to assessment, case planning, and ongoing casework. The approach is designed to help the caseworker focus on the family in order to support the safety and well-being of their children. The goal is to work in partnership with the family to help identify their strengths, focus on everyday life events, and help them build the skills necessary to manage situations that are difficult for them. This approach targets specific everyday events in the life of a family that have caused the family difficulty and represent a situation in which at least one family member cannot reliably maintain the behavior that the family needs to accomplish its goals. The model combines the best of the problem-focused relapse prevention approaches that evolved from work with addiction, violence, and helplessness, with solution-focused models that evolved from family systems casework and therapy.[279]	Children ages 0–17 and their parents/caregivers	Varies according to family needs	**3** (Promising)[280]	N/A	Yes	CO

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) Predominantly cognitive – behavioral and Dialectical Behavioral Therapy and Complex Trauma theory. The curriculum also incorporates elements from early versions of Trauma Adaptive Recovery Group Education and Therapy (TARGET)[281] and Trauma and Grief Components Therapy (TGCT).[282] Key components: Mindfulness practice, Problem Solving and Meaning Making, Relationship building/ Communication Skills, Distress Tolerance, and psychoeducation regarding stress, trauma, and triggers.[283]	Ages 12–21 for adolescents with complex trauma. Prevents runaways,	16, 60 minute sessions Duration: 12 or more weeks	**3** (Promising)+ rating based on outcome research as no registry recognizes this intervention but it combine effective strategies[284]	N/A	Yes[285]	Yes
Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP-ART) ***SITCAP-ART*** is a comprehensive trauma intervention program, modified from the original *Structured Sensory Intervention for Traumatized Children, Adolescents and Parents (SITCAP)* program. It integrates cognitive strategies with sensory/implicit strategies. When memory cannot be linked linguistically in a contextual framework, it remains at the symbolic level for which there are no words to describe. To retrieve that memory so it can be encoded, given a language, and then integrated into consciousness, it must be retrieved and externalized in its symbolic perceptual (iconic) form.	Ages 12–17, children/ adolescents & parents/caregivers. At-risk or adjudicated youth with a history of trauma and/or loss.	Weekly 1-hour sessions Duration: 8–10 weeks	**3** (Promising)	N/A (Training on-site or via TLD Institute trainings – min 2 day training ($300–$900/person)	Yes[286]	
Trauma and Grief Component Therapy for Adolescents (TGCT-A) A manualized group or individual treatment program for trauma-exposed or traumatically bereaved older children and adolescents that may be implemented in school,	Ages 12–20	50–75 minute weekly sessions Duration:for 12–26 weeks[287]	**3** (Promising)[288]	N/A	Yes[289]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Mental Health						
community mental health, clinic, or other service settings. The program has been implemented with a wide range of trauma-exposed and traumatically bereaved older child and adolescent populations, in both the United States and international settings. These populations include youth impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events.						
Wraparound (child treatment focus) Team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties.	Children age 0–17	Intensive engagement and planning process of 2, 60–90 minute sessions and 2 team sessions in the first month. Duration: About 14 months	**3** (Promising)	Yes but varies by the study[290]	Yes	AR, HI, NE, RI, TN

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support) A community-based prevention and diversion program utilizing Wraparound Family Team Conferencing to successfully engage and serve families who are at risk of child abuse and neglect.[291]	Families at high risk for abuse or neglect with children ages 0–17	Varies by needs of family. Averages 5–10 hours per week, with higher intensity at entry to program Duration: 6 months	**3** (Promising)	N/A	Yes	
Treatment For Youth With Substance Abuse						
Seeking Safety (for youth) A present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. The treatment is available as a book, providing both client handouts and clinician guidelines. The treatment may be conducted in group or individual format for adolescents (both females, and males) in various settings (e.g., outpatient, inpatient, residential, home care, and schools). ***Seeking Safety*** consists of 25 topics that can be conducted in any order and number. Examples of topics are Safety, Asking for Help, Setting Boundaries in Relationships, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Recovery Thinking, Taking Good Care of Yourself, Commitment, Coping with Triggers, Self-Nurturing, Red and Green Flags, and Life Choices.[292]	Children and adolescents ages: 12–17 with \substance abuse and trauma [Seeking Safety has also been rated by the CEBC in the areas of Substance Abuse Treatment (Adult) and Trauma Treatment.]	• Group intervention (between 2 and 50 participants per group); is also available as an individual intervention. Sessions intensity is flexible: 1 hour once per week, others 1.5 hours twice a week, etc. Duration: 3–6 months	**3** (Promising)	Cost: $526 (2013)[293]	Yes[294]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Treatment for Adults with Substance Abuse						
Alcohol Behavioral Couple Therapy This is an outpatient treatment for individuals with an alcohol use disorder, which includes their intimate partners in the treatment program. ABCT assumes that an individual's alcohol use has an impact on a couple's relationship and that this relationship conflict can similarly affect the individual's alcohol use. Based on social learning theory and the family systems model, ABCT incorporates communication, problem-solving, self-control, and contingency-management skills to maintain abstinence from substance use and promote healthy relationship functioning.	Adults with Alcohol Use and Alcohol Use Disorder	12–20 weekly sessions of up to 90 minutes each, with both the client and intimate partner.[295] Duration: 21 weeks	**3** (Promising)+ NREP rating of promising	N/A	Yes	
Cognitive-Behavioral Coping-Skills Therapy for alcohol or drug use disorders Encompasses a variety of interventions that emphasize different targets. The individual and group treatments include motivational interventions, contingency management strategies, and Relapse Prevention and related interventions with a focus on functional analysis.[296]	Adults	Not available	**3** (Promising) Not CEBC	Cost: $842 (2013) Savings: $5,572 B-C: $21.95[297]	Not available	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
Matrix Model Intensive Outpatient program The Matrix model is an intensive, outpatient treatment approach for individuals with substance use disorders, which was developed through 30 years of experience in real-world treatment settings. The intervention integrates aspects of several treatment approaches, including cognitive-behavioral therapy, contingency management, motivational interviewing, 12-step facilitation, family involvement, and supportive/person-centered therapy.	Adults	Duration: 16 weeks	**3** (Promising)+ NREPP for Stimulant Use	Cost: $1,281 Savings: ($2,748) B-C: ($2.15)[298]	Yes	ME
Seeking Safety (for adults) See the description in the catalog entry above.[299]	Adults with substance abuse and trauma	Group intervention 1-1.5 hour once or twice per week Duration: 3–6 months (See the description in the catalog entry above.)	**3** (Promising)	$526 (2013)[300]	Yes[301]	
Sobriety Treatment and Recovery Teams (START) START pairs child protective services workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. (Note this is a case	Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor	Weekly home visits by CPS caseworker and mentor; addiction and co-occurring MH treatment intensity as determined by assessment; for 14 months,	**3** (Promising)	N/A	Yes (Manual is currently in development)	IL, KY, NV

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
Substance Abuse Prevention and Treatment						
management and family support strategy that is designed to accompany SA treatment.)		including at least 6 months of documented sobriety before closing the case				
12-Step Facilitation Therapy for Substance Abuse (TSF) A brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse, alcoholism, and other drug abuse and addiction problems.	Adults[302]	TSF is implemented with individual clients or groups over 12–15 sessions. [303] The intervention is based on the behavioral, spiritual, and cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).[304] Duration: 15 weeks	3 (Promising)+ SAMHSA NREPP[305] *Campbell 2017 Review:* Significant effect was found for drug abuse at a 6 month follow-up but not at 12 months.[306]	Cost: $407 (1993) Savings: $5,392 B-C: $N/A[307]	Yes[308]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
All Babies Cry (ABC) A strengths-based prevention program that targets the parents of infants, with the goal of reducing incidences of child abuse during the first year of life. Infant crying is the most common precursor to child maltreatment in the first year of life. ABC aims to improve new parents' ability to understand and cope with infant crying. ABC is a multiple-dose intervention intended for use from hospital discharge through the infant's first months of life. The core program components include (1) a short video program for hospital closed-circuit TV systems or classroom introduction; (2) media, including videos, for families to access at home or on mobile platforms; and (3) a booklet with checklists and activities. The components employ positive visual messaging and focus subtly on males (the perpetrators of a majority of pediatric abusive head trauma cases).[309]	Adults to prevent child abuse	Duration: 3–6 months	**3** (Promising)+ NREPP rating of promising	N/A	Yes	
Circle of Security-Home Visiting-4 (COS-HV4) ***COS-HV4*** is a version of Circle of Security that includes a mandatory home visiting component consisting of 4 home visits. One of the special features is use f videotaping parent-child interactions. The protocol focuses on: 1. Teaching caregivers the fundamentals of attachment theory (i.e., children's use of the caregiver as a secure base from which to explore and a safe haven in times of distress) by introducing a user-friendly graphic to the caregivers that they can refer to throughout the program 2. Exploring not only parenting behaviors but also internal working models	Families with children younger than 6 years old in high-risk populations such as child enrolled in Early Head Start, teen moms, or parents with irritable babies	One 3-hour assessment session followed by a 1.5-hour session every two to three weeks Duration: four home visits (after an out-of-home assessment) over a period of three months	**3** (Promising)	N/A	Yes[311]	MT

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
3. Presenting caregivers with a simple structure for considering the ways in which their internal working models influence their cognitive, affective, and behavioral responses to their children, thus helping caregivers gain awareness and understanding of the non-conscious, problematic responses they sometimes have to their children's needs.[310]						
Collaborative Problem Solving (CPS) ***CPS*** is an approach to understanding and helping children with behavioral challenges who may carry a variety of psychiatric diagnoses, including oppositional defiant disorder, conduct disorder, attention-deficit/hyperactivity disorder, mood disorders, bipolar disorder, autism spectrum disorders, posttraumatic stress disorder, etc. ***CPS*** uses a structured problem solving process to help adults pursue their expectations while reducing challenging behavior and building helping relationships and thinking skills. Specifically, the ***CPS*** approach focuses on teaching the neurocognitive skills that challenging kids lack related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures and instead focuses on teaching at-risk kids the skills they need to succeed. ***CPS*** provides a common philosophy, language and process with clear guideposts that can be used across settings. In addition, ***CPS*** operationalizes principles of trauma-informed care.[312]	Parents/caregivers of children ages 3 – 21 and the children themselves regarding parenting skills and child behavior related to oppositional defiant disorder or conduct disorder such as distractibility-hyperactivity and adaptability.	Weekly for 1 hour. Can also be delivered in-home with greater frequency and intensity, such as twice a week for 90 minutes. Parent training group sessions occur once a week for 90 minutes over the course of 4 or 8 weeks. Duration: 4-12 weeks	3 (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
Early Head Start-Home Visiting (EHS-HV) Early Head Start–Home Visiting is a comprehensive, two-generation federal initiative aimed at enhancing the development of infants and toddlers while strengthening families. The program is founded on nine principles: (1) high-quality services; (2) activities that promote healthy development and identify atypical development at the earliest stage possible; (3) positive relationships and continuity, with an emphasis on the role of the parent as the child's first, and most important, relationship; (4) activities that offer parents a meaningful and strategic role in the program's vision, services, and governance; (5) inclusion strategies that respect the unique developmental trajectories of young children in the context of a typical setting, including children with disabilities; (6) cultural competence that acknowledges the profound role that culture plays in early development; (7) comprehensiveness, flexibility, and responsiveness of services that allow children and families to move across various program options over time as their life situation demands; (8) transition planning; and (9) collaboration with community partnerships that allow programs to expand their services.[313]	Pregnant women with children ages birth to 3 years[314] Successfully improves: Child development and school readiness, Positive parenting practices, Family economic self-sufficiency, Linkages and referrals[315]	1 weekly 90-minute home visit, 2 group socialization activities per month Duration: at least 1 year	**3** (Promising) HOM-VEE report	N/A	N/A	
Infant Health and Development Program (IHDP) The Infant Health and Development Program (IHDP) is an early intervention program for preterm (< 37 weeks gestation), low birthweight (< 2,500 grams) infants that aims to improve children's cognitive and behavioral outcomes. This three-year intervention includes home visits, weekday attendance at an educational child day care program, and bimonthly parent group meetings.	Birth to 35 months	Duration: 3 years, including home visits and weekly educational child day care program	**3** (Promising) Not CEBC, research outcomes: Child health, Positive parenting practices[316]	Cost: $13,636 (2016) Loss: ($41,188) B-C: ($0.04)[317]	N/A	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Parenting Skills Training and Parent Education						
GenerationPMTO (Individual Delivery Format) GenerationPMTO was formerly known as Parent Management Training - the Oregon Model (PMTO®). *GenerationPMTO (Individual Delivery Format)* is a parent training intervention that can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent-led, reunification, and foster families. The intervention can be used as a preventative program and a treatment program. It can be delivered through individual family treatment in agencies or home-based and via telephone/video conference delivery, books, audiotapes and video recordings.[318]	Parents of children ages 2–18	10–25 individual or family sessions Duration: 3–6 months (or longer)[319]	**3** (Promising)	Cost: $619 Savings: $5,587 B-C: $9.50[320]	Yes[321]	CO, MD, TX
Parents as Teachers Parents as Teachers is an early childhood parent education, family support and well-being, and school readiness home visiting model based on the premise that "all children will learn, grow, and develop to realize their full potential." Based on theories of human ecology, empowerment, self-efficacy, attribution, and developmental parenting, ***Parents as Teachers*** involves the training and certification of parent educators who work with families using a comprehensive curriculum. Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn. An agency may choose to use the Parents as Teachers model to focus services primarily on pregnant women and families with children from birth to age 3 or through kindergarten.[322]	Families with an expectant mother or parents of children up to kindergarten entry (usually 5 years)	Duration: home visits of approximately 60 minutes monthly. At least 12 home visits annually to families with one or no high-needs characteristics. At least 24 home visits annually to families with two or more high-needs characteristics. At least 2 years.	**3** (Promising)	N/A	Yes	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) AF-CBT is designed for families who are referred for problems related to management of anger and/or aggression, including the use of coercion and/or physical force. This includes anger and verbal aggression, family conflict, and behavior problem such as physical threats, and physical abuse.	Children and adolescents ages 5–17 and caregivers who are physically abusive or expose their children to IPAV	20 sessions at about 1–1.5 hours/each Duration: about 12 weeks [323]	**3** (Promising)	N/A ($1500 per therapist to be trained.[324]	Not available	
Child FIRST (Child and Family Interagency, Resource, Support, and Training) Child FIRST, is a home-based parent–child intervention. The intervention targets young children with social-emotional problems and aims to decrease emotional and learning problems and child abuse and neglect. The program provides a two-person team of home visitors (a mental health clinician and a care coordinator) to regularly visit the family in their home, provide therapeutic services, and coordination with other services in the community.[325]	Parents with children birth to 4 years or older with difficulties in Maternal health, Child development and school readiness, child maltreatment, linkage to services and referrals[326]	Not available	**3** (Promising)+ Blueprints[327]	N/A	N/A	
Cool Kids[328] Utilizes CBT, program that teaches children and their parents how to better manage the child's anxiety. It can be run either individually or in groups and involves the participation of both children and their parents. The program aims to teach clear and practical skills to both the child and parents. Variations of the program also exist for children with comorbid autism, adolescents with comorbid depression, and for delivery in school settings.	Parents and their children ages 7–17	6–10, 1–2 hour sessions (varies by the specific type of Cool Kids program)[329] Duration: 10–12 weeks	**3** (Promising)	Average cost of assessment and treatment is $2460 AUD (Australian) manual/workbook required, $20–40. E-learning workshop $600 AUD	Yes[330]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Cue-Centered Treatment (CCT) Combines elements of cognitive behavioral, psychodynamic, expressive and family therapies to address conditions, behaviors, emotions and physiology (consequences of child/youth's trauma exposure)	Youth 8–18 with chronic history of trauma, adversity and ongoing stress	45 minute weekly sessions Duration: 15–18 weeks	**3** (Promising)	N/A	Yes[331]	
Domestic Abuse Intervention Project - The Duluth Model (DAIP)[332] Use of a psychoeducational approach in which a feminist philosophy is taught with the assumption that battering occurs as a result of societally sanctioned male dominance and female submissiveness.	Adult perpetrators of domestic or interpersonal violence (IPV)	Weekly sessions Duration: 6 or more months	**3** (Promising)[333]	Cost: $1,365 (2011)	Yes[334]	
Early Pathways Program (EPP) Home-based, parent-child therapy program for children with significant behavior and/or emotional problems. Designed specifically for a diverse population of very young children who come from families living in poverty, most of whom meet criteria for a psychiatric diagnosis. Emphasizes psychoeducation, direct clinician modeling to parents and other primary caretakers of effective strategies to strengthen the child's positive behaviors and reduce challenging ones, parent practice of new strategies with clinician feedback, and parent coaching.	Ages 0–6	Weekly sessions Duration: average of 8–12 weeks with booster sessions added as needed	**3** (Promising)	N/A Online training for providers is free; a manual costs $55[335]	Yes[336]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Families First In-home intervention that addresses family conflict, parenting skills, child abuse, childhood emotional issues, disruptive behavioral problems including criminal conduct and other-at-risk situations that children, parents and families face. Utilizes the Risk Need and Responsivity Model tailored to family need.	Children and adolescents and family 0–17 (High risk children and families. Can be used with children in their biological, kin, or out-of-home placements.	6–10 hours per week (3–4 home visits) Duration: 10–12 weeks	**3** (Promising)	N/A	Yes[337]	IN
Family Centered Treatment[338] FCT is designed to find simple, practical, and common sense solutions for families faced with disruption or dissolution of their family. Critical components of FCT are derivatives of Eco-Structural Family Therapy and Emotionally Focused Therapy	Children 0–17	2 multiple-hour sessions per week Lengthier/more frequent sessions available based on assessed need; 24-hr on call support Duration: 6 months	**3** (Promising)	N/A	Yes	IN
Parent Child Assistance Program (PCAP)[339] Helps link women and their families with a comprehensive array of appropriate and available community resources and services, and develop a network of contacts and relationships with client's family and friends, and provide advocacy for other family members as needed. Home visits are provided by paraprofessional client advocates with similar life experiences as the mothers.	Parents of children age 0–3	Visits are weekly for the first six weeks after birth, then bi weekly or more frequently as needed. Duration: 11 to 36 months.	**3** (Promising)	Substantial savings [340]	Yes	OK

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Promoting First Relationships (PFR) **PFR** is a manualized home visiting intervention/prevention program which includes parent training components based on strengths-based practice, practical, and in-depth strategies for promoting secure and healthy relationships between caregivers and young children (birth to 3 years). Features of ***PFR*** include: (a) Videotaping caregiver-child interactions to provide insight into real-life situations and help the caregiver reflect on the underlying needs of the child and how those needs impact behavior; (b) Giving positive and instructive feedback that builds caregivers' competence with and commitment to their children; and (c) Focusing on the deeper emotional feelings and needs underlying children's distress and behaviors.[341]	Children ages birth to 3 years. Focuses on improving healthy relationships between caregivers and young children	1 hour per week for ten weeks Duration: 10 or more weeks	**3** (Promising) Has lowered the rate of foster care placements and increased certain parent attitudes and parenting skills.[342]	N/A	Yes[343]	
Risk Reduction through Family Therapy (RRFT) An integrative, ecologically informed, and exposure-based approach to addressing co-occurring symptoms of PTSD (and other mental health problems), substance use problems, and other risk behaviors often experienced by trauma-exposed adolescents. RRFT is novel in its integration of these components, given that standard care for trauma-exposed youth often entails treatment of substance use problems separate from treatment of other trauma-related psychopathology. RRFT is individualized to the needs, strengths, developmental factors, and cultural background of each adolescent and family.[344]	Trauma-exposed adolescents aged 13–18 years who experience co-occurring trauma-related mental health problems (e.g., posttraumatic stress disorder [PTSD], depression), substance use problems, and other risk behaviors (e.g., risky sexual behavior, non-suicidal self-injury)	18–24 weekly, 60–90 minute sessions with periodic check-ins between scheduled appointments. Duration: 24 weeks	**3** (Promising)	N/A	Yes[345]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Step-by-Step Parenting Program© Breaks down essential child-care skills for children from birth to about 3 years or age into small steps. A wide-range of parenting skills are covered related to child health, safety, and development, including: newborn care; feeding and nutrition; diapering; bathing; home and sleep safety; first aid; toilet training; parent-child interactions; and positive behavior support.[346]	Parents who lack parenting skills, parents with learning differences, risk of child neglect, risk of child developmental delay and behavior problems	1 home visit per week for 1.5–2 hours; the number of visits may be extended to 2–3 visits per week, Duration: 6 -24 months	**3** (Promising)	N/A	Yes	
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) For children and caregivers experiencing traumatic stress; very frequently with single parents or with families whose children have limited contact with bio parents (foster kids and residential placements) and diversity of religious affiliations.[347]	Ages 10–18+	10 sessions Duration: 10–12 weeks	**3** (Promising) One RCT of 59 delinquent teen girls found effects compared to treatment as usual. TARGET was favored with small to medium effects for PTSD (0.53), anxiety symptoms (0.32), posttraumatic cognitions (0.21), and emotion regulation (-0.27). (Ford, et al., 2012)	N/A (Training is provided only to programs/ agencies and cost varies depending on number of staff trained; typical range = $15,000 - $75,000 per year)	Yes[348]	

Program Model or Intervention	Ages and Problem or Skill Area Addressed	Treatment Duration	Level of Effectiveness/ Effect Sizes	Cost & Cost-Savings	Manual Available	Waiver Inter-vention
In-Home Parent Skill-Based Programs: Individual and Family Counseling						
Wraparound (in-home parent support focus) Team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties.[349]	Parents of children ages 0–17	Intensive engagement and planning process of 2, 60–90 minute sessions and 2 team sessions in the first month. Duration: About 14 months	**3** (Promising)	Yes but varies by the study[350]	Yes	AR, HI, NE, RI, TN

[1] Studies that help Blues Program meet FFPSA evidence criteria include:

- Stice, E., Rohde, P., Seeley, J. R., & Gau, J. M. (2008). Brief cognitive-behavioral depression prevention program for high-risk adolescents outperforms two alternative interventions: A randomized efficacy trial. Journal of Consulting and Clinical Psychology, 76(4), 595-606.
- Rohde, P., Stice, E., Shaw, H., & Briere, F. N. (2014). Indicated cognitive behavioral group depression prevention compared to bibliotherapy and brochure control: Acute effects of an effectiveness trial with adolescents. Journal of Consulting and Clinical Psychology, 82 (1), 65-74.
- Stice, E., Rohde, P., Gau, J. M., & Wade, E. (2010). Efficacy trial of a brief cognitive-behavioral depression prevention program for high-risk adolescents: Effects at 1- and 2-year follow-up. Journal of Consulting and Clinical Psychology, 78(6), 856-867.
- Rohde, P., Stice, E., Shaw, H., & Gau, J. M. (2015). Effectiveness Trial of an Indicated Cognitive-Behavioral Group Adolescent Depression Prevention Program versus Bibliotherapy and Brochure Control at 1- and 2-Year Follow-Up. Journal of Consulting and Clinical Psychology, 83(4), 736–747. http://doi.org/10.1037/ccp0000022

[2] Studies that help Building Confidence meet FFPSA evidence criteria include two main studies with sample sizes less than 50 but with 40 or more children:

- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B. C., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry,* 45(3), 314-321.
- Chiu, Angela W., Langer, David A., McLeod, Bryce D., Har, Kim, Drahota, Amy, Galla, Brian M., . . . Wood, Jeffrey J. (2013). Effectiveness of Modular CBT for Child anxiety in elementary schools. *School Psychology Quarterl*y, 28(2), 141-153.
- Wood, Jeffrey J., McLeod, Bryce D., Piacentini, John C., & Sigman, Marian. (2009). One-year follow-up of family versus child cbt for anxiety disorders: exploring the roles of child age and parental intrusiveness. *Child Psychiatry and Human Development,* 40(2), 301-316.
- Galla, Brian M., Wood, Jeffrey J., Chiu, Angela W., Langer, David A., Jacobs, Jeffrey, Ifekwunigwe, Muriel, & Larkins, Clare. (2012). One year follow-up to modular cognitive behavioral therapy for the treatment of pediatric anxiety disorders in an elementary school setting. *Child Psychiatry and Human Development,* 43(2), 219-226.

[3] Studies that help Chicago Parent Program meet FFPSA evidence criteria include:

- Gross, D., Garvey, C., Julion, W., Fogg, L., Tucker, S., & Mokros, H. (2009). Efficacy of the Chicago Parent Program with Low-Income African American and Latino parents of young children. *Prevention Science: The Official Journal of the Society for Prevention Research,* 10(1), 54–65. http://doi.org/10.1007/s11121-008-0116-7
- Breitenstein, S. M., Gross, D., Fogg, L., Ridge, A., Garvey, C., Julion, W., & Tucker, S. (2012). The Chicago Parent Program: Comparing 1-Year outcomes for African American and Latino parents of young children. *Research in Nursing & Health*, 35(5), 475–489. http://doi.org/10.1002/nur.21489
- Additional research may be found at: http://www.chicagoparentprogram.org/our-research

[4] Studies that help CBT for Child & Adolescent Depression meet FFPSA evidence criteria include:

- Brent, D., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., . . . Johnson, B. (1997). A Clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, 54(9), 877-885.
- Clarke, Gregory, DeBar, Lynn L., Pearson, John A., Dickerson, John F., Lynch, Frances L., Gullion, Christina M., & Leo, Michael C. (2016). Cognitive behavioral therapy in primary care for youth declining antidepressants: A randomized trial. *Pediatrics*, 137(5), 1.
- Brent, Kolko, Birmaher, Baugher, Bridge, Roth, & Holder. (1998). Predictors of Treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(9), 906-914.
- Reinecke, Ryan, & Dubois. (1998). Cognitive-Behavioral Therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(1), 26-34.
- A cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/542

[5] Studies that help CBT Group Therapy for Children with Anxiety meet FFPSA evidence criteria include:

- Barrett, P. (1998). Evaluation of cognitive-behavioral group treatments for childhood anxiety disorders. *Journal of Clinical Child Psychology*, 27(4), 459-468.
- Wergeland, Fjermestad, Marin, Haugland, Bjaastad, Oeding, . . . Heiervang. (2014). An effectiveness study of individual vs. group cognitive behavioral therapy for anxiety disorders in youth. *Behaviour Research and Therapy*, 57(1), 1-12.
- Hudson, Rapee, Deveney, Schniering, Lyneham, & Bovopoulos. (2009). Cognitive-behavioral treatment versus an active control for children and adolescents with anxiety disorders: A randomized trial. Journal of the American Academy of Child & Adolescent Psychiatry, 48(5), 533-544.
- Lau, Chan, Li, & Au. (2010). Effectiveness of group cognitive-behavioral treatment for childhood anxiety in community clinics. *Behaviour Research and Therapy*, 48(11), 1067-1077.
- A cost-benefit analysis conducted by the Washington State Institute of Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/Program/66

[6] Studies that help CBT Parent Counseling for Young Children with Anxiety meet FFPSA evidence criteria include:

- Waters, Ford, Wharton, & Cobham. (2009). Cognitive-behavioural therapy for young children with anxiety disorders: Comparison of a Child Parent condition versus a Parent Only condition. *Behaviour Research and Therapy*, 47(8), 654-662.
- Rapee, R., Kennedy, S., Ingram, M., Edwards, S., & Sweeney, L. (2010). Altering the trajectory of anxiety in at-risk young children. *American Journal of Psychiatry*, 167(12), 1518-1525.
- Kennedy, Rapee, & Edwards. (2009). A selective intervention program for inhibited preschool-aged children of parents with an anxiety disorder: effects on current anxiety disorders and temperament. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(6), 602-609.

[7] Studies that help Dialectical Behavior Therapy (DBT) meet FFPSA evidence criteria include:

- Mccauley, E., Berk, M., Asarnow, J., Adrian, M., Cohen, J., Korslund, K., . . . Linehan, M. (2018). Efficacy of Dialectical Behavior Therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry*, 20 June 2018.
- Linehan, M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., . . . Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757-766.
- Neacsiu, Lungu, Harned, Rizvi, & Linehan. (2014). Impact of dialectical behavior therapy versus community treatment by experts on emotional experience, expression, and acceptance in borderline personality disorder. *Behaviour Research and Therapy*, 53(1), 47-54.
- Linehan, M., Armstrong, H., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatr*y, 48(12), 1060-1064.
- Additional research on Dialectical Behavior Therapy may be found here: https://behavioraltech.org/research/evidence/#domains

[8] Studies that help Families and Schools Together (FAST) meet FFPSA evidence criteria include:

- Kratochwill, T.R., McDonald, L., Levin, J.R., Young Bear-Tibbetts, H., & Demaray, M.K. (2004). Families and Schools Together: An Experimental analysis of a parent-mediated multi-family group program for american Indian children. *Journal of School Psychology*, 42(5), 359-383.
- McDonald, Lynn, Moberg, D. Paul, Brown, Roger, Rodriguez-Espiricueta, Ismael, Flores, Nydia I., Burke, Melissa P., & Coover, Gail. (2006). After-school multifamily groups: A randomized controlled trial involving low-income, urban, Latino children. *Children & Schools,* 28(1), 25-34.
- Kratochwill, Mcdonald, Levin, Scalia, & Coover. (2009). Families And Schools Together: An experimental study of multi-family support groups for children at risk. *Journal of School Psychology,* 47(4), 245-265.
- Additional research on FAST may be found here: https://www.familiesandschools.org/why-fast-works/ And a cost-benefit analysis from the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/150/Families-and-Schools-Together-FAST

[9] Studies that help Family-Focused Treatment for Adolescents (FFT-A) meet FFPSA evidence criteria include:

- Miklowitz, D., Schneck, C., George, E., Taylor, D., Sugar, C., Birmaher, B., . . . Axelson, D. (2014). Pharmacotherapy and Family-Focused Treatment for Adolescents With Bipolar I and II Disorders: A 2-Year Randomized Trial. American Journal of Psychiatry, 171(6), 658-667.
- Miklowitz, Axelson, George, Taylor, Schneck, Sullivan, . . . Birmaher. (2009). Expressed Emotion Moderates the Effects of Family-Focused Treatment for Bipolar Adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 48(6), 643-651.
- Miklowitz, George, Axelson, Kim, Birmaher, Schneck, . . . Brent. (2004). Family-focused treatment for adolescents with bipolar disorder. Journal of Affective Disorders, 82(S), S113-S128.

[10] Studies that help Interpersonal Psychotherapy-Adolescent Skills Training (IPA-AST) meet FFPSA evidence criteria include:

- Young, J., Jones, J., Sbrilli, M., Benas, J., Spiro, C., Haimm, C., . . . Gillham, J. (2018). Long-term effects from a school-based trial comparing Interpersonal Psychotherapy-Adolescent Skills Training to group counseling. *Journal of Clinical Child & Adolescent Psychology,* 1-10.
- Young, Jami F., Mufson, Laura, & Davies, Mark. (2006). Efficacy of Interpersonal Psychotherapy-Adolescent Skills Training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry,* 47(12), 1254-1262.
- Young, J., Mufson, L., & Gallop, R. (2010). Preventing depression: A randomized trial of interpersonal psychotherapy-adolescent skills training. *Depression and Anxiety*, 27(5), 426-433.
- Mufson, & Fairbanks. (1996). Interpersonal Psychotherapy for Depressed Adolescents: A one-year naturalistic follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry,* 35(9), 1145-1155.
- Mufson, L., Weissman, M., Moreau, D., & Garfinkel, R. (1999). Efficacy of Interpersonal Psychotherapy for depressed adolescents. *Archives of General Psychiatry*, 56(6), 573-579.

[11] Studies that help Wraparound meet FFPSA evidence criteria include:

- Carney, M. M., & Butell, F. (2003). Reducing juvenile recidivism: Evaluating the wraparound services model. *Research on Social Work Practice, 13*(5), 551-568. doi:10.1177/1049731503253364
- Clark, H. B., Lee, B., Prange, M. E., & McDonald, B. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child and Family Studies, 5*(1), 39-54. doi:10.1007/BF02234677
- Grimes, K.E., Schulz, M.F., Cohen, S.A., Mullin, B.O., Lehar, S.E., & Tien, S. (2011) Pursuing cost-effectiveness in mental health service delivery for youth with complex needs. *J Ment Health Policy Econ.*14(2):73-83. PMID: 21881163.
- Jeong, S., Lee, B. H., & Martin, J. H. (2014). Evaluating the effectiveness of a special needs diversionary program in reducing reoffending among mentally ill youthful offenders. *International Journal of Offender Therapy and Comparative Criminology*, 58(9), 1058–1080. doi:10.1177/0306624x13492403
- Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of Wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice, 19,* 678-685. doi:10.1177/1049731508329385
- Pullman, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using Wraparound. *Crime and Delinquency, 52*(3), 375-397. doi:10.1177/0011128705278632
- Rast, J., Bruns, E. J., Brown, E. C., Peterson, C. R., & Mears, S. L. (2008). *Outcomes of the wraparound process for children involved in the child welfare system: Results of a matched comparison study.* Manuscript submitted for publication.

[12] Studies that help Buprenorphine Maintenance Treatment for Opioid Use Disorder meet the FFPSA evidence criteria include:

- Johnson, R., Jaffe, J., & Fudala, P. (1992). A Controlled Trial of Buprenorphine Treatment for Opioid Dependence. JAMA, 267(20), 2750-2755.

- D'Onofrio, G., Chawarski, M., O'Connor, C., Pantalon, P., Busch, G., Owens, M., . . . Fiellin, H. (2017). Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. Journal of General Internal Medicine, 32(6), 660-666.
- O'connor, Oliveto, Shi, Triffleman, Carroll, Kosten, . . . Schottenfeld. (1998). A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone clinic. The American Journal of Medicine, 105(2), 100-105.
- Johnson, Eissenberg, Stitzer, Strain, Liebson, & Bigelow. (1995). A placebo controlled clinical trial of buprenorphine as a treatment for opioid dependence. Drug and Alcohol Dependence, 40(1), 17-25.
- Knudsen, Ducharme, & Roman. (2006). Early adoption of buprenorphine in substance abuse treatment centers: Data from the private and public sectors. Journal of Substance Abuse Treatment, 30(4), 363-373.

[13] Studies that help Assertive Continuing Care (ACC) meet FFPSA evidence criteria include:

- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., Passetti, Lora L., Petry, Nancy M., & Nezu, Arthur M. (2014). A Randomized Trial of Assertive Continuing Care and Contingency Management for Adolescents With Substance Use Disorders. Journal of Consulting and Clinical Psychology, 82(1), 40-51.
- Garner, Bryan R., Godley, Mark D., Funk, Rodney R., Dennis, Michael L., Godley, Susan H., & Shaffer, Howard J. (2007). The Impact of Continuing Care Adherence on Environmental Risks, Substance Use, and Substance-Related Problems Following Adolescent Residential Treatment. Psychology of Addictive Behaviors, 21(4), 488-497.
- Godley, Mark D., Godley, Susan H., Dennis, Michael L., Funk, Rodney R., & Passetti, Lora L. (2007). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. Addiction, 102(1), 81-93.

[14] Studies that help Adolescent Community Reinforcement Approach (A-CRA) meet FFPSA evidence criteria include:

- Dennis, Godley, Diamond, Tims, Babor, Donaldson, . . . Funk. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. Journal of Substance Abuse Treatment, 27(3), 197-213.
- Hunter, B. D., Godley, S. H., Hesson-McInnis, M. S., & Roozen, H. G. (2014). Longitudinal change mechanisms for substance use and illegal activity for adolescents in treatment. Psychology of Addictive Behaviors, 28(2), 507-515.
- Slesnick, Prestopnik, Meyers, & Glassman. (2007). Treatment outcome for street-living, homeless youth. Addictive Behaviors, 32(6), 1237-1251.

[15] Studies that help Adolescent Coping with Depression (CWD-A) meet FFPSA evidence criteria include:

- Lewinsohn, Clarke, Hops, & Andrews. (1990). Cognitive-behavioral treatment for depressed adolescents. Behavior Therapy, 21(4), 385-401.
- Clarke, Rohde, Lewinsohn, Hops, & Seeley. (1999). Cognitive-Behavioral Treatment of Adolescent Depression: Efficacy of Acute Group Treatment and Booster Sessions. Journal of the American Academy of Child & Adolescent Psychiatry, 38(3), 272-279.
- Clarke, G., Hornbrook, Lynch, Polen, Gale, Beardslee, . . . Seeley. (2001). A Randomized Trial of a Group Cognitive Intervention for Preventing Depression in Adolescent Offspring of Depressed Parents. Archives of General Psychiatry, 58(12), 1127-1134.
- Clarke, Hornbrook, Lynch, Polen, Gale, O'connor, . . . Debar. (2002). Group Cognitive-Behavioral Treatment for Depressed Adolescent Offspring of Depressed Parents in a Health Maintenance Organization. Journal of the American Academy of Child & Adolescent Psychiatry, 41(3), 305-313.

[16] Studies that help Brief Marijuana Dependence Counseling (BMDC) meet FFPSA evidence criteria include:

- Babor, Thomas F. (2004). Brief treatments for cannabis dependence: Findings from a randomized multisite trial. *Journal of Consulting and Clinical Psycholo*gy, 72(3), 455-466.
- Litt, M., Kadden, R., Kabela-Cormier, E., & Petry, N. (2008). Coping skills training and contingency management treatments for marijuana dependence: Exploring mechanisms of behavior change. *Addiction*, 103(4), 638-648.
- The BMDC program manual may be found here: https://www.integration.samhsa.gov/clinical-practice/sbirt/brief_counseling_for_marijuana_dependence.pdf and a cost-benefit analysis conducted by the Washington State Institute for Public Policy may be found here: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/306/Brief-Marijuana-Dependence-Counseling

[17] Studies that help Ecologically Based Family Therapy (EBFT) meet FFPSA evidence criteria include:

- Slesnick, & Prestopnik. (2005). Ecologically based family therapy outcome with substance abusing runaway adolescents. *Journal of Adolescence,* 28(2), 277-298.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy*, 35(3), 255-277.

[18] Studies that help Functional Family Therapy (FFT) for adolescents with SUDs meet the FFPSA evidence criteria include:

- Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments, *Journal of Consulting and Clinical Psychology, 69*(5), 802-813.
- Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital & Family Therapy, 35*(3), 255-277.
- Slesnick, N., & Prestopnik, J. (2004). Office versus home-based family therapy for runaway, alcohol abusing adolescents: Examination of factors associated with treatment attendance. *Alcoholism Treatment Quarterly, 22*(2), 3-19.
- Alexander J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*(3), 219-225.
- Parsons, B., & Alexander, J. (1973). Short-term family intervention: A therapy outcome study. *Journal of Consulting and Clinical Psychology, 41*(2), 195-201.
- Alexander, J., Barton, C., Schiavo, R., & Parsons, B. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology, 44*(4), 656-664.
- Klein, N., Alexander, J., & Parsons, B. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*(3), 469-474.
- Friedman, A. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy, 17*(4), 335-347.
- Rohde, P., Waldron, H. B., Turner, C. W., Brody, J., & Jorgensen, J. (2014). Sequenced Versus Coordinated Treatment for Adolescents With Comorbid Depressive and Substance Use Disorders. *Journal of Consulting & Clinical Psychology*, *82*(2), 342-348. doi:10.1037/a0035808

[19] Studies that help Helping Women Recover & Beyond Trauma (HWR/BT) for substance abuse treatment in women meet the FFPSA evidence criteria include:

- Messina, N., Grella, C. E., Cartier, J., & Torres, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of Substance Abuse Treatment, 38*(2), 97–107.
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender responsive drug court treatment: A randomized controlled trial. *Criminal Justice and Behavior, 9*(12), 1539-1558.
- Covington, S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs, SARC Supplement 5,* 387-398.
- Saxena, P., Messina, N., & Grella, C. E., (2014). Who benefits from gender responsive treatment. Accounting for abuse history on longitudinal outcomes for women in prison. *Criminal Justice and Behavior, 41*(4), 417–432.

[20] Studies that help Interim Methadone Maintenance for Opioid use (IMM) meet the FFPSA evidence criteria include:

- Schwartz, R. P., Highfield, D. A., Jaffe, J. H., Brady, J. V., Butler, C. B., Rouse, C. O., ... & Breteler, M. M. (2006). A randomized controlled trial of interim methadone maintenance. *Archives of General Psychiatry*, *63*(1), 102-109.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Schwartz, R. P., Kelly, S. M., O'Grady, K. E., Gandhi, D., & Jaffe, J. H. (2011). Interim methadone treatment compared to standard methadone treatment: 4-month findings. *Journal of substance abuse treatment*, *41*(1), 21-29.
- Schwartz, R. P., Kelly, S. M., O'grady, K. E., Gandhi, D., & Jaffe, J. H. (2012). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*(5), 943-952.
- Gruber, V. A., Delucchi, K. L., Kielstein, A., & Batki, S. L. (2008). A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. *Drug and alcohol dependence*, *94*(1-3), 199-206.
- Schwartz, R. P., Jaffe, J. H., O'Grady, K. E., Kinlock, T. W., Gordon, M. S., Kelly, S. M., ... & Ahmed, A. (2009). Interim methadone treatment: impact on arrests. *Drug and Alcohol Dependence*, *103*(3), 148-154.
- Schwartz, R. P., Kelly, S. M., Mitchell, S. G., Gryczynski, J., O'Grady, K. E., Gandhi, D., & ... Jaffe, J. H. (2017). Patient-centered methadone treatment: a randomized clinical trial. *Addiction*, *112*(3), 454-464. doi:10.1111/add.13622
- Yancovitz, S. K., Des Jarlais, D. C., Peskoe Peyser, N., Drew, E., Friedmann, P., Trigg, H. L., & Robinson, J. W. (1991). A Randomized Trial of an Interim Methadone Maintenance Clinic. *American Journal Of Public Health*, *81*(9), 1185-1191.

- Gryczynski, J., Schwartz, R., O'Grady, K., & Jaffe, J. (2009). Treatment Entry among Individuals on a Waiting List for Methadone Maintenance. *American Journal Of Drug & Alcohol Abuse*, *35*(5), 290-294. doi:10.1080/00952990902968577
- Interim methadone maintenance therapy makes a difference. (2006). *Inpharma Weekly*, (1529), 8.

[21]Studies that help Family Spirit meet the FFPSA evidence criteria include these below:

- Barlow A, Varipatis-Baker E, Speakman K, et al. Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. *Arch Pediatr Adolesc Med*. 2006; 160(11):1101-1107.
- Barlow, A., Mullany, B., Neault, N., et al. (2015). Paraprofessional Delivered, Home-Visiting Intervention for American Indian Teen Mothers and Children: Three-Year Outcomes from a Randomized Controlled Trial. *American Journal of Psychiatry*, 172(2), 154-162. doi: 10.1176/appi.ajp.2014.14030332.
- Walkup J.T., Barlow, A., Mullany, B.C., et al. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *J Am Acad Child Adolesc Psychiatry,* 48(6), 591-601.

[22] Studies that help Home Instruction for Parents of Preschool Youngsters (HIPPY) meet the FFPSA evidence criteria include:

- Baker, A. J. L., Piotrkowski, C. S., & Brooks-Gunn, J. (1998). The effects of the Home Instruction Program for Preschool Youngsters (HIPPY) on children's school performance at the end of the program and one year later. *Early Childhood Research Quarterly, 13*(4), 571-588.
- Brown, A., & Lee, J. (2014). School performance in elementary, middle, and high school: A comparison of children based on HIPPY participation during the preschool years. *School Community, 24*(2), 83-106.
- Nievar, M. A., Jacobson, A., Chen, Q., Johnson, U., & Dier, S. (2011). Impact of HIPPY on home learning environments of Latino families. *Early Childhood Research Quarterly, 26*, 268-277.
- Barhava-Monteith, G., Harre, N., & Field, J. (1999). A promising start: An evaluation of the HIPPY program in New Zealand. *Early Child Development and Care, 159*, 145-157.
- Bradley, R. H., & Gilkey, B. (2002). The impact of the Home Instructional Program for Preschool Youngsters (HIPPY) on school performance in 3rd and 6th Grades. *Early Education and Development, 13*(3), 301-311.
- Brown, A. L. (2013). The impact of early intervention on the school readiness of children born to teenage mothers. *Journal of Early Childhood Research.* Advance online publication. doi: 10.1177/1476718X13479048

[23]Studies that help SafeCare meet the FFPSA evidence criteria:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,
- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.

[24] Studies that help Child-Parent Psychotherapy (CPP) meet the FFPSA evidence criteria include:

- Cicchetti, D., Rogosh, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*, 623-649.
- Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of Toddler-Parent psychotherapy to increase attachment security in off-spring of depressed mothers. *Attachment & Human Development, 1*(1), 34-66.
- Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-Parent Psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913-918. doi:10.1097.01.chi.0000222784.03735.92
- Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005**)**. Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241-1448.
- Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive interaction and outcome with anxiously attached dyads. *Child Development, 62,* 199-209.

[25] Studies that help Functional Family Therapy (FFT) meet the FFPSA evidence criteria for the outcomes listed in the table include those below. Also see https://www.fftllc.com/documents/FFT-CW-Model-Effectiveness.pdf

- Baglivio, M. T., Jackowski, K., Greenwald, M. A. and Howell, J. C. (2014), Serious, Violent, and Chronic Juvenile Offenders. Criminology & Public Policy, 13: 83-116. doi:10.1111/1745-9133.12064
- Barnoski, R. (2004, January). *Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders* (Document No. 04-01-1201). Olympia: Washington State Institute for Public Policy.
- Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. American Journal of Family Therapy, 13(3), 16–26.
- Darnell, A.J., & Schuler, M.S. (2015). Quasi-experimental study of Functional Family Therapy effectiveness for juvenile justice aftercare in a racially and ethnically diverse community sample. *Children and Youth Services Review, 50*, 75-82.
- Gordon, D. A., Graves, K., & Arbuthnot, J. (1995). The effect of Functional Family Therapy for delinquents on adult criminal behavior. Criminal Justice and Behavior, 22(1), 60–73.
- Hansson, K., Cederblad, M., & Hook, B. (2000). Functional family therapy: A method for treating juvenile delinquents. Socialvetenskaplig tidskrift, 3, 231-243. [Being translated into English.]
- Hansson, K., Johansson, Drott-Englén, & Benderix (2004). Functional Family Therapy in child psychiatric practice. *Nordisk Psykologi*, 56, 4, 304–320. [Being translated into English.]
- Kerig, P. K., & Alexander, J. F. (2012). Family Matters: Integrating Trauma Treatment into Functional Family Therapy for Traumatized Delinquent Youth. *Journal of Child & Adolescent Trauma*, *5*(3), 205-223. doi:10.1080/19361521.2012.697103
- Rohde, P., Waldron, H., Turner, C., Brody, J., & Jorgensen, J. (2014). Sequenced versus coordinated treatment for adolescents with comorbid depressive and substance use disorders. *Journal Of Consulting And Clinical Psychology,* 82(2):342-8. doi: 10.1037/a0035808
- Sexton, T., & Turner, C. W. (2010). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Journal Of Family Psychology*, *24*(3), 339-348. doi:10.1037/a0019406
- Stanton, M.D., & Shadish, W.R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin.*122, 170–191.
- Stout, B.D & Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. *Journal of Child and Family Studies*, 22:311–321 DOI 10.1007/s10826-012-9580-6
- Waldron, H. B., Slesnick, N., Brody, J. L., Turner, C. W., & Peterson, T. R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7- month assessments. *Journal of Consulting and Clinical Psychology*, 69, 802-813.

[26] Studies that help HOMEBUILDERS meet the FFPSA evidence criteria are documented in these two meta-analyses:

- Walton, E. (1998). In-home family focused reunification: A six-year follow-up of a successful experiment. *Social Work Research, 22*(4), 205-214.
- Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review, 18*(4/5), 335-361.
- Forrester, D., Copello, A., Waissbein, C., & Pokhrel, S. (2008). Evaluation of an intensive family preservation service for families affected by parental substance misuse. *Child Abuse Review*, *17*(6), 410-426.
- Department for Community Based Services. (2008) Kentucky's Family Preservation Program: Comprehensive Program Evaluation. (DCBS).
- Stuva, D., Ringle, J. L., Thompson, R. W., Chmelka, B., Juliano, N., & Bohn, K. (2016). In-Home Family Services: Providing Lasting Results to Crisis Helpline Callers. *American Journal Of Family Therapy*, *44*(5), 245-254. doi:10.1080/01926187.2016.1223566
- Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & van der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review*, *34*(8), 1472–1479. doi:10.1016/j.childyouth.2012.04.002
- Schweitzer, D. D., Pecora, P. J., Nelson, K., Walters, B., & Blythe, B. J. (2015). Building the evidence base for intensive family preservation services. *Journal of Public Child Welfare*, *9*(5), 423–443. doi:10.1080/15548732.2015.1090363

[27] Studies that help Building Confidence meet FFPSA evidence criteria include:

- Justice Research Center (July 2009) Parenting with Love and Limits Research Outcome – 2009-2010
- Karam, E. A., Sterrett, E. M., & Kiaer, L. (2015). The integration of family and group therapy as an alternative to juvenile incarceration: A quasi-experimental evaluation using parenting with love and limits. *Family Process*, *56*,

- Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs . *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4.
- Winokur-Early, K, Chapman, S. F., & Hand, G. A. (2013). Family-focused juvenile reentry services: A quasi-experimental design evaluation of recidivism outcomes. *Journal of Juvenile Justice, 2*(2), 1–22.

[28] http://wsipp.wa.gov/BenefitCost/Program/668 and http://wsipp.wa.gov/BenefitCost

[29] In cases where the cost of the program is less than the alternative (usually treatment as usual), a benefit cost ratio cannot be calculated because the savings are realized up-front.

[30] https://contextualscience.org/list_of_resources_for_learning_act

[31] http://wsipp.wa.gov/BenefitCost/Program/756

[32] https://contextualscience.org/list_of_resources_for_learning_act

[33] http://wsipp.wa.gov/BenefitCost/Program/668

[34] http://wsipp.wa.gov/BenefitCost/Program/668 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[35] https://contextualscience.org/list_of_resources_for_learning_act

[36] http://wsipp.wa.gov/BenefitCost/Program/667

[37] http://wsipp.wa.gov/BenefitCost/Program/667 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[38] https://contextualscience.org/list_of_resources_for_learning_act

[39] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[40] https://contextualscience.org/list_of_resources_for_learning_act

[41]For CEBC rating and summary, see: http://www.cebc4cw.org/program/aggression-replacement-training/

[42] Source: WSIPP, 6-2016; http://www.wsipp.wa.gov/BenefitCost

[43] WSIPP (2017) http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost

[44] http://aggressionreplacementtraining.com/

[45] https://www.infantcaregiverproject.com/training-in-abc

[46] Personal communication, Mary Dozier, July 2, 2018. See http://Abcintervention.org

[47] http://legacy.nreppadmin.net/ViewIntervention.aspx?id=305

[48] (Berkowitz, Stover, & Marans, 2010).

[49] Total costs for 1 agency (up to 30 trainees) = 10,800 $3000 x 2) for 2-day training + $4800 (12 x 400) for 6 months of biweekly (12) consultation calls for 6 months for 2 sets of trainees ($200/ per call for 15 trainees each).

[50] http://www.cebc4cw.org/program/child-and-family-traumatic-stress-intervention-cftsi/detailed

[51]Rotter, M., & Carr, A. (2010). *Targeting criminal recidivism in justice-involved people with mental illness: Structured clinical approaches.* Washington, DC: The CMHS National GAINS Center. Retrieved from: http://gainscenter.samhsa.gov/cms-assets/documents/69181-899513.rottercarr2010.pdf. Several types of CBT have been highlighted as helpful for child welfare: remote CBT for anxious children, individual CBT for anxious children, parent CBT for anxious children, CBT for depressed adolescents, and trauma-focused CBT. For session length see: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=106. For reviews of traditional CBT interventions, see:
Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26,* 17-31.
Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychology, 160,* 1223-1232.

[52] In-Albon, T., & Schneider, S. (2006). Psychotherapy of Childhood Anxiety Disorders: A Meta-Analysis. *Psychotherapy and Psychosomatics*, *76*(1), 15–24. http://doi.org/10.1159/000096361

[53] Reynolds, S., Wilson, C., Austin, J., & Hooper, L. (2012). Effects of psychotherapy for anxiety in children and adolescents: a meta-analytic review. *Clinical Psychology Review*, *32*(4), 251–62. http://doi.org/10.1016/j.cpr.2012.01.005

[54] Reynolds, S., Wilson, C., Austin, J., & Hooper, L. (2012).

[55] WSIPP, June -2016: http://www.wsipp.wa.gov/BenefitCost

[56] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[57] http://wsipp.wa.gov/BenefitCost/Program/71

[58] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[59] http://wsipp.wa.gov/BenefitCost/Program/71 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[60] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[61] http://www.wsipp.wa.gov/ReportFile/1466

[62] http://wsipp.wa.gov/BenefitCost/Program/87

[63] http://wsipp.wa.gov/BenefitCost/Program/87 and http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[64] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[65] http://wsipp.wa.gov/BenefitCost/Program/241

[66] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[67] http://wsipp.wa.gov/BenefitCost/Program/241 and \http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[68] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[69] https://academic.oup.com/schizophreniabulletin/article/40/5/958/2886806

[70] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[71] http://wsipp.wa.gov/BenefitCost/Program/494 and Washington State Institute for Public Policy (2017a). *Adult mental health.* Retrieved April 20, 2018, from http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[72] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[73] http://www.mychildwithoutlimits.org/plan/common-treatments-and-therapies/cognitive-therapy/espanol-terapia-cognitiva-del-comportamiento/

[74] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[75] http://wsipp.wa.gov/BenefitCost/Program/64

[76] http://www.abct.org/Resources/?m=mResources&fa=ClinicalResources

[77] http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/

[78] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed

[79] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/detailed

[80] http://wsipp.wa.gov/BenefitCost/Program/155 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[81] https://secure.workbookpublishing.com/cat_prod.php?cPath=21_26

[82] http://wsipp.wa.gov/BenefitCost/Program/650 and WSIPP (2017) http://wsipp.wa.gov/BenefitCost

[83] http://www.copingpower.com/Manuals.aspx

[84] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/detailed

[85] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/

[86] Washington State Institute for Public Policy (2017a). *Adult mental health.* Retrieved from http://www.wsipp.wa.gov/BenefitCost/Pdf/8/WSIPP_BenefitCost_Adult-Mental-Health

[87] http://wsipp.wa.gov/BenefitCost/Program/635 and http://www.traumarecoveryhapstore.com/Manuals_c_14.html

[88]EMDR information:

- CEBC summary and rating: Retrieved Sept. 16, 2015, from: http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/
- Eye Movement Desensitization and Reprocessing Institute, Inc. (2012). *What is EMDR?* Retrieved from http://www.emdr.com/general-information/what-is-emdr.html

- Field, A., & Cottrell, D. (2011). Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: A systematic review of the evidence for family therapists. *Journal of Family Therapy*, *33*(4), 374-388.
- Soberman, G. B., Greenwald, R., & Rule, D. L. (2002). A controlled study of Eye Movement Desensitization and Reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, & Trauma*, *6*(1), 217-236.

[89] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/detailed

[90] http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/detailed

[91] http://wsipp.wa.gov/BenefitCost/Program/156

[92] http://www.emdr.com/product-category/books/

[93] http://www.cebc4cw.org/program/mindfulness-based-cognitive-therapy/detailed

[94] http://www.cebc4cw.org/program/multidimensional-family-therapy/detailed

[95] http://www.mdft.org/Training-Materials

[96] http://wsipp.wa.gov/BenefitCost/Program/76 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[97] http://www.pcit.org/store/c2/Manuals.html

[98] http://www.cebc4cw.org/program/problem-solving-skills-training/detailed

[99] See http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/detailed

[100] http://www.med.upenn.edu/ctsa/workshops_ptsd.html

[101] http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/detailed

[102] Mannarino, A. P., Cohen, J. A., Runyon, M. K., Deblinger, E., & Steer, R. A. (2012). Trauma-Focused Cognitive-Behavioral Therapy for children sustained impact of treatment 6 and 12 months later. *Child Maltreatment, 17*(3), 231-241.

[103]National Child Traumatic Stress Network. (2012). *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).* Los Angeles, CA: University of California, Los Angeles. Retrieved from http://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/Theoretical%20Perspective/TF-CBT%20fact%20sheet%20therapists.pdf.

[104] http://wsipp.wa.gov/BenefitCost/Program/155

[105] https://tfcbt2.musc.edu/resources

[106] http://wsipp.wa.gov/BenefitCost/Program/80

[107] http://wsipp.wa.gov/BenefitCost/Program/80

[108] http://www.cebc4cw.org/program/triple-p-positive-parenting-program-level-4-level-4-triple-p/detailed

[109] https://www.communitiesthatcare.net/Prevention%20Strategies%20Guide/introduction.pdf

[110] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=392

[111] http://wsipp.wa.gov/BenefitCost/Program/115

[112] http://www.sdrg.org/ctcresource/Community%20Building%20and%20Foundational%20Material/Tools%20for%20Community%20Leaders.pdf

[113] The effect was strongest at post-intervention SMD 0.79 (95%CI 0.48 to 1.09) and weaker at short follow-up SMD0.17 (95%CI 0.09 to 0.26]), and medium follow-up SMD 0.15 (95%CI 0.04 to 0.25]). For long follow-up, the effect was not significant SMD 0.06 (95%CI -0.16 to 0.28). See https://www.campbellcollaboration.org/library/multidimension-family-therapy-youth-drug-use.html, p. 27.

[114] http://wsipp.wa.gov/BenefitCost/Program/497 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[115] http://www.motivationalinterviewing.org/books

[116] http://www.cebc4cw.org/program/multidimensional-family-therapy/detailed

[117] Dose titrates down as the treatment progresses. The dose is more intense in the first third of treatment and is gradually reduced to 1 session per week during the last 4–6 weeks.

[118] Pooled results of the four studies providing data on drug abuse frequency reduction favored MDFT. The effect of MDFT for youth drug abuse frequency reduction was small at 6 months post-intake (overall around 20 percent of a standard deviation for the different control combinations) (SMD = -0.24; 95% CI -0.43 to -0.06; p=0.01 compared to CBT, peer group, TAU and

MET/CBT5). It was not statistically significant at 12 month follow-up compared to CBT, peer group, TAU and MET/CBT5/ACRA. See https://www.campbellcollaboration.org/library/multidimension-family-therapy-youth-drug-use.html

[119] http://wsipp.wa.gov/BenefitCost/Program/195 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[120] http://www.mdft.org/Training-Materials

[121] http://wsipp.wa.gov/BenefitCost/Program/652

[122] http://wsipp.wa.gov/BenefitCost/Program/652

[123] http://pediatrics.aappublications.org/content/132/Supplement_2/S140.long

[124] ++Not yet rated by the CEBC but two RCT studies have been conducted on this program. The Family Connects program has been studied in two rigorous randomized controlled trials, the results of which have been published in highly-regarded journals including Pediatrics and the American Journal of Public Health. ***Higher-quality parenting behaviors:*** Durham Connects mothers reported significantly more positive parenting behaviors with their infant, such as, hugging and reading. Researchers, who were unaware of which families they were observing had been enrolled in Durham Connects, also found that mothers in the program provided higher-quality parenting, such as sensitivity to, and acceptance of, the infant. ***Enhanced home environments***: Researchers found Durham Connects families had higher quality home environments when it came to such factors as safety, books, toys and learning materials. ***Improved mother mental health:*** Durham Connects mothers were 28 percent less likely to report possible clinical anxiety. ***Reduced emergency medical care for infants:*** Durham Connects mothers reported 34 percent less total infant emergency medical care. Research shows that decrease is sustained through age 2. For effect sizes see: McLeigh, J. D., McDonell, J. R., & Melton, G. B. (2015). Community differences in the implementation of Strong Communities for Children. *Child abuse & neglect*, *41*, 97-112.
See http://www.familyconnects.org/evidencebase/

[125] http://pediatrics.aappublications.org/content/132/Supplement_2/S140.long

[126] Based on the findings, researchers estimate that for cities of a similar size averaging about 3,187 births a year, an annual investment of $2.2 million in nurse home visiting would result in a community health care cost savings of about $7 million in the first two years of a child's life. See http://www.familyconnects.org/evidencebase/

[127] http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/

[128] http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/detailed

[129] http://wsipp.wa.gov/BenefitCost/Program/119

[130] http://wsipp.wa.gov/BenefitCost/Program/119

[131] http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/detailed

[132] https://homvee.acf.hhs.gov/Implementation/3/Nurse-Family-Partnership-NFP-/14/5/

[133] Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (at about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last four visits are monthly until the child is two years old.

[134] http://wsipp.wa.gov/BenefitCost/Program/35 and http://wsipp.wa.gov/BenefitCost

[135] https://medicine.yale.edu/childstudy/communitypartnerships/mtb/

[136] https://medicine.yale.edu/childstudy/research/implementation/community/mindingthebaby/

[137] Information provided by Crista Marchesseault, Operations Director for Minding the Baby (mcrista.marchesseault@yale.edu)

[138] Information provided by Crista Marchesseault, Operations Director for Minding the Baby (mcrista.marchesseault@yale.edu)

[139] http://wsipp.wa.gov/BenefitCost/Program/158 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[140] http://www.cebc4cw.org/program/the-incredible-years/detailed

[141] http://drexel.edu/cnhp/academics/continuing-education/Health-Professions-CE-Programs/ABFT/

[142] Diamond (2013)

[143] The intervention is tailored to address the specific needs of each child and family and can be integrated into many service settings. See http://www.cebc4cw.org/program/family-check-up/detailed

[144] http://wsipp.wa.gov/BenefitCost/Program/380

[145] http://www.cebc4cw.org/program/family-check-up/detailed

[146] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=7

[147] http://www.blueprintsprograms.com/factsheet/blues-program

[148] http://www.blueprintsprograms.com/factsheet/blues-program

[149] http://wsipp.wa.gov/BenefitCost/Program/537 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[150] https://thebluesprogram.weebly.com/manuals.html P

[151]http://www.cebc4cw.org/program/building-confidence/detailed

[152] http://www.cebc4cw.org/program/childhaven-childhood-trauma-treatment/detailed

[153] Summary and evidence rating abstracted from SANMHSA NREP: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=106. Also see:

- Brent, D. A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., et al. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry, 54,* 877-885.
- Weersing, V. R., Iyengar, S., Kolko, D. J., Birmaher, B., & Brent, D. A. (2006). Effectiveness of cognitive-behavioral therapy for adolescent depression: A benchmarking investigation. *Behavior Therapy, 37*, 36-48.

[154] http://www.wsipp.wa.gov/BenefitCost/Program/542 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[155] https://www.guilford.com/books/CBT-for-Depression-in-Children-and-Adolescents/Kennard-Hughes-Foxwell/9781462525256

[156] http://www.wsipp.wa.gov/BenefitCost/Program/66

[157] http://www.wsipp.wa.gov/BenefitCost/Program/66 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[158] http://www.wsipp.wa.gov/BenefitCost/Program/66 CEBC rates Trauma-Focused CBT for children as "Well-Supported" for treatment of PTSD, of which anxiety is a symptom.

[159] http://wsipp.wa.gov/BenefitCost/Program/65

[160] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[161] CBT has been extensively researched. CEBC rates Trauma-Focused CBT for children as "Well-Supported" for treatment of PTSD, of which anxiety is a symptom.

[162] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[163] http://www.cebc4cw.org/program/collaborative-proactive-solutions/detailed

[164] http://www.cebc4cw.org/program/community-reinforcement-vouchers-approach/detailed

[165] http://www.cebc4cw.org/program/community-reinforcement-vouchers-approach/detailed

[166] http://wsipp.wa.gov/BenefitCost/Program/298

[167] DBT for Substance Abusers focuses on the following five main objectives: (1) motivating patients to change dysfunctional behaviors, (2) enhancing patient skills, (3) ensuring the new skills are used in daily life, (4) structuring the client's environment, and (5) training and consultation to improve the counselor's skills. For substance abusers, the primary target of the intervention is the substance abuse and specific goals include reducing abuse, alleviating withdrawal symptoms, reducing cravings, and avoiding opportunities and triggers for substance use. Abstracted from:

- Krawitz, R. (2013). Financial cost-effectiveness of, and other dialectical behavior therapy information, for funders, administrators and providers of services for people with borderline personality disorder. Waikato District Health Board, Hamilton, New Zealand. Abridged version retrieved from http://behavioraltech.org/downloads/Financial-Cost-Effectiveness-DBT.pdf
- Linahan, M. (2015). DBT® Skills Training Manual, Second Edition. New York: Guilford Press. Also see http://www.wsipp.wa.gov/BenefitCost/Program/339
- For ages and duration see SAMHSA NREP summary at : http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36

[168] An intensive residential treatment adaptation of DBT for women with PTSD associated with childhood sexual abuse was effective for reducing PTSD symptoms. See Harned, M. S., Jackson, S. C., Comtois, K. A., & Linehan, M.M. (2010). Dialectical behavior therapy as a precursor to PTSD treatment for suicidal and/or self-injuring women with borderline personality disorder. *Journal of Traumatic Stress*, 23, 421–429.

[169] Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse: A pilot study of an intensive residential treatment program. *Journal of Traumatic Stress*, 24, 102–106.

[170] https://childmind.org/article/dbt-dialectical-behavior-therapy/

[171]Groves, S., Backer, H. S., van den Bosch, W., & Miller, A. (2012). Dialectical behaviour therapy with adolescents. *Child and Adolescent Mental Health*, *17*(2), 65–75. http://doi.org/10.1111/j.1475-3588.2011.00611.x

[172] A 2012 Cochrane review found that DBT is the only treatment with sufficient research to conclude it is effective for people with borderline personality disorder. See https://www.cochrane.org/CD005652/BEHAV_psychological-therapies-borderline-personality-disorder. Overall, DBT has been designated as an empirically supported treatment with strong research support for treating BPD (American Psychological Association, Division 12).

[173] http://wsipp.wa.gov/BenefitCost/Program/264

[174]WSIPP has calculated Adult-focused Family Behavior Therapy cost savings and B/C ratio for providing DVT for youth in the juvenile justice system. The vast majority of the benefits ($56,000 out $59,000) for the program are due to reductions in crime (in a population already convicted of a crime). It is unlikely that DBT for borderline personality disorder and other complex mental health conditions would yield the same cost savings. See WSIPP (2017) http://wsipp.wa.gov/BenefitCost

[175] https://www.guilford.com/books/DBT-Skills-Training-Manual/Marsha-Linehan/9781462516995/summary

[176] More than 30 randomized controlled trials (RCTs), produced by nearly 20 independent research groups in nine countries have demonstrated the effectiveness of DBT. Meta-analyses of this extensive research have found moderate to large significant effects indicating DBT is more effective than treatment as usual in reducing suicide attempts, non-suicidal self-injury, and anger, and improving general functioning among people with borderline personality disorder (Stoffers et al., 2012; Kliem et al., 2010). For example, DBT decreased suicide attempts by 50% and psychiatric hospitalizations for suicidality by 73% when compared to community treatment by non-behavioral experts (Linehan et al., 2006). The available research suggests that DBT is comparably effective as other comprehensive psychotherapies for BPD. See Kliem S., Kröger, C., & Kosfelder, J.(2010). Dialectical behavior therapy for borderline personality disorder: a meta-analysis using mixed-effects modeling. *J Consult Clin Psychology*, 78 (6):936-51. doi: 10.1037/a0021015. And Stoffers-Winterling J.M., Völlm, B.A., Rücker, G., Timmer, A., Huband, N. & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. In *Cochrane Database of Systematic Reviews*, No. 8, New York: John Wiley & Sons, Ltd, DOI: 10.1002/14651858.CD005652.pub2 Retrieved from https://doi.org//10.1002/14651858.CD005652.pub2

[177] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

[178] https://www.newharbinger.com/blog/dbt-adolescent-self-harm-and-suicidality

[179] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=375

[180] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=375

[181] http://wsipp.wa.gov/BenefitCost/Program/150

[182] Http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[183] http://itp.wceruw.org/documents/FAST.pdf

[184] http://www.cebc4cw.org/program/family-focused-treatment-for-adolescents/detailed

[185] https://global.oup.com/academic/product/preventing-adolescent-depression-9780190243180

[186] http://www.cebc4cw.org/program/multi-family-psychoeducational-psychotherapy/detailed

[187] http://www.blueprintsprograms.com/factsheet/new-beginnings-for-children-of-divorce

[188] http://www.blueprintsprograms.com/factsheet/new-beginnings-for-children-of-divorce

[189] http://www.cebc4cw.org/program/positive-peer-culture/detailed

[190] http://www.cebc4cw.org/program/positive-peer-culture/detailed

[191] http://www.cebc4cw.org/program/primary-and-secondary-control-enhancement-training/detailed

[192] http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-school-age-group-2/detailed

[193] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy-tf-cbt-sexual-behavior-problems-in-children-treatment-of/

[194] http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy-tf-cbt-sexual-behavior-problems-in-children-treatment-of/detailed

[195] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=154#hide4

[196] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=116

[197] http://wsipp.wa.gov/BenefitCost/Program/298

[198] http://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/detailed

[199] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=176#hide4

[200] Reductions in non-opioid drug use (e.g., cannabis, amphetamine, ecstasy or cocaine) among young people aged 11-21 years were measured. The main conclusion of the review was that there is a lack of firm evidence on the effect of FBT. t 12 month post-intake, Azrin et al. (2001) found no statistically significant difference between FBT and the comparison treatment, SMD=-0.03 (95% CI -0.58, 0.52). For family functioning, measured at end of treatment, the standardized mean difference was 0.58 (95% CI 0.02, 1.13) reported by parents and 0.29 (95% CI -0.72, 1.30) reported by youth. See https://www.campbellcollaboration.org/library/family-behaviour-therapy-youth-drug-use-treatment.html, p. 9; and Azrin, N. H., Donohue, B., Teichner, G. A., Crum, T., Howell, J. & DeCato, L. A. (2001). A Controlled Evaluation and Description of Individual-Cognitive Problem Solving and Family-Behavior Therapies in Dually-Diagnosed Conduct-Disordered and Substance-Dependent Youth. Journal of Child & Adolescent Substance Abuse, 11, 1-43.

[201] http://wsipp.wa.gov/BenefitCost/Program/306

[202] See http://www.cebc4cw.org/program/brief-strategic-family-therapy/detailed *Condensed from description found at http://archives.drugabuse.gov/TXManuals/BSFT/BSFT2.html on May 2, 2014.*

[203] A summary of BSFT can be found here: https://brief-strategic-family-therapy.com/what-we-do/

[204] See Santisteban, D., Suarez-Morales, L., Robbins, M., & Szapocznik, J. (2006). Brief Strategic Family Therapy: Lessons learned in efficacy research and challenges to blending research and practice. *Family Process, 45*(2), 259-271. And https://brief-strategic-family-therapy.com/what-we-do/

[205] https://brief-strategic-family-therapy.com/what-we-do/

[206] http://www.cebc4cw.org/program/ecologically-based-family-therapy/detailed

[207] http://www.cebc4cw.org/program/families-facing-the-future/detailed

[208] http://www.cebc4cw.org/program/families-facing-the-future/detailed

[209] Children attend 12 of these sessions to practice the skills with their parents. Parent sessions are conducted with groups of six to eight families.

[210] http://www.cebc4cw.org/program/families-facing-the-future/detailed

[211] http://www.cebc4cw.org/program/functional-family-therapy/

[212] https://www.campbellcollaboration.org/library/functional-family-therapy-youth-drug-use-treatment.html

[213] The cost savings b/ information for Functional Family Therapy is based on the youth involved in the juvenile justice system. Most of the monetary benefits come from reduced crime. See http://wsipp.wa.gov/BenefitCost/Program/663

[214] http://www.cebc4cw.org/program/functional-family-therapy/detailed

[215] http://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/detailed

[216] http://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/detailed

[217] https://nrepp.samhsa.gov/, Interim Methadone Maintenance

[218] http://wsipp.wa.gov/BenefitCost/Program/694 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[219] https://nrepp.samhsa.gov. (Note that the NREPP review of Buprenorphine for opioid use as effective is for "Brief Negotiation Interview with Emergency Department Initiated Buprenorphine).

[220] http://wsipp.wa.gov/BenefitCost/Program/695

[221] Patients also receive counseling therapies such as cognitive behavioral treatment or motivational enhancement therapy. Injections are typically administered monthly for one to six months.

[222] http://www.wsipp.wa.gov/BenefitCost/Program/592

[223] http://wsipp.wa.gov/BenefitCost/Program/662

[224] http://www.cebc4cw.org/program/avance-parent-child-education-program/detailed

[225] http://www.cebc4cw.org/program/avance-parent-child-education-program/detailed

[226] http://wsipp.wa.gov/BenefitCost/Program/748

[227] https://www.hippyusa.org/the-hippy-model/starting-a-program/

[228] http://wsipp.wa.gov/BenefitCost/Program/160 and http://wsipp.wa.gov/BenefitCost

[229] http://www.cebc4cw.org/program/safecare/detailed

[230] http://www.tuningintokids.org.au/professionals/products/

[231] http://www.tuningintokids.org.au/professionals/products/

[232]http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[233] http://www.bsft.org/documents/BSFTNIDATherapyManual.pdf

[234] https://www.dropbox.com/s/ohjixk5t7z2khri/CPP%20Training%20Overview%2003132013.pdf

[235] Range of $826.67-1656.67 per trainee based on total costs for 1 trainer for 1 site (total costs range $24,800-$49,700) and not including indirect costs or costs of manuals. Training for one site occurs over an 18-month period https://www.dropbox.com/s/ohjixk5t7z2khri/CPP%20Training%20Overview%2003132013.pdf

[236] http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed

[237] Taxy, S., Liberman, A. M., Roman, J. K., & Downey, M. (2012). *The costs and benefits of Functional Family Therapy for Washington, DC*. Washington, DC: District of Columbia Crime Policy Institute and the Urban Institute. Retrieved from http://www.urban.org/UploadedPDF/412685-The-Costs-and-Benefits-of-Functional-Family-Therapy-for-Washington-DC.pdf. For additional information, see http://www.fftllc.com.

[238] http://fftllc.com/about-fft-training/clinical-model.html http://fftllc.com/about-fft-training/clinical-model.html http://fftllc.com/about-fft-training/clinical-model.html http://fftllc.com/about-fft-training/clinical-model.html

[239]A study published in 2017 compared the efficiency and effectiveness of Functional Family Therapy-Child Welfare (FFT-CW®, n = 1625) to Usual Care (UC: n = 2250) in reducing child maltreatment. Families receiving FFT-CW® completed treatment more quickly than UC and they were significantly more likely to meet all of the planned service goals. Higher treatment fidelity was associated with more favorable outcomes. Fewer FFT-CW® families were transferred to another program at closing, and they had fewer recurring allegations. FFT-CW had fewer out-of-home placements in families with higher levels of risk factors. The FFT-CW program was more efficient in completing service, and more effective than UC in meeting treatment goals while also avoiding adverse outcome. See Turner, C.W., Robbins, M.S., Rowlands, S.C. & Weaver, L.R. (2017). Summary of comparison between FFT-CW® and Usual Care sample from Administration for Children's Services. *Child Abuse and Neglect*, 69, 85-95.

[240] The New Jersey FFT study measured outcomes and cost savings from 2005 to 2011. See Stout, B. D., & Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. *Journal of Child and Family Studies*, 22(3), 311–321. doi:10.1007/s10826-012-9580-6 For additional information about FFT cost-savings see WSIPP (2017) http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost http://wsipp.wa.gov/BenefitCost

[241] https://www.dropbox.com/s/ohjixk5t7z2khri/CPP%20Training%20Overview%2003132013.pdf

[242] A meta-analysis of IPFS research published in 2012 found that intensive family preservation programs did have a medium and positive effect on family functioning, but were generally not effective in preventing out-of-home placement. Due to a limited number of studies examining family functioning, moderator effects were examined for out-of-home placement only. These moderator analyses revealed that the effect of intensive family preservation programs was moderated by sex and age of the child, parent age, number of children in the family, single parenthood, non-white ethnicity, and caseload of the social workers, but not by adherence to the Homebuilders model and intervention duration. In addition, study characteristics (study design and study quality), and publication characteristics (publication type, publication year and journal impact factor) were found to be associated with placement prevention outcomes. The finding that intensive family preservation programs were found to be effective in preventing foster care placement for multi-problem families, but not for families experiencing abuse and neglect can be explained as follows. In the latter case, out-of-home placement may simply be unavoidable (see also Schuerman, Rzepnicki, & Littell, 1994), whereas out-of-home placement may be prevented in multi-problem families where risk of placement is relatively low compared to families experiencing maltreatment (Al et al., 2012, p. 1476). Another meta-analysis of IFPS studies in five states, published in 2015, found that while it reported rates of repeat child maltreatment, the analysis used placement rates as the main outcome measure and compares effect sizes using Cohen's arcsine transformation for data reported as proportions. Significant differences in rates of child out-of-home placement and repeat maltreatment were found in some studies, particularly for higher risk families (Schweitzer et al., 2015, p. 423). See:

- Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & van der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review*, *34*(8), 1472–1479. doi:10.1016/j.childyouth.2012.04.002
- Schuerman, J. R., Rzepnicki, T. L., & Littell, J. H. (1994). Putting families first: An experiment in family preservation. New York: Aldine de Gruyter.
- Schweitzer, D. D., Pecora, P. J., Nelson, K., Walters, B., & Blythe, B. J. (2015). Building the evidence base for intensive family preservation services. *Journal of Public Child Welfare*, *9*(5), 423–443. doi:10.1080/15548732.2015.1090363

[243] http://wsipp.wa.gov/BenefitCost/Program/78 WSIPP (2017) http://wsipp.wa.gov/BenefitCost

[244] http://www.institutefamily.org/resources.asp

[245] http://mstservices.com/files/howitsdone.pdf

[246] A 2015 Campbell review found that the most rigorous (intent-to-treat) analysis found no significant differences between MST and usual services in restrictive out-of-home placements and arrests or convictions. Pooled results that include studies with data of varying quality tend to favor MST, but these relative effects are not significantly different from zero. The study sample size is small and effects are not consistent across studies; hence, it is not clear whether MST has clinically significant advantages over other services. See https://www.campbellcollaboration.org/library/multisystemic-therapy-social-emotional-behavioral-problems.html

[247] http://wsipp.wa.gov/BenefitCost/Program/36 and http://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health

[248] http://www.cebc4cw.org/program/multisystemic-therapy/detailed

[249] PLL has an additional component of six group education sessions conducted at a community location. The group component is used as an ongoing engagement strategy and to introduce parenting skills. However, all skills introduced in the group component are also reviewed 1:1 in-home during the six family coaching sessions and the group material can be presented in-home Personal Communication, Alison Blodgett, November 5, 2018).

[250] Sterrett-Hong, E. M., Karam, E., & Kiaer, L. (2017). Statewide implementation of Parenting with Love and Limits (PLL) among youth with co-existing emotional and behavioral problems to reduce return to service rates and treatment costs. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(5):792-809, doi:10.1007/s10488-016-0788-4

[251] http://wsipp.wa.gov/BenefitCost/Program/138

[252] http://www.cebc4cw.org/program/1-2-3-magic-effective-discipline-for-children-2-12/detailed

[253] https://www.123magic.com/books

[254]NREPP Moral Reconation Therapy summary retrieved Sept. 20, 2015, from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=11. For more information see:

- Deschamps, T. (1998). *MRT: Is it effective in decreasing recidivism rates with young offenders?* Unpublished master's thesis, University of Windsor, Windsor, Ontario, Canada.
- Little, G. L., Robinson, K. D., & Burnette, K. D. (1991). Treating drug offenders with Moral Reconation Therapy: A three-year report. *Psychological Reports*, 69, 1151-1154.
- Information re: training located here: http://www.blueprintsprograms.com/program-costs/adolescent-coping-with-depression Training cost = $**5,000** = $2000 / day for 1-2 day training sessions + travel costs for trainer. Following costs only for trained therapists to lead the group. No cost for curriculum or licensing. Training cost estimate does not include cost for the salaries of participating therapist who are being trained. (Source: Blueprints for Healthy Youth Development, hosted by the Center for the Study and Prevention of Violence (CSPV), at Institute of Behavior Science, Univ. of Colorado Boulder.)

[255] See entry for CBT for adolescent depression)

[256] https://research.kpchr.org/Research/Research-Areas/Mental-Health/Youth-Depression-Programs

[257] http://www.workbookpublishing.com/anxiety.html

[258] https://nrepp.samhsa.gov/ProgramProfile.aspx?id=1225

[259] The CCPT model has also been implemented in the school setting following a 16-session format delivered twice weekly for 30 minutes over 8 weeks. CCPT can be provided in the context of longer treatment requirements and may be used in a small group format.

[260] CEBC summary: http://www.cebc4cw.org/program/effective-black-parenting-program/detailed. Also see Myers, H. F., Alvy, K. T., Arlington, A., Richardson, M. A., Marigna, M., Huff, R., & Newcomb, M. D. (1992). The impact of a parent training program on inner-city African-American families, *Journal of Community Psychology, 20*(2), 132-147.

[261]CEBC review and summary retrieved Sept. 30, 2015, from: http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/detailed. See:http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/detailed. See:

- Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*, 965–971.
- Kelly, K. A., Rizvi, S. L., Monson, C. M., & Resick, P. A. (2009). The impact of sudden gains in cognitive behavioral therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 22*, 287–293.
- NREP summary retrieved Sept. 30, 2015, from: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=386.
- Resick, P. A., Williams, L. F., Suvak, M. K., Monson, C. M., & Gradus, J. L. (2012). Long-term outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors. *Journal of Consulting and Clinical Psychology, 80,* 201–210.

[262] https://www.guilford.com/books/Cognitive-Processing-Therapy-for-PTSD/Resick-Monson-Chard/9781462528646

[263] http://www.blueprintsprograms.com/program-costs/parent-child-interaction-therapy

[264] http://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780199916887.001.0001/med-9780199916887

[265] http://www.cebc4cw.org/program/fairy-tale-model-treating-problem-behaviors-a-trauma-informed-approach/detailed

[266] http://www.cebc4cw.org/program/family-connections/detailed

[267] Family Spirit is being implemented across the country in 120 tribal communities across 19 states. (Personal communication, Kristen Speakman, Ausust 8, 2018.)

[268] http://www.cebc4cw.org/program/helping-the-noncompliant-child/

[269] http://wsipp.wa.gov/BenefitCost/Program/541

[270] https://www.guilford.com/books/Helping-the-Noncompliant-Child/McMahon-Forehand/9781593852412

[271] http://www.cebc4cw.org/program/interpersonal-psychotherapy-for-depressed-adolescents/detailed

[272] http://www.cebc4cw.org/program/mindfulness-based-cognitive-therapy-for-children-mbct-c/detailed

[273] Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Lenggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse & Neglect, 37*(8), 596-607. doi:10.1016/j.chiabu.2013.04.004

[274] MST was developed by psychologists but has always had social workers involved and relies heavily on social ecological theory, in-home services, family work, and consultation with schools and other entities (e.g., juvenile services or CW) that are also involved with the family.

[275] http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/detailed

[276] Despite the fact that some program expenses like supervision, rent, and other non-personnel costs were not included, savings would be substantially greater if other outcomes associated with the prevention of maltreatment were included, such as medical costs (hospitalizations, chronic health conditions, doctor visits, prescriptions), non-medical costs (judicial and criminal services, special education), and lost productivity (lost earnings). See Maher, E. J., Corwin, T. W., Hodnett, R., & Faulk, K. (2012). A cost-savings analysis of a statewide parenting education program in child welfare. *Research on Social Work Practice, 22*, 615 - 625.

[277] http://www.cebc4cw.org/program/parents-anonymous/detailed

[278] http://www.cebc4cw.org/program/parents-anonymous/detailed

[279] http://www.cebc4cw.org/program/solution-based-casework/detailed

[280] http://www.cebc4cw.org/program/solution-based-casework/detailed

[281] Ford & Russo (2006),

[282] Layne, Saltzman, Pynoos, et al. (2000).

[283] See (DBT: Miller, Rathus, & Linehan, 2006),

[284] With SPACS, youth were half as likely to run away, were one-fourth less likely to experience placement interruptions (arrests, hospitalizations, runaways etc.), and showed improvement in risk behaviors measured with the Child and Adolescent Needs and Strengths (CANS) instrument.
See http://promising.futureswithoutviolence.org/?program=structured-psychotherapy-for-adolescents-responding-to-chronic-stress-sparcs

[285] http://resources.childhealthcare.org/resources/sparcs_general.pdf

[286] http://www.cebc4cw.org/program/sitcap-art/detailed

[287] http://www.cebc4cw.org/program/trauma-grief-component-therapy-for-adolescents/detailed

[288] Students in treatment condition reported significant (p < .05) pre- to post-treatment reductions in PTSD symptoms (58% at post-treatment; 81% at 4-month follow-up) compare favorably to those reported in a rigorously conducted treatment efficacy trials.

[289] http://www.cebc4cw.org/program/trauma-grief-component-therapy-for-adolescents/detailed

[290] See the Wraparound program initiative website at http://nwi.pdx.edu

[291] http://www.cebc4cw.org/program/c-a-r-e-s-coordination-advocacy-resources-education-and-support/detailed

[292] http://www.cebc4cw.org/program/seeking-safety-for-adolescents/detailed

[293] http://wsipp.wa.gov/BenefitCost/Program/307

[294] https://www.treatment-innovations.org/store/p2/Seeking_Safety_book_-_English_language.html

[295] ABCT begins with a 2–3-hour assessment for detailed treatment planning to determine contributing factors to alcohol use, the state of the relationship, and the reason for abstinence.

[296]McHugh K.R., Hearon B.A., & Otto M.W. (2010). Cognitive-behavioral therapy for substance use disorders. *Psychiatr. Clin. N. America*, 33:511–525. doi: 10.1016/j.psc.2010.04.012

[297] http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[298] http://www.wsipp.wa.gov/BenefitCost/Program/292

[299]http://www.cebc4cw.org/program/seeking-safety-for-adolescents/detailed

[300] http://wsipp.wa.gov/BenefitCost/Program/307

[301] https://www.treatment-innovations.org/store/p2/Seeking_Safety_book_-_English_language.html

[302] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=358

[303] http://wsipp.wa.gov/BenefitCost/Program/313

[304] https://www.nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=358

[305] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-4

[306] https://www.campbellcollaboration.org/library/12-step-programmes-illicit-drug-abuse-reduction.html

[307] http://wsipp.wa.gov/BenefitCost/Program/313 and http://www.wsipp.wa.gov/BenefitCost/Pdf/7/WSIPP_BenefitCost_Substance-Use-Disorders

[308] https://pubs.niaaa.nih.gov/publications/projectmatch/match01.pdf

[309] The program promotes five protective factors that have been shown to increase the likelihood of positive outcomes for young children and their families and to reduce the likelihood of child abuse and neglect: 1) parental resilience, 2) social connections, 3) knowledge of parenting and child development, 4) concrete support in times of need, and 5) social and emotional competence of children. The program's components are developed to provide new parents with practical demonstrations of infant soothing and strategies for managing normal stress in parenting. See https://nrepp.samhsa.gov/ProgramProfile.aspx?id=118#hide4

[310] http://www.cebc4cw.org/program/circle-of-security-home-visiting-4/detailed

[311] https://www.circleofsecurityinternational.com/books

[312]Abstracted from the CEBC website: http://www.cebc4cw.org/program/collaborative-problem-solving/

[313] https://homvee.acf.hhs.gov/Implementation/3/Early-Head-Start-Home-Visiting--EHS-HV--Implementation/8

[314] https://homvee.acf.hhs.gov/Implementation/3/Early-Head-Start-Home-Visiting--EHS-HV--Implementation/8

[315] Federal HOMVEE program summary

[316] Federal HOMVEE home visiting program summary.

[317] http://wsipp.wa.gov/BenefitCost/Program/749

[318] http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/detailed

[319] http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/detailed

[320] http://wsipp.wa.gov/BenefitCost/Program/539 http://wsipp.wa.gov/BenefitCost/Program/544

[321] http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/detailed

[322] Abstracted from CEBC: http://www.cebc4cw.org/program/parents-as-teachers/

[323] Parents and youth meet separately for instruction during the first hour and together for family activities during the second hour.

[324] Dr. Kolko says: per participant cost varies by who is providing it, who pays for it, insurance regulation dictates, delivery setting, etc.

[325] http://wsipp.wa.gov/BenefitCost/Program/388

[326] Federal HOMVEE home visiting program summary.

[327] http://www.blueprintsprograms.com

[328]Perini, S.J., Wuthrich, V.M. & Rapee, R.M. (2013).Cool Kids in Denmark: Commentary on a cognitive-behavioral therapy group for anxious youth. *Pragmatic Case Studies in Psychotherapy,* (9), Module 3, Article 4, pp. 359-370.

[329] Perini et al., (2013).

[330] http://www.cebc4cw.org/program/cool-kids/detailed

[331] https://global.oup.com/academic/product/cue-centered-therapy-for-youth-experiencing-posttraumatic-symptoms-9780190201326

[332] Arias, Arce, & Vilariño. (2013). Batterer intervention programmes: A meta-analytic review of effectiveness. *Psychosocial Intervention*, 22(2), 153-160.

[333] One meta-analysis found a "lack of a significant treatment effect" for the Duluth Model. See Arias, Arce, & Vilarino, (2013),

[334] https://www.theduluthmodel.org/product-category/booksmanuals/

[335] http://www.marquette.edu/education/early-pathways/

[336] http://www.marquette.edu/education/early-pathways/

[337] http://www.cebc4cw.org/program/families-first/detailed

[338] http://www.cebc4cw.org/program/family-centered-treatment/

[339] http://www.cebc4cw.org/program/parent-child-assistance-program/detailed

[340] Varies by outcome – see Maher, E.J. & Grant, T. (2013). *Parent-Child Assistance Program outcomes suggest sources of cost savings for Washington State.* (Research brief) Seattle: Casey Family Programs. And http://www.wsipp.wa.gov/BenefitCost/Program/346

[341] See http://pfrprogram.org/ and http://www.cebc4cw.org/program/promoting-first-relationships/

[342]A RCT study was recently published on open CPS investigation cases but the outcomes measured do not include repeat child maltreatment

[343] http://www.cebc4cw.org/program/promoting-first-relationships/detailed

[344] See http://www.cebc4cw.org/program/risk-reduction-through-family-therapy/detailed

[345] http://www.cebc4cw.org/program/risk-reduction-through-family-therapy/detailed

[346] http://www.cebc4cw.org/program/step-by-step-parenting-program/detailed

[347] No meta-analysis of TARGET-A has been completed to date. Ford, Julian D., Steinberg, Karen L., Hawke, Josephine, Levine, Joan, & Zhang, Wanli. (2012). Randomized Trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child and Adolescent Psychology*, 41(1), 27-37.

[348] http://www.cebc4cw.org/program/trauma-affect-regulation-guide-for-education-and-therapy-adolescents/detailed

[349] See http://www.cebc4cw.org/program/wraparound/detailed

[350] See the Wraparound program initiative website at http://nwi.pdx.edu

HHS Initial Practice Criteria and First List of Services and Programs Selected for Review as part of the *Title IV-E Prevention Services Clearinghouse*

The Family First Prevention Services Act requires HHS to conduct an independent systematic review of evidence to rate services and programs as promising, supported, and well-supported practices.

On June 22, 2018, HHS published a Federal Register Notice (FRN; 83 FR 29122) requesting public comment on initial criteria and potential services and programs to be considered for systematic review in the *Title IV-E Prevention Services Clearinghouse (herein the Clearinghouse)*. The initial criteria were intended to (a) determine eligibility of programs and services for review by the Clearinghouse, (b) prioritize eligible programs and services for review, (c) determine eligibility of studies aligned with prioritized programs and services, (d) prioritize eligible studies for rating, (e) rate studies, and (f) rate programs and services as promising, supported, and well-supported practices. The FRN also requested recommendations of potential services and programs to be considered for systematic review. The comment period closed on July 22, 2018. Over 360 responses were received, most containing multiple comments. Commenters included state and local administrators, service and program developers, foundations, non-profit organizations, researchers and evaluators, and other stakeholders.

This attachment includes revised initial criteria and the first dozen services and programs selected for systematic review. The Clearinghouse will select additional services and programs for review on a rolling basis. In developing these revised initial criteria and selecting the first dozen services and programs, HHS considered public comments on the FRN and input from federal partners, as well as other key stakeholders including the California Evidence-Based Clearinghouse.

Overall, public comments recommended adopting broad and inclusive criteria to determine services or programs and associated studies considered for review. Public comments and feasibility considerations informed several notable revisions to the initial criteria. For example, the revised initial criteria no longer consider target population/sample, implementation period, trauma-informed approach, magnitude of effects, and in-home delivery setting in determining eligibility, prioritization, or rating. When possible, the Clearinghouse will document and release additional information beyond that considered as part of the revised initial criteria. This additional information may include, but is not limited to details about: the extent to which the service or program is provided under an organizational structure or framework in accordance with principles of a trauma informed approach and/or represents a trauma specific intervention; intended target population of service or program; availability of culturally specific, location or population-based adaptation of service or program; service or program delivery setting; and study specific information such as effect sizes, power, and additional detail on study sample and subsample.

I. Revised Initial Criteria

The Clearinghouse will use the *Service or Program Eligibility and Prioritization Criteria* to identify and prioritize services and programs for review. Subsequently, the Clearinghouse will

use the *Study Eligibility and Prioritization Criteria* to identify and prioritize our review of studies for each of the selected services and programs. The Clearinghouse will use the *Study Rating Criteria* to assess the design, execution, and impacts of studies. The Clearinghouse will use the *Service or Program Rating Criteria* to rate services or programs as "promising," "supported," "well-supported," or "does not currently meet criteria." A more detailed description of the revised initial criteria and procedures for systematic review and re-review along with definitions of key terminology will be included in the forthcoming Title IV-E Prevention Services Clearinghouse Procedures Handbook.

1. *Service or Program Eligibility Criteria.* Services or programs must, at a minimum, meet the following criteria to be eligible for review by the Clearinghouse [sections 471(e)(1) and 471(e)(4)(C) of the Social Security Act (the Act)]:
    a. Types of Services and Programs. Eligibility will be limited to mental health and substance abuse prevention and treatment services and in-home parent skill-based programs as well as kinship navigator programs.
    b. Book/Manual/Writings Available. Eligibility will be limited to services or programs that have a book, manual, or other available documentation that specifies the components of the practice protocol and describes how to administer the practice.

2. *Service or Program Prioritization Criteria.* Timing and resources may not allow for the Clearinghouse to conduct a detailed review of all services and programs that meet the *Service or Program Eligibility Criteria.* Services or programs will be prioritized for Clearinghouse review using the following criteria:
    a. Target Outcomes. Services or programs that aim to impact target outcomes identified by the Clearinghouse will be prioritized for review [section 471(e)(4)(C) of the Act]. Target outcomes for mental health and substance abuse prevention and treatment services and in-home parent skill-based programs will include a wide array of outcomes that fall broadly under the following domains: child safety, child permanency, child well-being, and adult (parent and kin caregiver) well-being. Target outcomes for kinship navigator programs will include all outcome domains listed above as well as access to, referral to, and satisfaction with services and programs.
    b. In Use/Active. Services or programs currently in use with a book, manual, or other documentation available in English will be prioritized.
    c. Implementation and Fidelity Support. Services or Programs that have implementation training and staff support and/or fidelity monitoring tools and resources available to implementers in English will be prioritized.

Initially, the *Title IV-E Prevention Services Clearinghouse* will give particular consideration to services and programs recommended by state and local government administrators in response to the FRN, included as part of existing evidence reviews, and/or evaluated by Title IV-E Child Welfare Waiver Demonstrations. The Clearinghouse will also give particular consideration to ensure services and programs from each category (i.e., mental health, substance abuse, in-home parent, or kinship navigator) are represented.

3. *Study Eligibility Criteria.* Studies examining each of the selected services and programs will be screened for eligibility for inclusion in the Clearinghouse using the following criteria:
    a. Source. Eligibility will be limited to studies included in peer-reviewed journal articles and/or publicly available literature that may include, but is not limited to federal, state, and local government and foundation reports.
    b. Study Design. Eligibility will be limited to study designs that assess effectiveness (i.e., impact) using quantitative methods and utilize an appropriate control. Eligible study designs include Randomized Controlled Trials (RCT), Quasi-Experimental Designs (QED), and other non-experimental designs that utilize an appropriate control.
    c. Target Outcomes. Eligibility will be limited to studies that examine the impact of the service or program on at least one 'target outcome.' Target outcomes for studies of mental health and substance abuse prevention and treatment services and in-home parent skill-based programs will include a wide array of outcomes that fall broadly under the following domains: child safety, child permanency, child well-being, and adult (parent and kin caregiver) well-being. Target outcomes for studies of kinship navigator programs will include all outcome domains listed above as well as access to, referral to, and satisfaction with services and programs.
    d. Study Available in English. Eligibility will be limited to studies available in English.

    Initially, the *Title IV-E Prevention Services Clearinghouse* will give particular consideration to studies published or prepared in or after 1990.

4. *Study Prioritization Criteria.* Timing and resources may not allow for the Clearinghouse to conduct a detailed review of all studies determined within a selected service or program to be eligible according to the *Study Eligibility Criteria.* The order and depth of review for studies will be determined on the basis of study features that may include sample size, duration of sustained effects examined, and type of study design.

5. *Study Rating Criteria.* The Clearinghouse will rate studies using the following criteria:
    a. Study Design and Execution. Building from the standards of existing evidence reviews such as the What Works Clearinghouse (WWC) and Home Visiting Evidence of Effectiveness (HomVEE), the Clearinghouse will assess studies on the basis of study design, overall and differential sample attrition, the equivalence of intervention and comparison groups at baseline (as applicable), and when necessary, procedures accounting for clustering. In addition, the study must account for confounding factors and examine at least one "target outcome" (see *Study Eligibility Criteria)* using a measure that is reliable and achieves face validity. Inconsistencies in systematic administration, as noted in study text, will also be considered. Studies will be rated as "high," "moderate," or "low." The study-level ratings will provide an indicator of the extent to which a study provides unbiased estimates of model impacts.

b. Effects. The following effects, defined using conventional standards of statistical significance, will be examined in the full analysis sample for studies that achieve a "high" or "moderate" rating on Study Design and Execution:
   i. Favorable Effects. Studies will be rated based on whether they demonstrate at least one meaningful favorable effect (i.e., positive significant effect) on a 'target outcome.'
   ii. Unfavorable Effects. Studies will be rated based on the number of unfavorable effects (i.e., negative significant effects) on either 'target' or non-target outcomes.
   iii. Sustained Favorable Effect. Studies with at least one meaningful favorable effect on a 'target outcome' will be rated on whether or not they demonstrate a favorable effect sustained beyond the end of treatment. Studies will be classified as not demonstrating a sustained favorable effect (i.e., effects are demonstrated for less than 6 months), demonstrating a sustained favorable effect of 6 months or more (but less than 12 months), or demonstrating a sustained favorable effect of 12 months or more.

Initially, due to time and resource constraints, the Clearinghouse will use only effects resulting from analyses of the full study sample for rating. This decision may be reconsidered in the future.

6. *Service or Program Rating Criteria.* The Clearinghouse will rate a service or program as a 'promising,' 'supported,' or 'well-supported' practice if it meets the below criteria that collectively assess the strength of evidence for a practice and build from the *Study Rating Criteria* [section 471(e)(4)(C) of the Act].
   a. *Promising Practice:* A service or program will be rated as a 'promising practice' if the service or program has at least one study that achieves a rating of 'moderate' or 'high' on Study Design and Execution and demonstrates a favorable effect on at least one 'target outcome.'
   b. *Supported Practice:* A service or program will be rated as a 'supported practice' if the service or program has at least one study carried out in a usual care or practice setting that achieves a rating of 'moderate' or 'high' on Study Design and Execution and demonstrates a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome.
   c. *Well-Supported Practice:* A service or program will be rated as a 'well-supported practice' if the service or program has at least two studies with non-overlapping analytic samples carried out in a usual care or practice setting that achieve a rating of 'moderate' or 'high' on Study Design and Execution. At least one of the studies must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.
   d. *Does Not Currently Meet Criteria:* A service or program will be rated as 'does not currently meet criteria' if the service or program has been reviewed and does not currently meet the evidence criteria for 'promising,' 'supported,' or 'well-supported" practices.

In accordance with the Family First Prevention Services Act, a service or program will not be rated as a 'promising,' 'supported,' or 'well-supported practice' if there is an empirical basis, as evidenced by multiple unfavorable effects on target or non-target outcomes across reviewed studies that suggest the overall weight of evidence does not support the benefits of the service or program.

II. First Services and Programs Selected for Systematic Review

HHS received and carefully considered a high volume of recommendations for services and programs to review as part of the Clearinghouse. The recommendations have informed the first services and programs selected for review and will inform additional services and programs to be selected for review on a rolling basis. Building from recommendations received from the FRN, federal partners, and other key stakeholders, as well as new information gathered, the Clearinghouse will utilize the forthcoming procedures and revised initial criteria to identify and prioritize additional services and programs for review.

The first services and programs selected for systematic review met at least two of the following conditions: (1) recommendation from State or local government administrators in response to the FRN; (2) rated by the California Evidence-Based Clearinghouse; (3) evaluated by Title IV-E Child Welfare Waiver Demonstrations; (4) recipient of a Family Connection Discretionary Grant; and/or (5) recommendation solicited from federal partners in the Administration for Children and Families, Health Resources and Services Administration, the National Institutes of Health, the Centers for Disease Control and Prevention, the Office of the Assistant Secretary for Planning and Evaluation, and the Substance Abuse and Mental Health Services Administration. Findings from the review of the first dozen services and programs are scheduled for release in Spring 2019. This review will rate programs as "promising," "supported," "well-supported," or "does not currently meet criteria." The Clearinghouse will select additional services and programs for review on a rolling basis using the revised initial criteria.

Prevention Services and Programs
Mental Health:
Parent-Child Interaction Therapy
Trauma Focused-Cognitive Behavioral Therapy
Multisystemic Therapy[1]
Functional Family Therapy

Substance Abuse:
Motivational Interviewing
Multisystemic Therapy[2]
Families Facing the Future
Methadone Maintenance Therapy

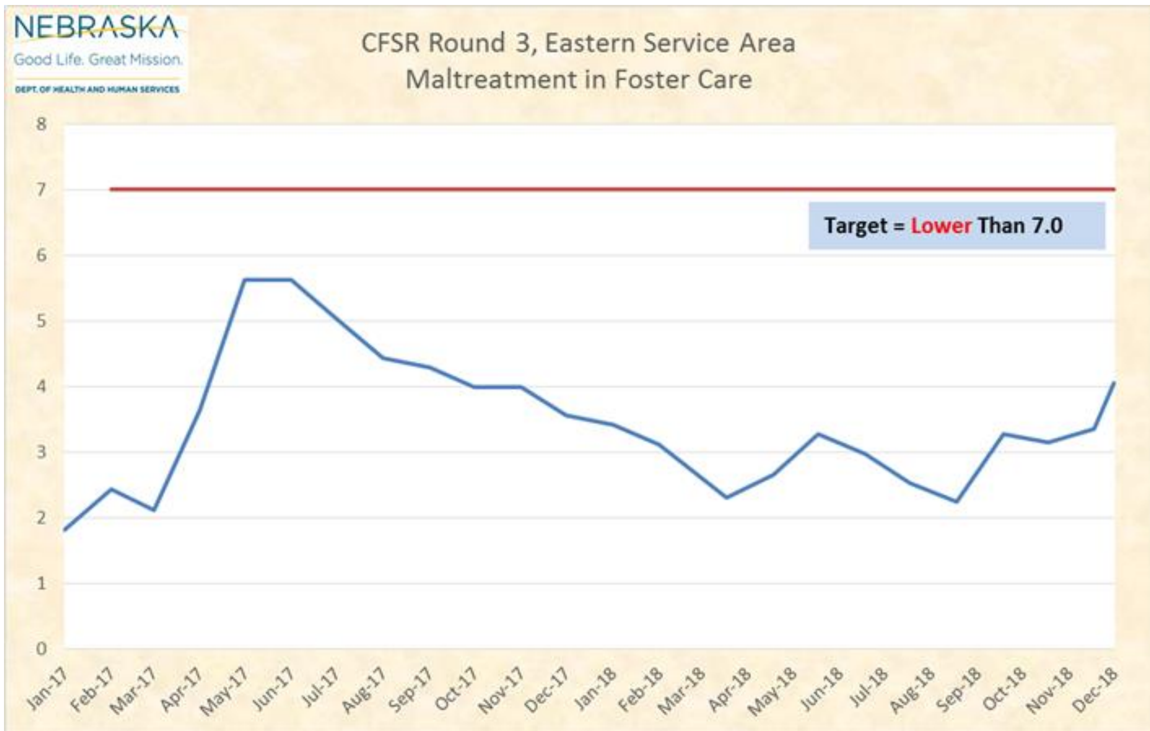
[1] Also included under the "Substance Abuse" category
[2] Also included under the "Mental Health" category

In-Home Parent Skill-Based:
Nurse-Family Partnership
Healthy Families America
Parents as Teachers

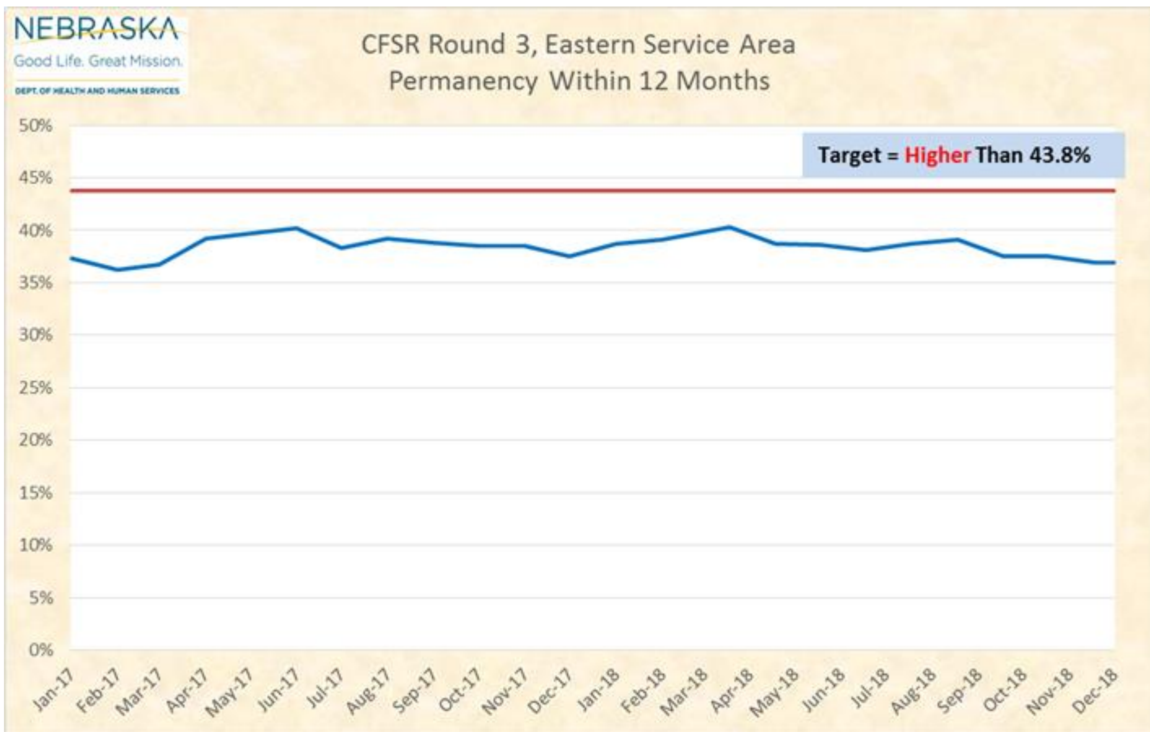
Kinship Navigator Programs
Children's Home Society of New Jersey Kinship Navigator Model
Children's Home Inc. Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-Tech)

The Clearinghouse will release procedures for implementing the *Service or Program Eligibility and Prioritization Criteria* along with definitions of key terminology in the forthcoming Title IV-E Prevention Services Clearinghouse Procedures Handbook.

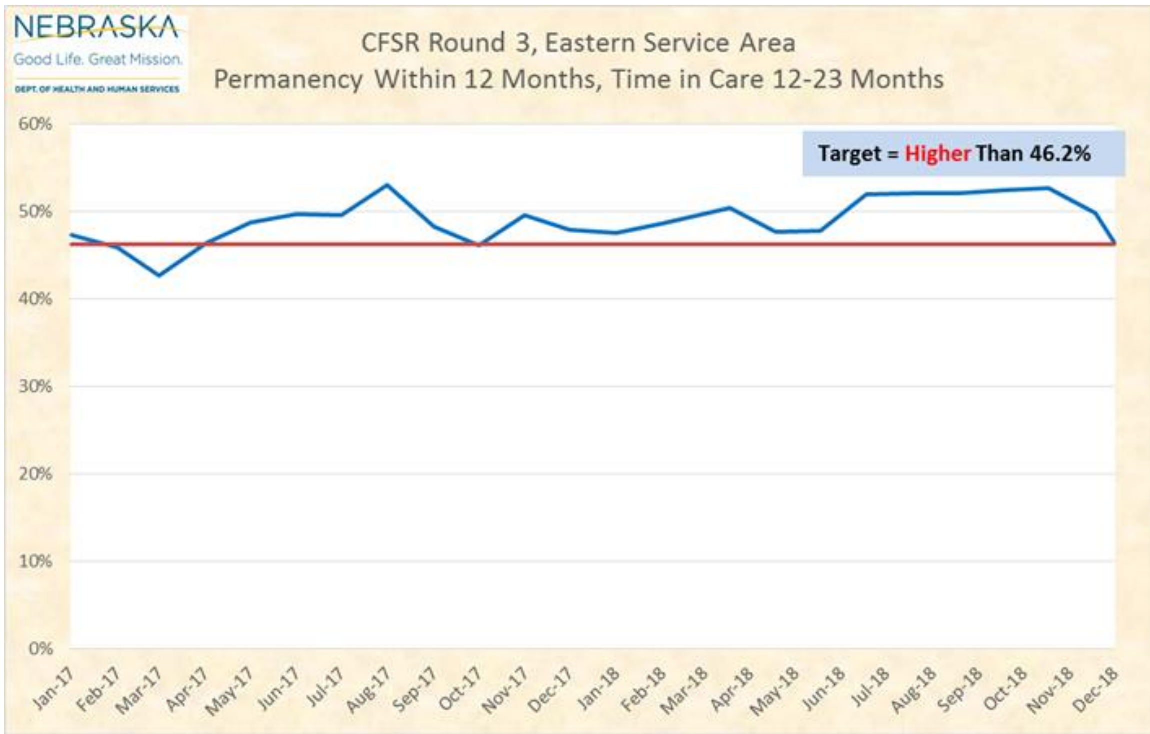
NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
CFSR Round 3, Eastern Service Area
Recurrence Within 12 Months
Target = Lower Than 7.9%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
CFSR Round 3, Eastern Service Area
Maltreatment in Foster Care
Target = Lower Than 7.0
8
7
6
5
4
3
2
1
0
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18

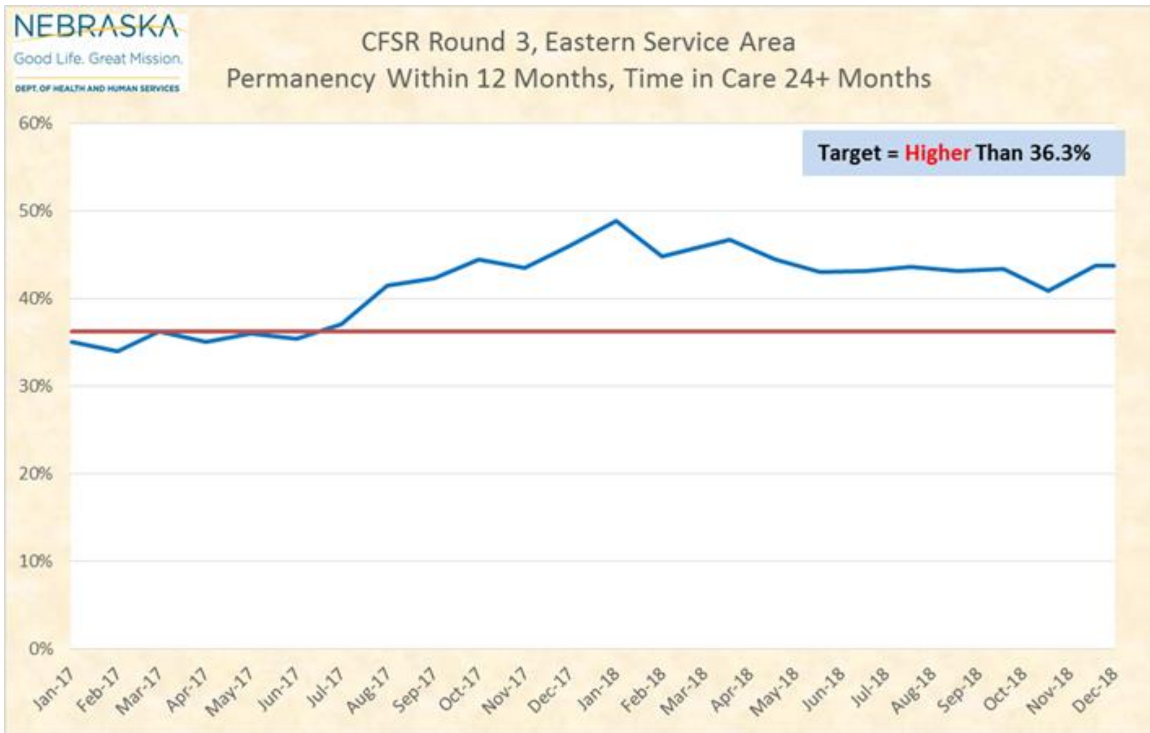
NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
CFSR Round 3, Eastern Service Area
Placement Stability
Target = Lower Than 4.12
5
4
3
2
1
0
Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18


NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
CFSR Round 3, Eastern Service Area
Permanency Within 12 Months
Target = Higher Than 43.8%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18

ATTACHMENT NINE Eastern Service Area Performance –



ATTACHMENT NINE Eastern Service Area Performance –



ATTACHMENT TEN

	A	B	C	D	E	F	G	H	I	J
1										
2										
3	**Sum of Amount**	**Column Labels**								
4	**Row Labels**	**7/31/2016**	**8/31/2016**	**9/30/2016**	**10/31/2016**	**11/30/2016**	**12/31/2016**	**1/31/2017**	**2/28/2017**	**3/31/2017**
5	ACADEMIC TUTORING	$2,483	$7,453	$4,216	$3,495	$736	$14,408	$3,420	$4,334	
6	AGENCY SUPP FOSTER CARE	$618,074	$541,181	$516,714	$560,530	$528,095	$378,619	$651,065	$530,465	$542,651
7	ASSMNT DRUG ALCOHOL	$386	$193				$386	$395	$390	$197
8	CASE CONFERENCE									
9	CFS PRESCHOOL CARE	$1,929	$1,715	$1,495	$4,279	$2,604	$16,157	$300	$1,538	
10	CFS SCHOOL AGE CARE									
11	CLOTHING				$50					
12	COURT COSTS	$79								
13	DAY REPORTING CENTER	$120					$840			
14	DAY TREATMENT PSYCH	$1,222	$1,543							
15	DD PLACEMENT DAILY COST									
16	DRUG TEST LAB CONFIRM	$21,110	$31,705	$17,515	$20,935	$20,825	$51,740	$23,980	$49,445	$30,330
17	DRUG TEST SPEC COLLECT	$33,989	$54,477	$39,836	$38,657	$35,033	$108,942	$46,717	$111,575	$61,371
18	DV PREVENTION CLASSES	$300		$590	$450	$400	$1,250		$360	$360
19	DV PREVENTION INTAKE									
20	ELECTRONIC MONITOR/TRACK		$566		$146	$548	$1,392	$566	$1,008	$2,200
21	EMERGENCY SHELTER CENTER	$32,685	$11,418	$33,902	$8,835	$38,067	$78,290	$2,314	$15,626	$27,266
22	FAMILY GROUP CONFERENCING	$13,500	$18,900	$18,900	$13,500	$5,400	$35,100	$8,100	$24,300	$18,900
23	FAMILY SUPPORT SERVICES	$94,272	$98,478	$57,094	$121,314	$96,380	$201,505	$76,810	$193,742	$112,373
24	FAMILY WORKS									
25	FILING FEES							$88		
26	GROCERY/MEAL PURCHASE	$108			$9					
27	GROUP HOME CARE	$177,697	$81,218	$123,056	$79,558	$101,053	$372,070	$72,360	$274,316	$184,600
28	HOME SUPPORTED SERVICES									
29	HOUSEHOLD SUPPLIES	$160			$145					
30	HOUSING DEPOSIT								$60	
31	IN-HOME FAMILY SUPPORT									
32	INIT DIAGNOSTIC INTERVIEW	$2,633	$2,611	$1,026	$755	$1,371	$3,136	$719	$3,114	$450
33	INTENSIVE FAM PRESERVE	$36,711	$32,016	$37,760	$23,908	$47,872	$112,370	$42,320	$89,984	$46,932

	A	B	C	D	E	F	G	H	I	J
3	**Sum of Amount**	**Column Labels**								
4	**Row Labels**	**7/31/2016**	**8/31/2016**	**9/30/2016**	**10/31/2016**	**11/30/2016**	**12/31/2016**	**1/31/2017**	**2/28/2017**	**3/31/2017**
34	INTENSIVE IN HOME									
35	INTENSIVE OUTPATIENT SVS					$30	$146		$340	
36	INTERPRETER	$1,435	$13,816	$2,826	$13,193	$16,301	$10,736	$5,268	$15,983	$14,767
37	LEGAL FEES	$87			$209				$101	
38	LOA FAM GROUP CONFRNCING									
39	LOA FAMILY SUPPORT SVCS									
40	LOA MEDIATION									
41	LOA OUT OF HOME STIPEND									
42	MEDIATION	$1,500	$4,575		$300	$600	$3,475		$975	$300
43	MOTOR VEHICLE GAS	$2,870	$2,496	$2,980	$1,780	$370	$30	$1,840	$2,080	$220
44	MOTOR VEHICLE LICENSE FEE									
45	MOTOR VEHICLE REPAIRS								$50	
46	OUT OF HM MAINTENANCE	$1,450,814	$512,959	$521,194	$879,084	$1,073,043	$2,111,381	$1,304,833	$1,895,205	$1,224,726
47	OUT OF HM STRUCTURE	$110,492	$92,817	$93,860	$85,035	$78,423	$54,979	$79,348	$91,924	$65,198
48	OUT OF HM TREATMENT						$4,489			
49	OUT OF HOME FAMILY SUPPRT									
50	OUT OF HOME STIPEND	$99,406	$78,181	$80,842	$76,119	$69,930	$51,922	$67,163	$67,230	$61,614
51	PARENT EDUCATION	$165			$25					
52	PARENT/CHILD OBSERVATION						$3,670	$5,540	$8,240	$5,150
53	PARNT TIME/SUPRVSED VISIT									
54	PATHWAYS TO PERMANENCY									
55	PERSONAL NEEDS	$420	$571	$300	$300	$180	$1,020	$600	$445	$300
56	PHARMACOLOGICAL MANAGE	$153	$55							
57	PRESCRIPTIONS SUPPLIES	$144			$115				$4	
58	PRTF HOSPITAL BASED	$55,277	$56,639	$73,753	$57,071	$22,079	$412,873	$133,014	$191,702	$157,175
59	PRTF NON SPECIALIZED	$16,929	$19,228	$6,270	$1,654	$6,479	$48,339		$15,354	$465
60	PRTF SPECIALIZED	$19,785			$10,222	$8,903		$10,790		$10,453
61	PSYCHOLOGICAL TESTING	$3,016	$7,901	$8,753	$7,329	$4,515	$2,746	$3,129	$7,687	$1,590
62	PSYCHOTHERAPY FAMILY	$1,438	$615	$1,049	$1,141		$89	$454		$454
63	PSYCHOTHERAPY GROUP	$53	$26		$153			$108		$54
64	PSYCHOTHERAPY INDIVIDUAL	$4,613	$9,116	$2,777	$4,081	$2,797	$10,124	$5,307	$4,806	$3,877

ATTACHMENT TEN

	A	B	C	D	E	F	G	H	I	J
3	**Sum of Amount**	**Column Labels**								
4	**Row Labels**	**7/31/2016**	**8/31/2016**	**9/30/2016**	**10/31/2016**	**11/30/2016**	**12/31/2016**	**1/31/2017**	**2/28/2017**	**3/31/2017**
65	RELINQUISHMENT COUNSELING									
66	RENT	$25			$50					
67	REPORTING CTR SUPERVISION	$41,264	$46,049	$35,765	$45,296	$38,745	$129,399	$30,250	$77,162	$78,477
68	RESPITE CARE	$4,636	$6,866	$2,052	$2,519	$2,132	$17,546	$2,232	$9,800	$3,014
69	SAFETY MONITORING									
70	SCHOOL TRANSPORTATION	$1,790	$1,440	$220	$1,670	$3,560	$2,920	$5,120	$2,700	$4,010
71	SEX OFFENDER RISK ASSESS	$542					$1,084	$1,084	$521	
72	SPEC SVS OUT HOME CARE RE	$299,489	$448,938	$319,525	$363,277	$383,499	$864,819	$473,882	$776,964	$400,984
73	SPECL SVS OOH CARE REFORM									
74	STUDENT FEES	$73	$85	$35	$40				$30	
75	THERAPEUTIC VISIT									
76	THGH OUT OF HME TREATMENT									
77	THGH OUT OF HOME MAINT	$20,591		$13,803	$13,803		$35,782		$73,879	
78	TRACKER SERVICES	$3,036	$818	$898	$1,610	$2,376	$8,426		$2,878	$22,493
79	TRANS COMMERCIAL	$38,870	$63,396	$50,200	$26,157	$31,967	$97,487	$38,148	$109,120	$46,780
80	TUITION	$60		$70	$60					
81	VISIT SUPERVISION/MONITOR	$424,880	$580,154	$446,640	$541,165	$449,801	$1,347,259	$501,978	$1,132,566	$544,626
82	**Grand Total**	**$3,641,311**	**$2,830,216**	**$2,515,915**	**$3,010,024**	**$3,074,114**	**$6,596,945**	**$3,599,241**	**$5,788,001**	**$3,674,357**

ATTACHMENT TEN

	A	K	L	M	N	O	P	Q	R	S
1										
2										
3	**Sum of Amount**									
4	**Row Labels**	**4/30/2017**	**5/31/2017**	**6/30/2017**	**7/31/2017**	**8/31/2017**	**9/30/2017**	**10/31/2017**	**11/30/2017**	**12/31/2017**
5	ACADEMIC TUTORING	$3,462	$2,933	$3,602	$2,118	$1,152	$657	$5,676	$1,318	$1,556
6	AGENCY SUPP FOSTER CARE	$473,790	$559,711	$519,488	$609,691	$616,050	$622,337	$602,790	$586,681	$579,272
7	ASSMNT DRUG ALCOHOL	$197		$197		$193	$197		$465	$181
8	CASE CONFERENCE									
9	CFS PRESCHOOL CARE	$3,033	$2,219	$3,989	$1,356	$2,462	$1,444	$4,166	$19,007	$2,903
10	CFS SCHOOL AGE CARE									
11	CLOTHING									
12	COURT COSTS									
13	DAY REPORTING CENTER									
14	DAY TREATMENT PSYCH									
15	DD PLACEMENT DAILY COST									
16	DRUG TEST LAB CONFIRM	$28,720	$16,735	$59,605	$34,290	$29,295	$29,422	$42,190	$29,320	$32,795
17	DRUG TEST SPEC COLLECT	$56,938	$64,506	$83,503	$74,761	$68,654	$65,572	$80,378	$65,992	$68,328
18	DV PREVENTION CLASSES	$375	$370	$500		$280	$505	$1,483	$1,275	$465
19	DV PREVENTION INTAKE									
20	ELECTRONIC MONITOR/TRACK	$392		$854	$635	$566	$238	$420		
21	EMERGENCY SHELTER CENTER	$11,661	$45,114	$25,416	$24,897	$24,225	$20,142	$21,033	$13,140	$25,228
22	FAMILY GROUP CONFERENCING	$21,600								
23	FAMILY SUPPORT SERVICES	$100,766	$96,765	$99,924	$110,359	$122,183	$105,304	$65,573	$7,526	$2,295
24	FAMILY WORKS									
25	FILING FEES									
26	GROCERY/MEAL PURCHASE		$26							
27	GROUP HOME CARE	$72,875	$172,535	$96,008	$151,867	$95,138	$168,625	$122,826	$145,685	$139,720
28	HOME SUPPORTED SERVICES			$378						
29	HOUSEHOLD SUPPLIES									
30	HOUSING DEPOSIT									
31	IN-HOME FAMILY SUPPORT						$54,337	$156,046	$233,705	$226,789
32	INIT DIAGNOSTIC INTERVIEW	$2,061	$559	$1,913	$266	$5,108	$2,759	$569	$3,648	$3,514
33	INTENSIVE FAM PRESERVE	$35,010	$25,264	$26,112	$50,595	$65,040	$46,913	$29,152	$24,368	$28,880

ATTACHMENT TEN

	A	K	L	M	N	O	P	Q	R	S
3	**Sum of Amount**									
4	**Row Labels**	**4/30/2017**	**5/31/2017**	**6/30/2017**	**7/31/2017**	**8/31/2017**	**9/30/2017**	**10/31/2017**	**11/30/2017**	**12/31/2017**
34	INTENSIVE IN HOME									
35	INTENSIVE OUTPATIENT SVS			$449	$108	$2,018		$1,025	$2,500	$433
36	INTERPRETER	$2,130	$4,095	$7,281	$9,997	$11,991	$17,264	$10,689	$12,263	$10,010
37	LEGAL FEES	$72		$68			$57	$40	$16	
38	LOA FAM GROUP CONFRNCING		$24,300	$18,900	$29,700	$24,300	$8,100	$16,200	$16,200	$16,200
39	LOA FAMILY SUPPORT SVCS									
40	LOA MEDIATION		$1,725	$1,050	$150	$450	$450	$150	$1,050	$2,025
41	LOA OUT OF HOME STIPEND		$58,767	$68,772	$75,806	$78,624	$96,829	$96,785	$84,208	$80,576
42	MEDIATION	$150								
43	MOTOR VEHICLE GAS	$1,830	$320	$150	$370	$1,020	$800		$30	
44	MOTOR VEHICLE LICENSE FEE	$28					$27			
45	MOTOR VEHICLE REPAIRS									
46	OUT OF HM MAINTENANCE	$1,113,116	$1,276,079	$1,174,326	$1,337,435	$1,356,255	$1,393,331	$1,268,011	$1,241,846	$1,283,871
47	OUT OF HM STRUCTURE	$51,511	$58,960	$69,549	$81,709	$79,270	$84,071	$78,807	$71,852	$74,002
48	OUT OF HM TREATMENT									
49	OUT OF HOME FAMILY SUPPRT						$3,644	$31,180	$85,139	$88,773
50	OUT OF HOME STIPEND	$48,164								
51	PARENT EDUCATION		$35					$35		
52	PARENT/CHILD OBSERVATION	$2,440	$4,270	$2,360	$4,600	$5,200	$2,010	$3,900	$2,800	$3,320
53	PARNT TIME/SUPRVSED VISIT								$485,781	$564,159
54	PATHWAYS TO PERMANENCY									
55	PERSONAL NEEDS	$336	$180	$180	$180	$180	$180	$300	$300	$180
56	PHARMACOLOGICAL MANAGE	$75			$55					$75
57	PRESCRIPTIONS SUPPLIES				$4			$46		
58	PRTF HOSPITAL BASED	$139,063	$134,280	$115,306	$130,662	$67,821	$90,811	$49,652	$118,637	$146,706
59	PRTF NON SPECIALIZED	$11,443	$8,995			$5,122	$6,270		$11,135	$198
60	PRTF SPECIALIZED	$10,453	$7,081	$26,642						
61	PSYCHOLOGICAL TESTING	$6,635	$386	$2,536	$1,482	$12,705	$7,508	$3,192	$8,434	$7,297
62	PSYCHOTHERAPY FAMILY	$800	$190		$545		$87	$1,268	$1,529	$818
63	PSYCHOTHERAPY GROUP					$352				$235
64	PSYCHOTHERAPY INDIVIDUAL	$4,938	$4,515	$5,836	$8,232	$5,010	$8,657	$5,167	$10,434	$12,607

ATTACHMENT TEN

	A	K	L	M	N	O	P	Q	R	S
3	**Sum of Amount**									
4	**Row Labels**	**4/30/2017**	**5/31/2017**	**6/30/2017**	**7/31/2017**	**8/31/2017**	**9/30/2017**	**10/31/2017**	**11/30/2017**	**12/31/2017**
65	RELINQUISHMENT COUNSELING									
66	RENT					$371				
67	REPORTING CTR SUPERVISION	$49,679	$64,938	$35,311	$95,906	$57,783	$111,599	$75,039	$48,315	$73,333
68	RESPITE CARE	$3,128	$7,642	$2,288	$5,574	$7,585	$3,397	$21,193	$8,554	$3,829
69	SAFETY MONITORING									
70	SCHOOL TRANSPORTATION	$4,835	$4,620	$4,902	$6,572	$3,214	$516	$2,746	$2,330	$4,010
71	SEX OFFENDER RISK ASSESS		$536			$1,096				
72	SPEC SVS OUT HOME CARE RE	$509,662	$593,929	$433,539	$464,100	$404,932	$131,334	$40,562	$1,170	
73	SPECL SVS OOH CARE REFORM				$85,699	$263,750	$368,032	$392,984	$318,983	$353,673
74	STUDENT FEES									
75	THERAPEUTIC VISIT		$582,433	$633,307	$615,641	$657,085	$676,636	$627,045	$45,339	$8,717
76	THGH OUT OF HME TREATMENT		$60,816		$22,322			$17,099		$5,489
77	THGH OUT OF HOME MAINT	$15,870	$17,635		$22,381		$30,083	$9,880	$15,330	$3,993
78	TRACKER SERVICES	$5,174	$7,154	$3,142	$6,230	$9,372	$6,283	$5,069	$3,010	$3,960
79	TRANS COMMERCIAL	$51,300	$55,271	$48,364	$45,283	$38,877	$25,647	$37,990	$49,103	$59,246
80	TUITION						$1,300		$1,300	
81	VISIT SUPERVISION/MONITOR	$500,741								
82	**Grand Total**	**$3,344,455**	**$3,965,885**	**$3,575,745**	**$4,111,577**	**$4,124,727**	**$4,193,370**	**$3,928,356**	**$3,779,717**	**$3,919,662**

ATTACHMENT TEN

	A	T	U	V	W	X	Y	Z	AA	AB
1										
2										
3	**Sum of Amount**									
4	**Row Labels**	**1/31/2018**	**2/28/2018**	**3/31/2018**	**4/30/2018**	**5/31/2018**	**6/30/2018**	**7/31/2018**	**8/31/2018**	**9/30/2018**
5	ACADEMIC TUTORING	$891	$1,698		$5,130	$1,983	$1,559	$214	$2,648	$2,351
6	AGENCY SUPP FOSTER CARE	$528,844	$527,901	$502,164	$493,664	$503,198	$543,553	$558,785	$526,204	$523,075
7	ASSMNT DRUG ALCOHOL	$197	$395	$386	$1,794	$761	$330	$522	$197	$790
8	CASE CONFERENCE									
9	CFS PRESCHOOL CARE	$6,903	$9,987	$3,297	$9,735	$6,105	$6,211	$5,917	$1,667	$8,543
10	CFS SCHOOL AGE CARE					$1,015	$350			
11	CLOTHING									
12	COURT COSTS									
13	DAY REPORTING CENTER									
14	DAY TREATMENT PSYCH									
15	DD PLACEMENT DAILY COST					$93,767	$77,008		$112,612	$217,708
16	DRUG TEST LAB CONFIRM	$31,870	$33,885	$31,675	$27,230	$28,040	$26,535	$27,880	$350	$350
17	DRUG TEST SPEC COLLECT	$61,380	$53,200	$54,542	$46,854	$53,178	$44,674	$43,990	$40,520	$33,578
18	DV PREVENTION CLASSES	$815	$258	$1,071	$540	$340	$952	$367	$790	$1,709
19	DV PREVENTION INTAKE	$176					$420	$268		$222
20	ELECTRONIC MONITOR/TRACK					$181		$377	$421	
21	EMERGENCY SHELTER CENTER	$9,639	$34,929	$21,969	$19,296	$17,055	$13,617	$11,493	$13,887	$39,409
22	FAMILY GROUP CONFERENCING									
23	FAMILY SUPPORT SERVICES	$345								
24	FAMILY WORKS					$12,726			$41,454	$6,867
25	FILING FEES									
26	GROCERY/MEAL PURCHASE									
27	GROUP HOME CARE	$74,876	$227,733	$176,179	$179,453	$185,077	$118,989	$185,562	$131,214	$89,261
28	HOME SUPPORTED SERVICES									
29	HOUSEHOLD SUPPLIES									
30	HOUSING DEPOSIT									
31	IN-HOME FAMILY SUPPORT	$221,378	$213,252	$224,597	$208,558	$67,956	$58,893	$55,876	$37,909	$2,611
32	INIT DIAGNOSTIC INTERVIEW	$2,232	$2,627	$269	$5,562	$1,780	$3,726	$1,699	$2,599	$1,499
33	INTENSIVE FAM PRESERVE	$32,240	$26,208	$28,454	$26,116	$28,412	$23,520	$27,776	$12,512	$14,496

ATTACHMENT TEN

	A	T	U	V	W	X	Y	Z	AA	AB
3	**Sum of Amount**									
4	**Row Labels**	**1/31/2018**	**2/28/2018**	**3/31/2018**	**4/30/2018**	**5/31/2018**	**6/30/2018**	**7/31/2018**	**8/31/2018**	**9/30/2018**
34	INTENSIVE IN HOME					$168,624	$182,841	$185,932	$156,487	$181,542
35	INTENSIVE OUTPATIENT SVS		$724	$1,406	$73	$901	$100	$334		
36	INTERPRETER	$5,522	$4,420	$11,018	$7,488	$6,598	$7,114	$814	$11,233	$6,846
37	LEGAL FEES								$29	
38	LOA FAM GROUP CONFRNCING	$16,200	$2,700	$10,800	$16,200	$16,200	$24,300	$27,450	$10,800	$8,100
39	LOA FAMILY SUPPORT SVCS									$119
40	LOA MEDIATION		$150	$1,650	$150	$300	$750	$1,875	$1,350	$1,575
41	LOA OUT OF HOME STIPEND	$77,654	$90,284	$57,630	$48,626	$50,565	$49,702	$55,096	$48,832	$47,273
42	MEDIATION									
43	MOTOR VEHICLE GAS								$1,810	$1,810
44	MOTOR VEHICLE LICENSE FEE									
45	MOTOR VEHICLE REPAIRS									
46	OUT OF HM MAINTENANCE	$1,205,163	$1,176,722	$1,191,934	$1,087,923	$1,168,702	$1,186,374	$1,203,662	$1,128,384	$1,133,074
47	OUT OF HM STRUCTURE	$70,353	$61,982	$55,229	$48,280	$45,149	$43,141	$44,779	$39,407	$36,864
48	OUT OF HM TREATMENT									
49	OUT OF HOME FAMILY SUPPRT	$84,944	$85,655	$89,568	$78,912	$86,953	$71,232	$94,896	$79,927	$83,658
50	OUT OF HOME STIPEND									
51	PARENT EDUCATION									
52	PARENT/CHILD OBSERVATION	$3,004	$2,960	$3,640	$4,520	$2,440	$2,200	$2,040	$1,800	$680
53	PARNT TIME/SUPRVSED VISIT	$490,709	$521,085	$496,575	$431,150	$488,986	$478,125	$459,040	$507,651	$442,670
54	PATHWAYS TO PERMANENCY					$16,863	$34,254	$35,907	$50,105	$61,857
55	PERSONAL NEEDS	$690	$180	$240	$240	$134	$2			
56	PHARMACOLOGICAL MANAGE	$75			$200	$89		$85		
57	PRESCRIPTIONS SUPPLIES									
58	PRTF HOSPITAL BASED	$119,017	$207,099	$125,850	$143,689	$259,004	$21,917	$158,012	$164,678	$55,118
59	PRTF NON SPECIALIZED		$7,775	$4,537		$19,279	$3,135	$794		
60	PRTF SPECIALIZED			$2,360	$674	$5,058		$26,976	$337	
61	PSYCHOLOGICAL TESTING	$6,923	$7,036	$502	$10,778	$7,340	$6,651	$1,831	$3,663	$6,699
62	PSYCHOTHERAPY FAMILY	$349	$1,260	$174	$1,077	$329	$1,684	$640	$727	
63	PSYCHOTHERAPY GROUP		$235	$161	$27	$54	$189		$78	$104
64	PSYCHOTHERAPY INDIVIDUAL	$5,699	$6,681	$5,484	$10,609	$6,862	$7,854	$6,981	$9,169	$3,932

ATTACHMENT TEN

	A	T	U	V	W	X	Y	Z	AA	AB
3	**Sum of Amount**									
4	**Row Labels**	**1/31/2018**	**2/28/2018**	**3/31/2018**	**4/30/2018**	**5/31/2018**	**6/30/2018**	**7/31/2018**	**8/31/2018**	**9/30/2018**
65	RELINQUISHMENT COUNSELING				$1,430	$1,292		$858	$1,006	$240
66	RENT									
67	REPORTING CTR SUPERVISION	$51,626	$61,561	$42,719	$78,083	$43,473	$100,263	$48,627	$103,536	$78,288
68	RESPITE CARE	$3,922	$3,968	$4,341	$1,730	$2,360	$3,412	$5,886	$6,171	$1,610
69	SAFETY MONITORING					$2,513	$6,455	$975	$455	
70	SCHOOL TRANSPORTATION	$3,270	$2,380	$3,188	$3,572	$4,040	$6,528	$4,786	$2,010	$1,220
71	SEX OFFENDER RISK ASSESS		$542		$592					
72	SPEC SVS OUT HOME CARE RE	$1,131		$12,841		$4,807		$420		
73	SPECL SVS OOH CARE REFORM	$271,669	$155,756	$424,676	$509,900	$259,296	$176,239	$120,076	$102,649	$150,596
74	STUDENT FEES	$350			$100					
75	THERAPEUTIC VISIT	$4,033	$3,592	$1,113	$189	$2,226		$2,263	$240	
76	THGH OUT OF HME TREATMENT		$11,161		$11,344	$4,757				$14,638
77	THGH OUT OF HOME MAINT		$8,119	$12,848	$22,652	$24,038	$9,052	$22,891	$27,378	$4,437
78	TRACKER SERVICES	$3,194	$3,432	$2,957	$2,561	$5,148	$2,719	$2,429	$1,769	$1,637
79	TRANS COMMERCIAL	$49,968	$58,784	$52,787	$61,181	$77,375	$67,164	$77,634	$39,220	$22,952
80	TUITION		$1,300			$1,300			$1,300	
81	VISIT SUPERVISION/MONITOR									
82	**Grand Total**	**$3,447,249**	**$3,619,614**	**$3,660,832**	**$3,607,882**	**$3,784,628**	**$3,413,734**	**$3,514,714**	**$3,427,180**	**$3,290,009**

ATTACHMENT TEN

	A	AC	AD	AE	AF
1					
2					
3	**Sum of Amount**				
4	**Row Labels**	**10/31/2018**	**11/30/2018**	**12/31/2018**	**Grand Total**
5	ACADEMIC TUTORING	$898	$143	$455	$80,989
6	AGENCY SUPP FOSTER CARE	$482,389	$526,865	$456,510	$16,210,355
7	ASSMNT DRUG ALCOHOL	$1,042		$395	$10,188
8	CASE CONFERENCE		$2,500	$1,000	$3,500
9	CFS PRESCHOOL CARE	$5,002	$11,252	$3,876	$149,089
10	CFS SCHOOL AGE CARE				$1,365
11	CLOTHING				$50
12	COURT COSTS				$79
13	DAY REPORTING CENTER				$960
14	DAY TREATMENT PSYCH				$2,765
15	DD PLACEMENT DAILY COST		$203,593	$14,471	$719,159
16	DRUG TEST LAB CONFIRM	$155			$777,926
17	DRUG TEST SPEC COLLECT	$32,520	$27,220	$29,689	$1,680,574
18	DV PREVENTION CLASSES	$605	$665	$716	$17,790
19	DV PREVENTION INTAKE		$50	$150	$1,286
20	ELECTRONIC MONITOR/TRACK				$10,507
21	EMERGENCY SHELTER CENTER	$20,493	$18,336	$15,273	$694,653
22	FAMILY GROUP CONFERENCING				$178,200
23	FAMILY SUPPORT SERVICES				$1,763,009
24	FAMILY WORKS	$12,159	$19,215	$16,254	$108,675
25	FILING FEES				$88
26	GROCERY/MEAL PURCHASE				$142
27	GROUP HOME CARE	$79,965	$152,538	$88,920	$4,320,967
28	HOME SUPPORTED SERVICES				$378
29	HOUSEHOLD SUPPLIES				$305
30	HOUSING DEPOSIT				$60
31	IN-HOME FAMILY SUPPORT				$1,761,907
32	INIT DIAGNOSTIC INTERVIEW	$1,750	$2,944	$4,630	$67,529
33	INTENSIVE FAM PRESERVE	$15,728	$14,288	$31,056	$1,082,012

ATTACHMENT TEN

	A	AC	AD	AE	AF
3	**Sum of Amount**				
4	**Row Labels**	**10/31/2018**	**11/30/2018**	**12/31/2018**	**Grand Total**
34	INTENSIVE IN HOME	$166,771	$158,504	$137,296	$1,337,997
35	INTENSIVE OUTPATIENT SVS				$10,587
36	INTERPRETER	$2,174	$4,026	$5,313	$252,607
37	LEGAL FEES	$36		$52	$765
38	LOA FAM GROUP CONFRNCING	$13,500	$18,900	$29,700	$348,750
39	LOA FAMILY SUPPORT SVCS				$119
40	LOA MEDIATION	$300		$375	$15,525
41	LOA OUT OF HOME STIPEND	$48,559	$49,275	$49,499	$1,313,362
42	MEDIATION				$11,875
43	MOTOR VEHICLE GAS	$2,050	$316	$80	$25,252
44	MOTOR VEHICLE LICENSE FEE				$54
45	MOTOR VEHICLE REPAIRS				$50
46	OUT OF HM MAINTENANCE	$1,083,164	$1,108,997	$1,045,140	$36,136,747
47	OUT OF HM STRUCTURE	$38,437	$43,455	$45,419	$1,974,301
48	OUT OF HM TREATMENT				$4,489
49	OUT OF HOME FAMILY SUPPRT	$78,551	$67,507	$71,768	$1,182,305
50	OUT OF HOME STIPEND				$700,572
51	PARENT EDUCATION				$260
52	PARENT/CHILD OBSERVATION	$4,223	$1,280	$1,818	$84,104
53	PARNT TIME/SUPRVSED VISIT	$481,902	$460,525	$461,919	$6,770,277
54	PATHWAYS TO PERMANENCY	$67,719	$108,277	$118,588	$493,569
55	PERSONAL NEEDS		$60		$7,698
56	PHARMACOLOGICAL MANAGE		$130		$992
57	PRESCRIPTIONS SUPPLIES				$314
58	PRTF HOSPITAL BASED	$6,816	$33,202	$250,482	$3,697,406
59	PRTF NON SPECIALIZED		$6,339		$199,739
60	PRTF SPECIALIZED	$38,344			$178,080
61	PSYCHOLOGICAL TESTING	$4,097	$7,422	$22,177	$181,960
62	PSYCHOTHERAPY FAMILY	$363	$641	$3,070	$20,793
63	PSYCHOTHERAPY GROUP	$394	$456	$26	$2,707
64	PSYCHOTHERAPY INDIVIDUAL	$6,193	$9,767	$5,427	$197,552

ATTACHMENT TEN

	A	AC	AD	AE	AF
3	**Sum of Amount**				
4	**Row Labels**	**10/31/2018**	**11/30/2018**	**12/31/2018**	**Grand Total**
65	RELINQUISHMENT COUNSELING	$1,670	$846	$1,286	$8,628
66	RENT				$446
67	REPORTING CTR SUPERVISION	$71,995	$55,841	$62,976	$1,933,298
68	RESPITE CARE	$1,106	$5,841	$9,262	$163,596
69	SAFETY MONITORING	$910			$11,308
70	SCHOOL TRANSPORTATION	$1,534	$3,570	$3,980	$97,253
71	SEX OFFENDER RISK ASSESS		$592		$6,589
72	SPEC SVS OUT HOME CARE RE	$570			$6,930,374
73	SPECL SVS OOH CARE REFORM	$74,547	$116,150	$96,233	$4,240,906
74	STUDENT FEES		$20	$3,402	$4,135
75	THERAPEUTIC VISIT				$3,859,857
76	THGH OUT OF HME TREATMENT	$5,489	$5,842	$9,869	$168,827
77	THGH OUT OF HOME MAINT	$16,240	$17,497	$20,955	$459,137
78	TRACKER SERVICES	$1,426	$1,320	$660	$121,180
79	TRANS COMMERCIAL	$59,583	$57,930	$88,409	$1,626,189
80	TUITION				$6,690
81	VISIT SUPERVISION/MONITOR				$6,469,809
82	**Grand Total**	**$2,931,366**	**$3,324,135**	**$3,208,572**	**$110,903,535**

ATTACHMENT ELEVEN

COMMUNITY-BASED SERVICES RATES

Agency Supported Respite Care - $60/day, $10/hour up to 6 hours, travel time $4.50 per every 15 minutes and federal mileage reimbursement rate.

Drug Testing - $60.00 for one or more specimen collections

- up to $100.00 per each lab confirmation test for sweat patch

Family Support Service - $47.00 per each full hour of direct, face-to-face contact time assisting the child(ren) and/or family

DHHS shall pay the Contractor in 15 minute increments in those situations where the Family Support Worker has face-to-face contact time with the child(ren) and/or family1 – 15 minutes = $11.75; 16 – 30 minutes = $23.50; 31 -- 45 minutes = $35.25; 46 – 60 minutes = $47.00.

Travel time $4.50 every 15 minutes, and federal mileage reimbursement

In-home Safety Service - $47.00 per hour for direct, (face to face) contact time with the family while in the family home.

Travel time $4.50 every 15 minutes, and federal mileage reimbursement

Intensive Family Preservation Service

- Tier 1 Rate: When the distance between the IFP Therapist's starting point address and the family's home address is fifteen (15) miles or less, DHHS shall pay the Contractor a maximum of $4,096.26 per family for six weeks of service delivery.

- Tier 2 Rate: When the distance between the IFP Therapist's starting point address and the family's home address is at least sixteen (16) miles but not more than ninety-nine (99) miles, DHHS shall pay the Contractor a maximum of $6,623.82 per family for six weeks of service delivery.

- Tier 3 Rate: When the distance between the IFP Therapist's starting point address and the family's home address is one hundred (100) miles or more, DHHS shall pay the Contractor a maximum of $8,746.50 per family for six weeks of service delivery.

Intensive Family Reunification Service

- Tier 1 Rate: When the distance between the IFR Therapist's starting point address and the family's home address is fifteen (15) miles or less, DHHS shall pay the Contractor a daily rate of $45.52 per family for service delivery.

- Tier 2 Rate: When the distance between the IFR Therapist's starting point address and the family's home address is at least sixteen (16) miles but not more than ninety-nine (99) miles, DHHS shall pay the Contractor a daily rate of $73.60 per family for service delivery.

- Tier 3 Rate: When the distance between the IFR Therapist's starting point address and the family's home address is one hundred (100) miles or more, DHHS shall pay the Contractor a daily rate of $97.19 per family for service delivery.

Parenting Time/Supervised Visitation - $47.00 per each full hour of direct, face-to-face contact time assisting the child(ren) and/or family

DHHS shall pay the Contractor in 15 minute increments in those situations where the Family Support Worker has face-to-face contact time with the child(ren) and/or family1 – 15 minutes = $11.75; 16 – 30 minutes = $23.50; 31 -- 45 minutes = $35.25; 46 – 60 minutes = $47.00.

Travel time $4.50 every 15 minutes, and federal mileage reimbursement

Transitional Living/Life Skills Training

- $69.00 per day per youth for Transitional Living Services.
- $39.00 per hour per youth for Life Skills Instruction.

Division of Children and Family Services

State of Nebraska
Pete Ricketts, Governor

Division of Children and Family Services **Protection and Safety Procedure Update #34-2016**	
Regarding:	Ongoing Case Management
Rescinds:	#22-2016– Ongoing Case Management
Date Effective:	9/23/16
Contact:	Katie Weidner at 402-471-9700 or katie.weidner@nebraska.gov
Issued by:	Douglas J. Weinberg, Director, Division of Children and Family Services

Philosophy

The Division of Children and Family Services (DCFS) believes that families should be respected and valued. The family should lead and be an active part of the team that works toward ensuring their child's safety, permanency, educational, mental health, physical and well-being needs are met.
The overarching responsibility for the CFS Specialist is management of safety and risk factors of children and families involved with DCFS because of abuse, neglect, or dependency; the well-being of children in the custody of the agency and their siblings; and permanency for children for whom DCFS is responsible. This includes:

1. Providing for child safety and reducing risk of harm;
2. Establishing goals that address the reason for DCFS involvement, identifying the unmet needs that keep the family from achieving the goals, and developing strength based strategies to address the unmet needs;
3. Assisting families in identifying and accessing informal and formal supports and resources;
4. Increasing family self-sufficiency;
5. Empowering the family;
6. Promoting timely reunification when appropriate; and
7. Providing permanency for children for whom reunification or family preservation is not possible.

Procedure:

I. **ONGOING CASE MANAGEMENT OVERVIEW**

A. At the conclusion of the initial assessment, the CFS Specialist determines if ongoing services should be offered to the family based on the safety and risk assessments. If courts are involved, ongoing case management will be provided. If courts are not involved, case opening for ongoing case management will be based on the results of the safety and risk or prevention assessment. A CFS Specialist will be assigned an ongoing case and assume case management activities.

B. The CFS Specialist will work with the family and the Family Team to maintain the child in the home whenever it is safe to do so. It may be determined that a child can remain in the home with safety services. If it is determined that the child is not safe in the home, Law Enforcement may remove the child in an emergency or a court of competent jurisdiction can order a removal from the home. If the child is removed, the CFS

Specialist will make all efforts to reunify the child as soon as it is determined that the child can be safe in the home. In abuse, neglect, dependency cases and cases adjudicated as 3(c) Mentally Ill and Dangerous, the CFS Specialist will utilize the Structured Decision Making (SDM®) Reunification Assessment to determine if reunification should be recommended. A court of competent jurisdiction can also order that reunification occur.

C. The decision on recommending case closure in abuse, neglect, dependency cases and cases where the youth is adjudicated as Mentally Ill and Dangerous is based on information gathered for the SDM® Risk Reassessment and the assessment of child safety. Family progress will be evaluated at Family Team meetings.

II. <u>ONGOING SERVICES</u>

A. Families served through ongoing services: Ongoing services will be offered to all families where the children are determined to be:
   1. Unsafe;
   2. Conditionally safe;
   3. At high or very high risk for future maltreatment of their children; or
   4. In need of services and a court of competent jurisdiction has placed the child in the custody of the Department. This includes youth adjudicated as a 3(c) Mentally Ill and Dangerous.

B. **<u>Review available information:</u>** The CFS Specialist assigned to the case will thoroughly review information gathered during the Initial Assessment and during ongoing case management. The review of the history will be conducted by the CFS Specialist on all new cases and whenever a case is reassigned or transferred to a new case manager. It is critical that all previous reports and information be analyzed and taken into consideration. The history of the family is important because it provides critical information on the pattern of behaviors and provides indicators of past trauma that may impact eh parent's ability to safely parent their child.

C. **<u>Court Involved or Non-Court Involved</u>**: Families may work with DHHS without the involvement of the court or DHHS's involvement may be mandated by the court. All cases will remain open until the safety threats have been mitigated. Cases will remain open until the risk level has reduced to the point that the likelihood of future maltreatment is low to moderate or based on supervisory consultation. No case will be closed if the child is determined to be unsafe.

D. **<u>Court Involved Cases:</u>**
   1. Families whose children are placed in the care and custody of the Department are considered court involved with DCFS. A court involved case cannot be closed as long as the child is in the legal care and custody of DHHS pursuant to a court order.
      a) If the risk level is high or very high **<u>and</u>** the family is working with the Department **<u>and</u>** the CFS Specialist no longer sees a need for on-going court involvement, the CFS Specialist may ask the court to dismiss the court case and continue working with the family on a non-court involved basis. The Court must approve this request and issue an order discharging the child from the legal care and custody of DHHS.
      b) If the child is safe and risk is low or moderate the CFS Specialist will ask the court to dismiss the case.

E. **<u>Non-Court Involved Cases</u>**
   1. Non-court involved cases require that the family voluntarily agrees to work with

DCFS on the identified safety and risk issues.

2. Non-court involved cases must be provided the same access to services as court involved cases.
3. Non-court involved cases may move to be court involved if the family's situation changes to such a degree that child safety cannot be maintained in the home or the family is not making sufficient progress in remedying child safety concerns and risk of harm. The CFS Specialist will consult with his/her supervisor to determine if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention. This is a mandatory consultation point.
4. In cases where there is no identified safety threats but there is high or very high risk and the family refuses to work with DCFS, the CFS Specialist will consult with his/her supervisor to determine if DCFS should make a referral for a Child Abuse and Neglect Investigative or Treatment Team to review or if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention. This is a mandatory consultation point.

III. ENGAGING FAMILIES WITH SERVICES:

A. The CFS Specialist will make efforts to engage the family and offer interventions prior to requesting the County Attorney to file a petition.

B. When a CFS Specialist has made efforts to engage a family in services and the family refuses to actively participate or their participation is such that child safety or risk cannot be managed the CFS Specialist will consult with his or her supervisor to determine if a request to file should be prepared and forwarded to the County Attorney's office.

C. Despite the parent's engagement with services, a request to file must be sent to the county attorney when the CFS Specialist has information the parent/custodian has been using methamphetamine.

D. If a safety threat is identified during an assessment or the family's risk level is high or very high and the evidence leading to those decisions is based on one of the situations listed below. A request to file should be based on:

1. The presence of any safety threat(s) and the family is unwilling to engage in interventions.
2. There are no safety threat(s), but the family's risk level is high or very high and the evidence leading to those decisions is based on one of the situations listed below. A mandatory staffing with a supervisor is required to determine whether a request to file should be forwarded to the County Attorney's office. These include:
   a) Domestic Violence;
   b) Previous Termination of Parental Rights;
   c) Serious Physical Abuse (e.g. head trauma, broken bones, multiple injuries); or
   d) Sexual Abuse by a Parent.

E. There are no safety threat(s), but the family's risk level is high or very high and the family is unwilling to engage in interventions the CFS Specialist will consult with his or her supervisor to determine next steps.

F. The CFS Specialist is encouraged to involve the Investigative and/or Ongoing (LB1184) Team in discussion of all cases in which the family's risk level is high or very high and the family is unwilling to engage in interventions.

IV. ONGOING RESPONSIBILITIES OF THE CFS SPECIALIST:

A. The CFS Specialist will work collaboratively with the family, the Family Team, supervisors and other relevant persons involved with the family in order to:
   1. Ensure safety of the child;
   2. Establish and implement safety plans;
   3. Assist the family in identifying and accessing informal and formal supports and resources;
   4. Establish and implement the case plan;
   5. Work toward timely permanency for the child;
   6. Ensure child well-being (education and physical/mental health); and
   7. Plan for transition and discharge from CFS intervention.

V. ONGOING ASSESSMENTS:

A. Ongoing assessment of the family will be conducted regularly to provide information as to the progress the family is making toward goal achievement. Assessments include:
   1. SDM® Family Strengths and Needs Assessment (FSNA)(all court and non-court cases: abuse/neglect; dependency; 3(c)). (Conducted at least every 6 months)
   2. SDM® Risk Reassessment of In-Home Cases (Conducted at least every 90 days); and
   3. SDM® Reunification Assessment for families with children placed out of the home. (Conducted at least every 90 days.)

VI. SDM® SAFETY ASSESSMENTS AND SAFETY PLANNING.

A. The ongoing CFS Specialist is always be assessing for safety. The on-going CFS Specialist is responsible to assess for child safety and update the safety plan as often as needed based on the family's circumstances.

B. If a subsequent report of abuse or neglect is reported to the Hotline, the Initial Assessment process will be implemented as described in the Initial Assessment Section. A new safety and risk assessment will be completed.

VII. SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT

A. The CFS Specialist will complete the FSNA with the family. The purpose of the FSNA is to add to information gathered during the initial safety and risk or prevention assessments in order to identify safety related needs and strength based strategies so that a case plan can be developed. Using information gathered for the FSNA, case plan goals, strategies and services can be designed to effectively address the areas that directly impact child safety and risk of future harm for each family. The FSNA also addresses the well-being of every child in the family.

B. The CFS Specialist will conduct a FSNA on every open case and closed cases in the aftercare system.
   1. Each parent in a two parent household is assessed and scored separately.
   2. The child assessment portion is completed for each child who will be included in the case plan.
      a) For non-court involved cases this includes all children in the household. For court involved cases, this includes siblings of wards.
      b) If caregivers are no longer involved in the case plan, only the child assessment is required.

C. Timeframe:
   1. In order to complete the case plan within 60 days from case opening or initial placement in out-of-home care (whichever is earliest), the Family Strengths and Needs Assessment should begin within 7 calendar days of assignment or the completion of the initial assessment if the case is not transferred to a second CFS Specialist. Multiple contacts with the family may he necessary to gather sufficient information.
   2. The CFS Specialist will complete the initial FSNA prior to initial case plan development. The FSNA must be completed within 30 days after completion of the Risk or Prevention Assessment. (This includes cases transferred to another CFS Specialist for ongoing case management.)
   3. For all Child Abuse/Neglect, Dependency or 3(c) cases the initial FSNA and Case Plan will be completed within 60 days of the Intake being Accepted for Assessment.

D. The CFS Specialist should review the caregiver and child domains and definitions of the FSNA. The CFS Specialist will notice that there are item areas they are already assessing. Once the CFS Specialist is familiar with the items that must be assessed to completed the FSNA, the CFS Specialist will complete the FSNA using good social work practice to collect information from the child, caregiver, and/or collateral sources.

E. Reassessment of the FSNA occurs a minimum of every 6 months. The strengths and needs can be reassessed more frequently if necessary to coordinate with the dispositional review.

F. Documentation: The FSNA will be documented on N-FOCUS within 30 days of case assignment to ongoing, but no later than 60 calendar days of the initial custody date. Documentation of narrative must he provided that supports and explains the rationale/reason for each of the questions in the reunification assessment regardless of the final determination. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding decisions on each of the items.

VIII. COMPLETION OF THE FSNA

A. For each category, there are four possible responses:
   1. "a" This is a strength response. A caregiver/child with a response of "a" has exceptional skills or resources in this area. This is an enhanced capacity.
   2. "b" This is an "average" or adequate functioning response. This response is also used to score children who are too young to assess in some categories. A caregiver/child with a response of "b" has not achieved the exceptional skills or resources reflected by a response of "a" and may experience a degree of stress or struggle common to daily functioning, but is generally functioning well in the area. These responses are considered potential strengths, with the exception of children who are scored "b" in some categories because they are too young to assess. For example, an infant may be scored a "b" for delinquency because he or she is too young to be assessed in this area, but it should not be selected as a strength for case-planning purposes. This is a neutral capacity.
   3. "c" A caregiver/child is experiencing increased need in this domain. This is a diminished capacity.
   4. "d" A caregiver/child is experiencing extraordinary need in this domain. This is a diminished capacity.

B. Completion of the FSNA requires gathering information from all family members,

collaterals, and a review of records. It may be completed or modified during the course of family meetings. The CFS Specialist must be aware of culturally specific interpretation of appearances and must engage the family in culturally appropriate ways to make an accurate assessment. When it is difficult to distinguish between responses, additional assessments may be helpful (e.g., psychological, developmental, substance use assessment), particularly if the difference between one rating and another is likely to impact the identification and selection of priority needs.

When scoring, consider the entire scope of available information, including the family's perspective, information from collateral sources, existing records and documents, and worker observations. Often, different sources will suggest different responses (e.g., father states he has no problem with alcohol, but has two DUIs in the last year; mother states she believes he is an alcoholic; a court-ordered chemical dependency evaluation suggests alcohol dependency; father's brother states father has no problem with alcohol). The worker must make a determination based on social work assessment skills, taking into account the merits of each perspective. The household is assessed by completing all the items. If there are two caregivers, each is assessed and scored separately.

C. Section 1: "Caregiver" Each of the domains below represents a significant area of family functioning that may support or impede a family's ability to maintain the safety and well-being of children. There may be some overlap or interactions between domains (e.g., a need in the domain of substance abuse may impact parenting skills, resource management, and/or several other areas of functioning). Keeping this in mind, the CFS Specialist needs to assess the caregiver's functioning in each domain as it relates to his/her ability to effectively parent and protect the child.

D. The FSNA domains should be considered for each family/household member. The CFS Specialist will base the score on his/her assessment for each item, taking into account the family's perspective, child's perspective where appropriate, the CFS Specialist observations, collateral contacts, and available records. The definitions will be used to determine the most appropriate response.

E. In most cases, a finding of average functioning ("b") will be consistent with functioning in the domain that allows for minimally adequate parenting.

F. Minimally Adequate Parenting: Considering ethnic and cultural differences, an action whereby a caregiver ensures that the child is adequately fed; clothed appropriately for weather conditions; provided with adequate shelter; protected from severe physical, mental, and emotional harm; and provided with necessary medical care as required by law. A parent/parent substitute or caregiver may have personal and situational problems but meet minimum parenting standards.

G. **SN1. Substance Abuse/Use** (Substances: alcohol, illegal drugs, inhalants, prescription/over-the-counter drugs)

   1. Teaches and demonstrates a healthy understanding of alcohol and drugs. The caregiver teaches and demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behavior and society. Children are able to describe ways parents have conveyed messages about the effects of drugs and alcohol and/or consequences. The caregiver may be abstinent, or may drink alcohol or appropriately take prescribed drugs, but only in ways that do not negatively affect parenting skills and functioning.

   2. Alcohol or prescribed drug use/no use. Caregiver's choices about legal use or abstinence do not negatively affect parenting skills and functioning. The caregiver may have a history of substance abuse, may currently use alcohol or prescribed

drugs, or may be abstinent.

3. Alcohol or drug abuse. The caregiver continues to use despite negative consequences in some areas such as family, social, health, legal, or financial. The caregiver needs help to achieve and/or maintain abstinence from alcohol or drugs.
4. Chronic alcohol or drug abuse. The caregiver's use of alcohol or drugs results in behaviors that impede ability to meet his/her own and/or his/her child's basic needs. He/she experiences some degree of impairment in most areas including family, social, health, legal, and financial. He/she needs intensive structure and support to achieve abstinence from alcohol or drugs.

H. **SN2. Household Relationships/Domestic Violence**

1. Supportive. Internal or external stressors (e.g., illness, financial problems, divorce, and special needs) may be present, but the household maintains positive interactions (e.g., mutual affection, respect, open communication, empathy) and shares responsibilities mutually agreed upon by the household members. Household members mediate disputes and promote nonviolence in the home. Individuals are safe from threats, intimidation, or assaults by other household members. The caregiver demonstrates an effective or adequate coping ability regarding past abuse, if any.
2. Minor or occasional discord. Internal or external stressors are present, but the household is coping despite some disruption of positive interactions. Conflicts may be resolved through less adaptive strategies such as avoidance; however, household members do not control each other or threaten physical or sexual assault, and there is no current domestic violence.
3. Frequent discord or some domestic violence. Internal or external stressors are present, and the household is experiencing increased disruption of positive interactions coupled with lack of cooperation and/or emotional or verbal abuse. This may be evidenced by the following:
   a) A violent/controlling relationship has recently ended (i.e., within review period). One or both partners have decided to end the relationship, but the separation is recent and of uncertain finality.
   b) Custody and visitation issues are characterized by frequent conflicts.
   c) The caregiver's pattern of adult relationships creates significant stress for the child.
   d) Adult relationships are characterized by occasional physical outbursts that may result in minor injuries, and/or controlling behavior that results in isolation or restriction of activities.
4. Chronic discord or severe domestic violence. Internal or external stressors are present and the household experiences minimal positive interactions. This may be evidenced by the following:
   a) Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or DHHS.
   b) The caregiver's pattern of adult relationships places the child at risk for maltreatment and/or contributes to severe emotional distress.
   c) One or more household members use regular or severe physical violence. Individuals engage in physically assaultive behaviors toward other household members. Violent or controlling behavior has resulted in or may result in injury.
   d) Neither caregiver or only one caregiver is willing to seek help in reducing threats of violence, **or** previous treatment efforts have not been successful in

reducing domestic violence incidents.

I. **SN3. Coping Skills/Mental Health/Developmental Disability**

1. Strong coping skills. The caregiver demonstrates the ability to deal with adversity, crises, and long-term problems in a constructive manner. The caregiver demonstrates realistic and logical judgment. The caregiver displays resiliency and has a positive, hopeful attitude. The caregiver has taken action to address current concerns, and is able to actively contribute to the development of safety strategies.
2. Adequate coping skills. The caregiver demonstrates emotional responses that are consistent with circumstances and displays no apparent inability to cope with adversity, crises, or long-term problems. For example, a caregiver may be experiencing stress, sadness, or anger related to the current case, but is able to manage these feelings to the extent that he/she can participate in case and safety planning. The caregiver is not currently experiencing any symptoms that impair his/her ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.
3. Mild to moderate symptoms. Caregiver has difficulty coping with periodic stresses in his/her life. This may be related to a cognitive disability or demonstrated by periodic mental health symptoms such as depression, low self-esteem, or apathy, or the consistent use of a coping mechanism that exacerbates the situation. These symptoms periodically impair the caregiver's ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.
4. Chronic/severe symptoms. Caregiver has severe and chronic difficulty recognizing or coping with routine stress and daily challenges. The caregiver may have a cognitive disability or display chronic, severe mental health symptoms such as depression, apathy, severe low self-esteem, or unfounded mistrust of professionals and others who want to help. The caregiver is debilitated by these symptoms to the extent that he/she is consistently unable to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter. The caregiver may require hospitalization or intensive psychiatric care to control symptoms.

J. **SN4. Social Support System**

1. Strong support system. The family regularly engages with a strong, constructive, mutual support system. Individuals interact with extended family, friends, cultural, religious, and/or community support or services that provide a wide range of positive and available resources.
2. Adequate support system. As needs arise, the family uses extended family, friends, cultural, religious, and community resources to provide support and/or services such as child care, transportation, supervision, role modeling for caregiver(s) and child, parenting and emotional support, guidance, etc.
3. Limited support system. The family has limited support system, is isolated, or is reluctant to use available or identified support; **or** the family's social support system is neutral regarding caregiver choices that place the child(ren) at threat of harm.
4. No support system or support system is harmful. The family has no support system and does not utilize extended family and community resources; **or** the family's social support system enables or encourages the caregiver to make choices that place the child(ren) at threat of harm.
   a) Background check information alone does not indicate a harmful support

system member. When identifying a harmful support system, consider the behavior encouraged by the individuals and its impact on child safety.

K. **SN5. Parenting Skills:** If the current referral involves concerns regarding an only child who is a newborn at the time of referral, consider the caregiver's preparation for parenthood when making an initial assessment of this item. Subsequent reassessments should be based on caregiver behavior in the assessment period.

1. Strong skills. The caregiver displays good knowledge and understanding of age-appropriate parenting skills and integrates use on a daily basis. The caregiver expresses hope for and recognizes the child's abilities and strengths and encourages participation in family, school, and community. The caregiver actively participates with the child, for example, monitoring homework completion, participating in school meetings, etc. The caregiver is able to protect the child and plan ahead to ensure the child's safety. The caregiver advocates for family and responds to changing needs.
2. Adequately parents and protects child. The caregiver displays adequate parenting patterns that are age-appropriate for the child in areas of expectations, discipline, communication, protection, education, and nurturing. The caregiver is able to protect the child, but may have some difficulties with advance planning. Encourages and supports all children's social and emotional well-being, for example, participation in family, school, and community.
3. Inadequately parents and protects child. Improvement of basic parenting skills is needed by the caregiver, or child has exceptional needs for which parent requires specialized training. The caregiver has some unrealistic expectations and gaps in parenting skills; demonstrates limited knowledge of age-appropriate disciplinary methods or need for supervision; and/or lacks knowledge of child development, which interferes with effective parenting. The caregiver may have difficulty placing the child's needs ahead of his/her own or be unable to plan for child protection. Caregiver demonstrates an inability to support children's social and emotional well-being, for example, participation in family, school, and community; parent may model illegal behavior.
4. Destructive/abusive parenting. The caregiver displays destructive/abusive parenting patterns that result in significant harm to the child. The caregiver has unrealistic expectations and significant gaps in parenting skills; demonstrates poor knowledge of age-appropriate disciplinary methods or need for supervision; and/or lacks knowledge of child development, which interferes with effective parenting. The caregiver often does not place the child's needs ahead of his/her own and rarely or never plans for the child's safety. Caregiver discourages or prohibits participation in family, school, and community; caregiver may involve child in illegal behavior.

L. **SN6. Resource Management/Basic Needs**

1. Resources are sufficient to meet basic needs and are adequately managed. The caregiver has a history of consistently providing safe, healthy, and stable housing; nutritious food; and clothing. The caregiver successfully manages available resources to meet basic care needs related to health and safety.
2. Resources may be limited but are adequately managed. The caregiver provides housing, food, and clothing that meet minimal standards. The caregiver adequately manages available resources to meet basic care needs related to health and safety. This includes adhering to any assistance program requirements.
3. Resources are insufficient or not well-managed. The caregiver provides housing, but it does not meet the basic needs of the child due to conditions such as inadequate

plumbing, heating, wiring, or housekeeping. Food and/or clothing do not meet basic needs of the child. The caregiver does not adequately manage available resources, or does not adhere to assistance program requirements, which results in difficulty providing for basic care needs related to health and safety.

4. No resources, or resources are severely limited and/or mismanaged. In at least one of the following areas, household resources are limited or mismanaged to the extent that harm to household members has occurred. Conditions exist in the household that have caused illness or injury to family members, such as inadequate plumbing, heating, wiring, or housekeeping; there is no food, food is spoiled, or family members are malnourished. The child chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair. The family is homeless. The caregiver severely mismanages available resources, which results in unmet basic care needs related to health and safety.

M. **SN7. Cultural Identity** For this item, cultural identity may refer to an ethnic, religious, or social identity (community norms); sexual orientation; or gender identification that reflects the unique characteristics of the caregiver. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict and/or generational norms. Consider norms to be patterns of behavior that are accepted as appropriate within family or community.

1. Cultural component is supportive and no conflict is present. The caregiver identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.
2. No cultural component that supports or causes conflict.
   a) The caregiver identifies with a culture and its community; however, that cultural identity is not serving as a resource to him/her. He/she experiences no conflict related to cultural identity; **or**
   b) The caregiver identifies with a culture and its community, and that identification causes some conflict, which affects the child. However, the caregiver is making appropriate and reasonable efforts to support the child and minimize negative effects; **or**
   c) The caregiver has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.
3. Cultural component that causes some conflict.
   a) The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences some conflict related to cultural identity; **or**
   b) The caregiver has no particular identification with a culture, the absence of cultural identity is resulting in some conflict with family or community; this is having or may have an adverse impact on the child; and the caregiver is unable to unwilling to work to resolve the conflict.
4. Cultural component that causes significant conflict.
   a) The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences significant conflict related to cultural identity; **or**
   b) The caregiver has no particular identification with a culture; the absence of cultural identity is resulting in significant conflict with family or community; and this is having or may have an adverse impact on the child.

N. **SN8. Physical Health**

1. Consider the physical health of the caregiver as it relates to his/her ability to care for the child(ren) and/or to direct care for the children and him/herself.
2. Preventative health care is practiced. The caregiver teaches and promotes good health. The caregiver makes efforts to pursue resources and incorporate behaviors that promote health, such as modeling healthy eating habits, physical exercise, and personal hygiene for children in the household. The caregiver additionally displays the behaviors described in response "h".
3. Health issues do not affect family functioning. The caregiver has no current health concerns that affect family functioning. The caregiver accesses regular health services (traditional or effective non-traditional) for him/herself (e.g., medical/dental). The caregiver may have serious or chronic health problems, but is able to address these concerns and access resources to ensure that these concerns do not affect the care and protection of the child(ren).
4. Health concerns/disabilities affect family functioning. The caregiver has health concerns or conditions that affect family functioning and/or family resources.
5. Serious health concerns/disabilities result in inability to care for the child. The caregiver has serious/chronic health problem(s) or condition(s) that affects his/her ability to care for and/or protect the child.

O. **SN9. Identified Caregiver Strength/Need (not covered in SN1-SN8)**

1. Significant strength. A caregiver has identified an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.
2. Not applicable. The caregiver has no area of strength or need relevant for case planning that is not included in SN1-SN8.
3. Minor need. A caregiver has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.
4. Significant need. A caregiver has a serious need that has a significant impact on family functioning. The family perceives they would benefit from services and support that address the need.

P. **Section 2: Child** The CFS Specialist will rate each child according to the current level of functioning. For each item, if not applicable to the child's age, score as "b".

Q. **CSN1. Emotional/Behavioral**

1. Strong emotional adjustment. The child displays strong coping skills in dealing with crises and trauma, disappointment, and daily challenges. The child is able to develop and maintain trusting relationships. The child understands and accepts limits. The child is able to identify the need for, seek and accept guidance related to school, family, or community functioning.
2. Adequate emotional adjustment. The child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning. The child may demonstrate some depression, anxiety, or withdrawal symptoms that are situation related. The child maintains situationally appropriate emotional control. Developmentally appropriate acting out occurs. Child is able to understand and accept developmentally appropriate consequences.
3. Limited emotional adjustment. The child has a pattern of difficulty in dealing with situational stress, crises, or problems, which impairs functioning. The child displays periodic mental health symptoms including but not limited to depression, running

away, somatic complaints, hostile behavior, or apathy. Child has episodes of extreme acting out, which may include an inability to accept limits on or consequences for behavior.

4. Severely limited emotional adjustment. The child's ability to perform in one or more areas of functioning is severely impaired due to chronic/severe mental health symptoms, such as but not limited to fire-setting, suicidal behavior, or violent behavior toward people and/or animals. Child has a pattern of dysfunctional behavior that limits child or family activities (such as ability to play on a ball team, go to movies, eat at restaurants) or there is evidence that behavior is rapidly deteriorating.

R. **CSN2. Sexualize Behavior**

1. No sexualized behavior; child displays age-appropriate sexuality. The child does not display sexualized behaviors and his/her behavior is consistent with healthy sexual development.
2. Sexualized behavior is appropriately managed. The child may have experienced sexual abuse, but his/her responses do not interfere with his/her ability to interact appropriately with peers or adults. The child has no history of sexual acting out towards other children or towards adults. The child's behavior is consistent with healthy development, but may be inconsistent with the child's current setting (e.g., relationship with a foster sibling).
3. Concerning sexualized behavior. The child has occasional difficulty in maintaining appropriate behaviors and sexual boundaries. The child may engage in sexual attention-seeking behaviors with peers or adults.
4. Severely sexualized behavior. The child is unable to maintain appropriate boundaries to the extent that the child has created concern for his/her own safety or the safety of other children in the home and/or community.

S. **CSN3. Physical Health/Disability.** If the child is a state ward all required medical/dental/vision appointments and other requirements must be met regardless of item scoring. When scoring this item, the CFS Specialist will consider the child's needs independent of these regulations.

1. Good health. The child demonstrates good health and hygiene care involving awareness of nutrition and exercise. The child receives routine preventative and medical/dental/vision care and immunization. The child has no known health care needs, or has medical needs and demonstrates a strong understanding of and ability to monitor and meet these needs.
2. Adequate health. The child has no health care needs or has minor health problems, hygiene concerns, or a disability that can be addressed with minimal intervention that typically requires no formal training (e.g. oral medications). Child may not be current on immunizations or routine medical appointments, but this has not impacted the child's health.
3. Minor health/disability needs. The child has health care or disability needs and the child is at an age or developmental level that requires routine interventions to be provided by someone else; or the child is at an age or developmental level at which he/she could take responsibility for his/her own care, but has not yet demonstrated a willingness to do so.
4. Serious health/disability needs. The child has serious health problems or a disability that requires interventions that are typically provided by professionals or caregivers who have received substantial instruction (e.g., central line feeding,

paraplegic care, or wound dressing changes); or child has a medical condition and child's own behavior causes condition to worsen or health to deteriorate (child refuses to participate in medical care, monitoring of health care, taking medication, and/or altering behavior as prescribed).

T. **CSN4. Education**

1. Does child have a specialized educational plan? (Specialized educational plan includes individualized educational program [IEP], study team, 504 plan, etc.)
2. Outstanding academic achievement. The child is working above grade level and/or is exceeding the expectations of the specific educational plan.
3. Satisfactory academic achievement or child not of school age. The child is working at grade level and/or is meeting the expectations of the specific educational plan, or the child is not of school age. The child is meeting and following the expectations of an alternative educational program (e.g., GED).
4. Academic difficulty. The child is working below grade level in at least one but not more than half of academic subject areas, and/or child is struggling to meet the goals of the existing educational plan. The existing educational plan may need modification or the child may need to be assessed for an educational plan.
5. Severe academic difficulty. The child is working below grade level in more than half of academic subject areas and/or child is not meeting the goals of the existing educational plan. The existing educational plan needs modification. Also score "d" for a child who is required by law to attend school but is not attending.
6. If the child has a need in this domain, the CFS Specialist will indicate if truancy is a significant contributing factor by indicating 1) Yes; 2) No or 3) Not Applicable.

U. **CSN5. Family Relationships**

1. For children in out-of-home placement, the CFS Specialist will score the child's family, not his/her placement family.
2. Nurturing/supportive relationships. The child experiences positive interactions with family members. The child has a sense of belonging within the family. The family defines roles, has clear boundaries, and supports the child's growth and development.
3. Adequate relationships. The child experiences positive interactions with family members and feels safe and secure in the family, despite some minor family conflicts. The family may struggle to define roles and clarify boundaries, but the child's growth and development are supported.
4. Strained relationships. Stress/discord within the family interferes with the child's sense of safety and security. The family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own. The family may have ill-defined roles or lack of boundaries; as a result, the child's development is not well-supported.
5. Harmful relationships. Chronic family stress, conflict, or violence severely impedes the child's sense of safety and security. The family is unable to resolve stress, conflict, or violence on their own and is not able or willing to obtain outside assistance. The family may not define roles or boundaries within the household, or may define roles in ways that are harmful to household members.

V. **CSN6. Child Physical and Cognitive Development**

1. For this item, the CFS Specialist will base the assessment on developmental milestones. These milestones are further described in References section of this document. [i]

2. Advanced development. The child's physical and cognitive skills are above his/her chronological age level.
3. Age-appropriate development. The child's physical and cognitive skills are consistent with his/her chronological age level.
4. Limited development. The child does not exhibit most physical and cognitive skills expected for his/her chronological age level.
5. Severely limited development. Most of the child's physical and cognitive skills are two or more age levels behind chronological age expectations.

W. **CSN7. Substance Abuse**

1. Chooses drug-free lifestyle. The child does not use alcohol or other drugs and is aware of consequences of use. The child avoids peer relations/social activities involving alcohol and other drugs, and/or chooses not to use substances despite peer pressure/opportunities to do so.
2. No use/experimentation. The child does not use alcohol or other drugs. The child may have experimented with alcohol or other drugs, but there is no indication of sustained use. When considering indicators of sustained use, evaluate the impact of use on the child's functioning in school, family, and community (e.g., increase in conflict with parents or care providers, decline in school performance). If impact is not apparent, consider use to be experimentation.
3. Alcohol or other drug use. The child's alcohol or other drug use results in disruptive behavior and discord in school/community/family/work relationships. Negative impacts or alcohol/drug use have not progressed to the point that relationships with individuals or institutions (school, employment) have broken down. Use may have broadened to include multiple drugs.
4. Chronic alcohol or other drug use. The child's chronic alcohol or other drug use results in severe disruption of functioning, such as loss of relationships, job, school suspensions/expulsion/drop-out, problems with the law, and/or physical harm to self or others. The child may require intensive structure and support or medical intervention to achieve and maintain sobriety.

X. **CSN8. Cultural Identity**

1. For this item, cultural identity may refer to an **ethnic, religious, or social identity (community norms); sexual orientation; or gender identification** that reflects the unique characteristics of the caregiver. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict and/or generational norms. Consider norms to be patterns of behavior that are accepted as appropriate within family or community.
2. Cultural component is supportive and no conflict is present. The child identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.
3. No cultural component that supports or causes conflict. The child identifies with a culture and its community; however, that cultural identity is not serving as a resource to him/her. He/she experiences no conflict related to cultural identity; **or** the child has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.
4. Cultural component that causes some conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *some* conflict related to cultural identity; **or** the child

has no particular identification with a culture and the absence of cultural identity is resulting in *some* conflict with family or community.

5. Cultural component that causes significant conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *significant* conflict related to cultural identity; **or** the child has no particular identification with a culture and the absence of cultural identity is resulting in *significant* conflict with family or community.

Y. **CSN9. Peer/Adult Social Relationships**

1. Strong social relationships. The child enjoys and participates in a variety of constructive, age-appropriate social activities. The child enjoys reciprocal, positive relationships with others.
2. Adequate social relationships. The child demonstrates adequate social skills. The child maintains stable relationships with others; occasional conflicts are minor and easily resolved.
3. Limited social relationships. The child demonstrates inconsistent social skills; the child has limited positive interactions with others. Conflicts are more frequent and serious, and the child may be unable to resolve them.
4. Poor social relationships. The child has poor social skills, as demonstrated by frequent conflictual relationships or exclusive interactions with negative or exploitive peers, or the child is isolated and lacks a support system.

Z. **CSN10. Delinquent Behavior**

1. Delinquent behavior includes any action that, if committed by an adult, would constitute a crime. Also include crimes that are youth-specific (e.g., consuming alcohol).
2. Preventive activities. The child is involved in community service, other prosocial community activities, and/or crime prevention programs and takes a stance against crime. The child has no arrest history and there is no other indication of criminal behavior.
3. No current delinquent behavior. The child has no current indication of criminal behavior, **or** the child has successfully completed probation, OJS, or diversion, and there has been no criminal behavior in the past two years.
4. Occasional delinquent behavior. The child is engaging or has engaged in occasional, nonviolent delinquent behavior and may have been arrested or placed on probation or OJS. Also include children who have completed diversion within the past two years or are currently involved in a diversion program. Examples include but are not limited to children who have purchased or had possession of illegal drugs but have not yet been arrested.
5. Significant delinquent behavior. The child is involved or has been involved in any violent or repeated nonviolent delinquent behavior that has or may have resulted in consequences such as arrests, incarcerations, probation, diversion or OJS. Include children who have failed to complete probation or diversion.

AA. **CSN11. Life Skills.** Life Skills are assessed using the Ansell-Casey Life Skills Assessment. The Ansell-Casey Assessment has eight topic areas. Each topic has a score maximum of 5 points. To determine the child's needs using the Ansell-Casey assessment, add the scores of all eight topic areas. The total score of all eight topics provides the rating for this item.

1. No needs. The Ansell-Casey Life Skills Assessment Mastery score is between 30 and 40 for this child.

2. Low Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 20 and 29 for this child.
3. Moderate Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 12 and 19 for this child.
4. Significant Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 0 and 11 for this child.

BB. **CSN12. Identified Caregiver Strength/Need (not covered in CSN1-CSN11)**

1. Significant strength. A child has an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.
2. Not applicable. A child has no area of strength or need relevant for case planning that is not included in CSN1-CSN11.
3. Minor need. A child has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.
4. Significant need. A child has a serious need that has a significant impact on family functioning. The family perceives they would benefit from services and support that address the need.

CC. As part of the FSNA the CFS Specialist will:

1. Continue to verify the sufficiency of the Safety Plan;
2. Continue to elicit parent/caregiver perceptions regarding identified safety threats;
3. Reinforce the reduction and elimination of the safety threats;
4. Engage the parents/caregiver in a collaborative partnership for change;
5. Facilitate communication and interaction with parents/caregivers;
6. Recognize parent/caregiver readiness for change related to acknowledging safety threats and need to improve ability to protect their child;
7. Identify safety related needs;
8. Identify family/parent/caregiver strengths around which the case plan can be built; and
9. Identify potential Family Team members and informal resources.

IX. SDM® RISK REASSESSMENT OF IN-HOME CASES:

A. The Risk Reassessment combines items from the original risk assessment with additional items that evaluate a family's progress toward case plan goals.

B. Research has demonstrated that for the reassessment, a single index best categorizes risk for future maltreatment. Unlike the initial risk assessment, which contains separate indices for risk of neglect and risk of abuse, the risk reassessment is composed of a single index.

C. All in-home services cases, including child abuse/neglect, dependency and 3 (c) cases will be assessed by the CFS Specialist using the Risk Reassessment tool.

1. Cases in which any child remains in out-of-home placement with a goal of reunification should be assessed using the Reunification Assessment.

D. These cases will be assessed minimally every 90 days from the initial case plan OR every 90 days from the reunification of all the children to the family home. The reassessment should be completed sooner if there are new circumstances or new information that would affect risk or if a recommendation for case closure is being considered.

E. The Risk Reassessment guides the decision to keep a family preservation case (children

placed at home) open or to recommend case closure.

F. The Risk Reassessment will be documented on N-FOCUS within 7 calendar days of completion. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the answers in the risk reassessment regardless of the risk level. The CFS Specialist will utilize the narrative sections within the SDM assessment.

X. COMPLETION OF THE RISK REASSESSMENT:

A. **Items R1-R5:**

1. The CFS Specialist will use the definitions to determine the appropriate response for each item and enter the corresponding score.
2. Items R1 and R2 refer to the time period prior to the current referral. Scores for these items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

B. **R1 – Number of prior neglect or abuse investigations of any household adult.** The CFS Specialist will score the item based on the count of all investigations, substantiated or not, that were assigned for DHHS investigation for any type of abuse or neglect prior to the investigation resulting in the current case. Where possible, history from other county or state jurisdictions should be included. Exclude dependency intakes and investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

C. **R2 - Household previously had an open ongoing service case (voluntary or court-ordered) due to child abuse or neglect.** The CFS Specialist will mark "yes" if this household previously had an open family preservation or foster care case as a result of a prior investigation prior to the current referral. Include voluntary or court-ordered family services or foster care services; do not include delinquency services or dependency cases (e.g., 3B cases).

D. **R3 - Primary caregiver has a history of abuse or neglect as a child.**

1. The CFS Specialist will mark "yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. Include disclosure of incidents that would be screened in now.
2. R3 and R5 may change if new information is available or if there has been a change in the identified primary caregiver.

E. **R4 - Characteristics of children in the household.** The CFS Specialist will score this item based on credible statements by caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records. The CFS Specialist will mark each characteristic that is present and score 1 if any characteristic is present.

1. Score 0 if no child in the household exhibits characteristics listed below.
2. Score 1 if any child has any of the characteristics below.
   a) **Developmental disability,** as evidenced by intellectual disability or other developmental problem, including ADHD that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
   b) **Learning disability.** Child has an IEP to address a learning problem such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not

have one, who is in preschool, or who is not enrolled in school.

c) **Physical disability** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include only credible information about disabilities of long duration).

d) **Medically fragile or diagnosed with failure to thrive:** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention (include also infants under six months of age with physical conditions requiring medical intervention if the condition is likely to persist for six months or more), or has a diagnosis of failure to thrive by a physician.

3. R4 may change if a child's condition has changed, or if a child with a described condition is no longer part of the household (children in out-of-home placement with a plan to return home are considered part of the household, and the family should be reassessed using the reunification reassessment).

F. **R5 - Primary caregiver has a past or current mental health problem. The CFS Specialist will score the following based on the definitions below.**

1. Score 0 if the primary caregiver does not have a current or past mental health problem.
2. Score 1 if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
   a) Diagnosis of a DSM condition resulting from formal assessment by a mental health clinician;
   b) Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; or
   c) Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.
3. Indicate if the problem existed within the previous 12 months and/or prior to the previous 12 months. Also indicate if the primary caregiver is currently receiving treatment and what that treatment entails. Do not include diagnoses of ADHD or learning disabilities (e.g. dyslexia).
4. R3 and R5 may change if new information is available or if there has been a change in the identified primary caregiver.

G. **Items R6-R8:** These items are scored based only on observations, since the most recent assessment or reassessment. Using the definitions determine the appropriate response for each item and enter the corresponding score. Both the primary and secondary caregivers are assessed in these items.

H. **Item R6 - In the period since the last assessment, the caregiver has addressed an alcohol or drug problem.**

1. The CFS Specialist will assess each caregiver separately; the item is scored based on the caregiver demonstrating the more severe behavior. The CFS Specialist will indicate whether or not the caregiver has a current alcohol/drug abuse problem that interferes with the caregiver's or the family's functioning and he/she is not addressing the problem. Not addressing the problem may be evidenced by the following:
   a) Substance use that currently affects the caregiver's employment; criminal involvement; marital or family relationships; or his/her ability to provide

protection, supervision and care for the child.

   b) An arrest or citation since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing; possession charges for drugs or drug paraphernalia;
   c) Self-report of a current problem;
   d) Positive toxicology screen during assessment period, or refusal to comply with toxicology screens; or
   e) Health/medical problems resulting from current substance use.
2. The CFS Specialist will score the following:
   a) Score 0 if there is no history of an alcohol or drug abuse problem or is there is no current alcohol or drug abuse problem that requires intervention.
   b) Score 0 if there is an alcohol or drug abuse problem and the caregiver has addressed the problem.
   c) Score 1 if there is an alcohol or drug abuse problem and the caregiver has not addressed the problem.
3. Legal, non-abusive prescription drug use and responsible, non-abusive use of alcohol should be scored as an "a".

I. **<u>Item R7 - Problems with relationships among adults within the household.</u>**
   1. The CFS Specialist will score this item based on current status of adult relationships in the household.
      a) Score 0 if not applicable or there are no relationship problems observed.
      b) Score 1 if there are harmful/tumultuous adult relationships or domestic violence.
         (1) Adult relationships that are significantly conflictual or harmful to domestic functioning or to the care the child receives (but not at the level of domestic violence). Consider adult relationships in which basic household decisions (e.g., regarding chores, division of child care responsibilities) cannot be settled without conflict.
         (2) The household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult.

J. **<u>Item R8 - Primary caregiver provides physical care consistent with each child's needs.</u>**
   1. The CFS Specialist will mark "yes" if the caregiver is providing age-appropriate physical care for all children in the household. Examples may include the following:
      a) Obtaining standard immunizations (do not consider children who have not been immunized due to religious or philosophical objection);
      b) Obtaining medical care for severe, chronic, or recurrent illness;
      c) Providing the child with adequate food;
      d) Providing the child with adequately clean, weather-appropriate clothing;
      e) Preventing or addressing rodent or insect infestations;
      f) Providing adequate housing with operative plumbing and electricity (heating and cooling);
      g) Ensuring that poisonous substances or dangerous objects are not within reach of a small child; or
      h) Supporting or providing age/developmentally appropriate hygiene (bathing,

brushing teeth, changing diapers).

K. **Item R9 - Caregiver's progress with case plan outcomes and addressing critical needs.**

1. The CFS Specialist will score this item on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with case plan outcomes. If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of participation/progress.
   a) **Demonstrates new skills consistent with case plan outcomes and addressing critical needs OR is actively engaged in services and activities to gain new skills consistent with case plan outcomes.** The caregiver is demonstrating behavioral change consistent with the outcomes in the case plan (e.g., is able to manage substance use/abuse to provide for ongoing safety of children; is able to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary-setting; develops a mutually supportive relationship with partner to provide a safe home for children; provides emotional support for the child, etc.). This may include participation in activities identified on the case plan toward achievement of new skills and caregivers who successfully achieve desired behavior change through activities not specifically identified on the plan. Engagement in services and activities means that the caregiver's participation suggests acquisition and application of new skills, not just compliance with attendance. Compliance with services and activities without demonstration of acquisition of new skills consistent with case plan outcomes is not sufficient for scoring.
   b) **Does not demonstrate new skills consistent with case plan outcomes or addressing critical needs and/or participation is minimal and insufficient to contribute to achieving case plan outcomes or addressing critical needs.** This may include complete refusal to participate in services or activities, or participation that has failed to result in behavior change. Caregivers who are demonstrating some progress toward case plan objectives but insufficient progress overall should be scored here.
2. The most difficult part of reassessing risk is completing the case plan progress item (R9). The CFS Specialist can make this easier for yourself and the family by
   a) Using concrete, behavior-based goals.
   b) Using the Family Strengths and Needs Assessment (FSNA) to see if there has been a reduction in, or elimination of needs.
   c) Using the safety assessment to determine if safety threats been resolved
   d) Documenting each contact with the family quickly, focusing on recording observations that directly relate to case plan goals

L. **Scored Risk Level.** After entering the score for each individual item, enter the total score and indicate the corresponding risk level.

Score	Risk Level
0-1	☐ Low
2-4	☐ Moderate
5-7	☐ High
8+	☐ Very High

M. **Policy Overrides:**

1. There are certain conditions that are so serious that a risk level of very high should be assigned regardless of the risk reassessment score. The policy overrides refer to

incidents or conditions that occurred since the risk assessment or last reassessment. If one or more policy override conditions exist, mark "yes" for each reason for the override and mark "very high" for the final risk level.

2. Policy overrides require supervisory review.
   a) Sexual abuse case and perpetrator is likely to have access to the child. One or more of the children in this household are to have been victims of sexual abuse and actions or inaction by the caregivers indicate that there is a safety threat to the child because the perpetrator is likely to have unsupervised access.
   b) Non-accidental injury to a child under 2 years old. Any child under 2 years of age in the household has any physical injury resulting from the actions or inactions of a caregiver.
   c) Severe non-accidental injury. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; and the child requires medical treatment.
   d) Caregiver action or inaction resulted in death of a child due to abuse or neglect. Any child in the household has died as a result of actions or inactions by the caregiver.

N. **Discretionary Override:**
   1. A discretionary override is used whenever the CFS Specialist believes that the risk score does not accurately portray the family's actual risk level. The risk reassessment permits the CFS Specialist to increase or *decrease* the risk level by one step. The reason a CFS Specialist may now decrease the risk level is that after working with the family for a period of time, the CFS Specialist has acquired significant knowledge of the family.
   2. If a discretionary override applies, mark yes, indicate the reason, and mark the override risk level. Discretionary overrides require CFS Supervisory approval. The CFS Specialist then indicates the final risk level.

O. **Recommended Decision**

Risk Reassessment Case Status Recommendation	
Risk Level	**Recommendation**
Low	**Recommended Closure***
Moderate	**Recommended Closure***
High	**Recommend the case remain open**
Very High	**Recommend the case remain open**

***Low and moderate risk cases must be recommended for closure only if the case closure SDM® safety assessment finding is safe.**

For cases that remain open following Risk Reassessment, the new risk level guides minimum contact standards that will be in effect until the next Risk Reassessment is completed.

XI. SDM® REUNIFICATION ASSESSMENT:

A. The Reunification Assessment consists of four parts where the results are used to reach a permanency plan goal and to guide decisions about whether or not to return a child home.
   1. Risk Reassessment
   2. Parenting Time Evaluation
   3. Safety Reassessment and
   4. Permanency Plan Recommendation.

B. The CFS Specialist will conduct the Reunification Assessment on any ongoing case in which at least one child is in out-of-home placement with a goal of reunification. [Does not apply for OJS cases].

C. The CFS Specialist will not complete this assessment if a court determination has been made that reasonable efforts to reunify the child and parent are not required or for a child with a goal other than reunification. The CFS Specialist will proceed with updating the FSNA.

D. The CFS Specialist will conduct the Reunification Assessment at a minimum, every 90 days from the initial case plan. When possible (e.g., at 6 months, 12 months, etc.), the CFS Specialist will coordinate the reunification assessment with the FSNA and the new case plan.

E. If a Reunification Assessment is completed for purposes outside of the case planning time frame (e.g., court hearing), and the next case plan is due within 30 days, a new Reunification Assessment is not required with the new case plan. After the new case plan, the reunification assessment schedule should resume every 90 days from the case plan.

F. If critical incidents have occurred in the 30 days between the completion of a Reunification Assessment and a recommendation regarding reunification, the CFS Specialist will revise the previous Reunification Assessment if the assessment is not final; a new assessment is not required. If the Reunification Assessment is final, a new assessment is required.

G. The Reunification Assessment results inform the decision of whether a child is recommended for reunification or if a change to the permanency plan goal should be recommended. If families have effectively reduced risk, have achieved at least acceptable parenting time, and the home is safe or conditionally safe, reunification can be recommended by the CFS Specialist. The permanency plan guidelines and recommendation sections guide recommendations to return a child home, continue reunification efforts with this household, or recommend a change to the permanency goal.

H. The Reunification Assessment will be documented on N-FOCUS within 7 calendar days of completion. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the Reunification Assessment regardless of the final determination. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding decisions on each of the items.

XII. COMPLETION OF THE REUNIFICATION ASSESSMENT:

A. **Section 1: Reunification Risk Reassessment:** The CFS Specialist will complete the reunification risk reassessment and indicate the final risk level. The final risk level from Section 1 of the reunification assessment also determines the contact guidelines that will apply to the assessed household for the next review period.

B. **R1. Initial risk level or prevention level (after overrides) –** The initial risk level or prevention level for the referral is used to score this item. If there is no initial risk assessment or prevention assessment (for 3B cases) for this family, mark "e" and score as 4.
   1. Low – 0
   2. Moderate –
   3. High – 4
   4. Very high – 5 or
   5. No initial risk level – 4

C. **R2. Has there been a new substantiation (in this household) since the last assessment/reassessment?** The CFS Specialist will rate this item based on whether new allegations of maltreatment have been received (for this household) since the last assessment (if completed at case opening) or reassessment.
   1. Score 0 if no new allegation of maltreatment was substantiated by DHHS, or if DHHS made the agency aware of a concern in the household but did not investigate that concern.
   2. Score 6 if a new allegation of maltreatment was received and substantiated by DHHS.

D. **R3. Caregiver(s) progress with case plan.** The CFS Specialist will rate both caregivers based on whether each has mastered or is mastering skills learned from participation in programs and/or services. Indicate the progress for each caregiver in the home, but enter the score based on the caregiver with the least progress. The CFS Specialist will indicate if there is no secondary caregiver.
   1. Score minus 2 (-2) if the caregiver: Demonstrates new skills consistent with case plan outcomes and has successfully addressed identified critical needs. Has successfully changed behavior to improve ability to protect and care for children.
      a) Is demonstrating behavioral change consistent with case plan outcomes and addressing critical needs (e.g., is able to manage substance use/abuse to provide for ongoing safety of children; is able to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary-setting; develops a mutually supportive relationship with partner to provide a safe home for children); and
      b) Has successfully completed all recommended services, is actively participating in services, OR is pursuing objectives detailed in case plan.
   2. The caregiver's compliance with services and activities without demonstration of acquisition of new skills consistent with case plan objectives and addressing critical needs is not sufficient for scoring.
   3. Demonstrates few new skills consistent with case plan outcomes and addressing critical needs. Minimal participation in pursuing outcomes. The CFS Specialist will score 0 if the caregiver has demonstrated some behavioral change consistent with case plan outcomes <u>and</u> addressing critical needs. The caregiver is minimally participating in services <u>or</u> has made progress but is not fully complying with activities in the plan.
   4. Does not demonstrate new skills consistent with case plan outcomes <u>or</u> addressing critical needs. May have participated in activities but is not meeting objectives; refuses involvement in services or failed to comply/participate as required. The CFS Specialist will score 4 if the caregiver has demonstrated minimal or no behavioral change consistent with case plan outcomes or addressing critical needs. The

caregiver refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills due to a failure or inability to participate.

E. **Scored Risk Level. The CFS Specialist will assign the family's risk level based on the following chart:**

Score	Risk Level
☐ -2 to 1	☐ Low
☐ 2 to 3	☐ Moderate
☐ 4 to 5	☐ High
☐ 6 and above	☐ Very High

F. **Policy Overrides:** There are certain conditions so serious that a risk level of very high should be assigned regardless of the risk reassessment score. The policy overrides refer to incidents or conditions that occurred only during the current review period (i.e., since the initial risk assessment or last reassessment). If one or more policy override conditions exist, the CFS Specialist will select "yes" for each reason for the override and select "very high" for the final risk level. Policy overrides require supervisory review.

1. Sexual abuse case and perpetrator is likely to have access to the child. One or more of the children in this household are to have been victims of sexual abuse AND actions or inaction by the caregivers indicate that there is a safety threat to the child because the perpetrator is likely to have unsupervised access.
2. Non-accidental injury to a child under 2 years old. Any child under 2 years of age in the household has any physical injury resulting from the actions or inactions of a caregiver.
3. Severe non-accidental injury. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; AND the child requires medical treatment.
4. Caregiver action or inaction resulted in death of a child due to abuse or neglect. Any child in the household has died as a result of actions or inactions by the caregiver.

G. **Discretionary Override:** The CFS Specialist may request a discretionary override that would move the final score up or down one risk level. This request must be approved by a supervisor.

1. When a judge orders a child to be placed in out-of-home care, an override should be considered but should not be the reason sole reason to override the CFS Specialists assessment.

H. **Section 2: Parenting Time Evaluation:**

1. For each child, the CFS Specialist will indicate the level at which the caregiver demonstrating the least progress has participated in the parenting time plan.
2. Only combinations of frequency and quality that fall into the shaded section of the grid may be considered acceptable.
3. The parenting time evaluation considers the caregivers parenting time separately for each child. When assessing parenting time, the CFS Specialist will consider the

caregiver making the least progress.

Parenting Time Frequency	Quality of Face-to Face Visit			
	Strong	Adequate	Limited	Destructive
Totally	[shaded]	[shaded]		
Routinely	[shaded]	[shaded]		
Sporadically				
Rarely or never				

Note: Shaded cells indicate acceptable parenting time. Unshaded cells indicate unacceptable parenting time.

4. The CFS Specialist will utilize the following guidelines to determine the quality and frequency of parenting time visits.
5. Parenting time frequency will be evaluated by looking at the following:
   a) Visits that are appreciably shortened by late arrival/early departure are considered missed.
   b) Do not consider as missed visits those that were missed due to child unavailability.
   c) Do not consider as missed visits missed due to illness of a child living with the caregiver, or severe weather.
   d) When a legitimate reason to miss a visit (e.g., caregiver illness or caregiver work schedule) is used with unusual frequency, consider asking the caregiver to provide documentation.
6. To calculate the parenting time percentage, divide the number of visits the caregiver successfully attended by the number of visits scheduled in the review period.
   a) Totally: Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).
   b) Routinely: Caregiver may miss visits occasionally and rarely requests to reschedule visits in advance (65-89% compliance)
   c) Sporadically: Caregiver misses or cancels visits, or reschedules many scheduled visits at the last minute (i.e. less than 24 hours prior to visit: 26-64% compliance).
   d) Rarely or never: Caregiver does not visit or attends 25% or fewer of the allowed visits (0-25% compliance). Also select "rarely or never" if any of the following conditions are present:
      (1) Caregiver has failed to visit, or visits have been suspended due to parental behavior. The caregiver has attended none of the scheduled visits during the review period and has not provided a reasonable explanation or attempted to reschedule; or there were no scheduled visits during the review period or visits were cancelled by the agency due to the parent's behavior (e.g., repeated problems with substance abuse during parenting time, therapist's recommendation that parenting time be discontinued, parents threatening to abscond with the children).
      (2) Visitation is not required. The court has ordered that no visits occur, due to safety concerns for the child; or parental rights are no longer intact.
      (3) Caregiver has been unable to visit child. The caregiver has not visited the child during the review period because he/she is unable due to physical

incapacity (e.g., hospitalization), incarceration, or because the caregiver could not be located.

7. The quality of the visit is based on the CFS Specialist's direct observation whenever possible, supplemented by observation of the child, reports from foster parents, etc. When parenting time is not supervised, the CFS Specialist may rely on other information, such as child or therapist reports, the physical condition of children when they return from parenting time, observation of caregiver preparation for parenting time (e.g., purchase of snacks or diapers, provision of age-appropriate toys), reports of caregiver timeliness in picking up or returning children, and contact by caregivers subsequent to unforeseen events (e.g., caregiver contacting worker promptly if a child is accidentally injured during a visit or to report unintended contact with a person who is not permitted access to the child).

Quality of Caregiver Child Interaction	
Strong	• Consistently demonstrates protective and supportive behaviors toward the child that are consistent with case plan outcomes throughout the entire review period. • Responds in an engaging and nurturing manner to the child's cues and behaviors. • Identifies and responds appropriately to the child's emotional and physical care needs. • Demonstrates effective behavior management strategies. • Puts child's needs ahead of his/her own needs. • Demonstrates a focus on the child during visits; shows empathy to child. • Engages the child in age-appropriate activities at own initiative. • Conducts himself/herself appropriately during visits. • Initiates participation in school, other child activities, and medical appointments. • Visitation has progressed to include extended visits.
Adequate	• Consistently demonstrates protective and supportive behaviors toward the child that are consistent with case plan outcomes. • Demonstrates an ability to recognize child's behaviors and cues; generally responds appropriately to behavior and cues. • Identifies the child's physical and emotional needs; responds adequately to these needs. • Demonstrates effective behavior management strategies. • Generally puts child's needs ahead of his/her own. • Demonstrates a focus on the child during visits; shows empathy to child. • Conducts himself/herself appropriately during visits. • Participates in school, other child activities, and medical appointments.
Limited	• Demonstrates an ability to recognize child's cues and behaviors, but needs guidance in establishing an appropriate response to these cues and behaviors. • Recognizes a need to set limits with child, but enforces limits or behavior management in an inconsistent or detrimental manner. • Demonstrates an ability to identify child's physical and/or emotional needs, but may need assistance in consistently responding to the child in an appropriate manner. • Occasionally puts the child's needs ahead of his/her own. • Conducts him/herself appropriately during visits.
Destructive	• Demonstrates lack of understanding for child's cues and behaviors or an inability to respond appropriately to the child's cues and behaviors. • Demonstrates limited or no ability to establish effective behavior management

	strategies. • Has not demonstrated an ability to identify or respond to the child's physical or emotional care needs. • Rarely puts child's needs ahead of his/her own. • May have persisted in maltreatment during visitation. • May not be focused on child during parenting time and/or conducts himself/herself inappropriately during visit (examples of inappropriate conduct include but are not limited to arriving for parenting time while substance-affected, or cursing at/violently arguing with worker in presence of child).

I. **Parenting Time Overrides:** The CFS Specialist will indicate if any condition exists that should override the parenting time evaluation to **unacceptable.**

1. Policy: Parenting time is supervised for safety. This override must always be selected by the CFS Specialist whenever parenting time is supervised, regardless of whether or not it is court ordered. This includes all instances even when the CFS Specialist may disagree with the court order or determines that there is no safety issue requiring supervision. The court has ordered supervised visitation and the policy override would be marked as unacceptable. Drop-In monitoring of parent/child contact is not considered for an override.
2. Policy: No visits have occurred in the family home.
3. Policy: Visitation has not progressed to include extended visits.
4. Discretionary: The CFS Specialist must document a reason for this override and must have supervisory approval.

J. **Section 3: Reunification Safety Reassessment:**

1. **Section A. Safety Threat Assessment:** The CFS Specialist will begin by identifying and describing the safety threats that were present at the time the children were taken into protective placement.
   a) If the household currently being considered for reunification was not the removal household, indicate that this is a non-removal household when explaining why safety threats that brought the child into care no longer apply.
   b) For non-removal households, there may not be any past safety threats to document in the first part of Section A.
2. In the second part of Section A, the CFS Specialist will identify any safety threats that are currently present in the household being considered for reunification. During the safety assessment the CFS Specialist must consider the characteristics and behaviors of all adults who will have access to the children if they are reunified into the household, as well as the physical safety of the home itself.
3. It is important that the CFS Specialist carefully considers and assesses for each safety threat and works with the family to identify strategies to immediately contain each threat. In some situations, it may not be possible to contain identified safety threats. If it is not possible to mitigate the safety threat through a safety plan, the CFS Specialist should consider adding efforts to resolve the threat to the case plan.

K. **Safety Threats:** The following threats are behaviors or conditions that may place a child in immediate danger of serious harm if returned home. The CFS Specialist will identify the presence of each threat by endorsing the item.

1. Caregiver made a plausible threat to cause serious physical harm, as indicated by any of the following:
   a) Caregiver fears he/she will maltreat the child and/or requests that placement

continue.

b) Current threat to cause serious harm or retaliate against the child. Threat of action that would result in serious harm, or household member plans to retaliate against the child for DHHS investigation or intervention. This threat may be verbal or may be indicated by physical behavior towards the child. Include credible reports of caregiver statements by others.

2. Caregiver does not protect/is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
   a) Caregiver does not protect or is unable to protect the child from serious harm or threatened harm by other family members, other household members, or others having access to the child. Caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age, emotional or physical disability, or developmental stage.
   b) An individual with known violent criminal behavior/history resided in the home or caregiver allows access to the child. Caregiver may or may not know about individual's history. Include homes where gang activity occurs or where there is violent illegal activity in the home.
      Examples include but are not limited to the following:
      (1) Mother and grandfather both reside in the household. Grandfather has a history of using inappropriate physical discipline. Mother believes that grandfather will not change his behavior and does not think that she can stop him.
      (2) Father is aware that a cousin has sexually abused one of the children being considered for reunification, but will not restrict cousin's access to the home.
3. Caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. Needs may be basic or exceptional.
   a) Caregiver does not or cannot provide appropriate supervision for the child, considering the child's age and developmental level, e.g., allowing a toddler to play unsupervised in front of a busy street.
   b) Caregiver does not or cannot make appropriate child care arrangements, e.g., leaving children with a babysitter who has significant substance abuse problems.
   c) Caregiver does not have the ability to provide or the capacity to keep (refrigerate or heat) food or drink for the child.
   d) Caregiver does not or cannot provide the child with clothing that would protect him/her from severe weather.
   e) Caregiver does not have the resources necessary to safely transport child to necessary medical or mental health appointments due to lack of transportation (public or private vehicle) or lack of nearby facilities.
   f) Child has significant medical or mental health needs, and credible concerns exist regarding caregiver's ability to maintain child's safety or the safety of other vulnerable children in the home.
   g) Caregiver has no housing or is currently residing in a temporary or short-term emergency shelter. If the child were returned to the caregiver, the child's needs for minimally safe conditions (water, structurally safe environment, protection

from severe weather elements) would not be met.

h) Caregiver does not or cannot ensure safe sleeping arrangements for children, taking into consideration age and vulnerabilities of children, e.g., infant sleeping arrangements that include soft surfaces that present suffocation risk.

4. **The physical conditions are hazardous and immediately threatening to the health and/or safety of the child.** Based on the child's age, emotional or physical disability, and developmental status, the child's physical living conditions (including but not limited to the following) are hazardous and immediately threatening:
   a) Leaking gas from stove or heating unit;
   b) Substance or objects accessible to the child that may endanger his/her health and/or safety (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities; unsecured weapons);
   c) Lack of water or utilities (heat, plumbing, electricity), and no alternate, safe provisions are made;
   d) Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows;
   e) Exposed electrical wires;
   f) Excessive garbage or rotted or spoiled food that threatens health;
   g) Serious illness or significant injury is likely to occur due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites, severe infestations);
   h) Evidence of human or animal waste throughout living quarters;
   i) Housing that does not meet minimal community safety standards, e.g., buildings that have been condemned or determined to be unsound by housing authority or other professional inspection.

5. **The severity of previous maltreatment <u>and</u> current circumstances suggest that the child's safety may be of immediate concern.** To endorse this item, there must be either a previous incident or pattern of incidents **<u>and</u>** concern about current circumstances.

Previous maltreatment includes any of the following:	**AND** Previous maltreatment includes any of the following:
• Prior death of a child as a result of maltreatment. • Prior serious injury to the child other than accidental: Caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impaired the health or well-being of the child *and required medical treatment*. Include any sexual abuse that required medical treatment.	• Caregiver has limited resources for parenting support. • Caregiver has had limited opportunity to demonstrate improved parenting for more than 48 hours at a time and/or under significant stress. • Caregiver continues to show no remorse or responsibility for previous behavior that resulted in harm to a child. • Case manager and/or others involved in the case have credible concerns regarding the child's safety if he/she returned home.

• Drug-exposed infant. Prior to the current case, a child was born drug-exposed, meaning having a positive toxicology screen at birth for mother or child, and a current caregiver considered for reunification was the birth parent. • Prior termination of parental rights or permanent placement of another child: The caregiver had parental rights terminated as a result of CA/N, or has had a child permanently placed outside his/her custody (i.e., guardianship or other planned permanent placement). • Prior removal of a child or failed reunification: Removal/placement of a child by DHHS or other responsible agency or concerned party was necessary for the child's safety, or child has reentered foster care after prior reunification attempts.	

6. **Child behaviors place or would place the child at imminent threat of serious harm, in spite of appropriate response by caregiver.** To mark this threat, **three** conditions **must** be present:

The child is currently engaging in or habitually engages in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from home and place themselves in unsafe living/sleeping situations, children who engage in prostitution, children who engage in self-harming behaviors if returned to the home (e.g., prior reunifications have failed due to child behaviors or child has stated an intent to	**AND** The child's caregiver(s) have responded or are currently responding appropriately and making reasonable efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child and increasing direct supervision and monitoring of the child.	**AND** The caregiver's current or prior efforts, although appropriate, are/were insufficient to prevent the child from engaging in the behavior in the future.

return to such behaviors).		

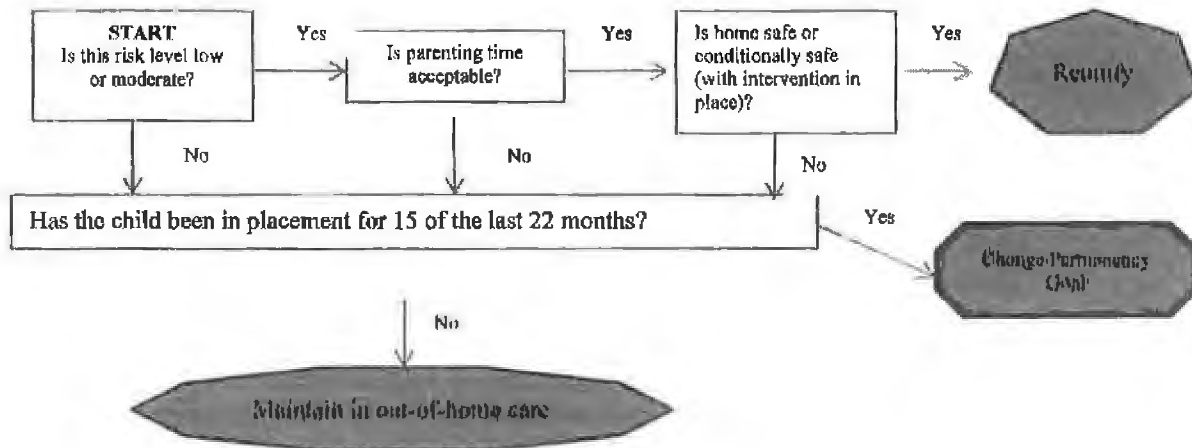
7. **Other (specify).** The CFS Specialist will select this safety threat if no other threat applies and the CFS Specialist can describe the situation and the threat.

L. **Safety Decision:** After the CFS Specialist has identified the past and current safety threats, the CFS Specialist will base the safety decision on whether or not the family has made **sustainable change** to resolve the safety threats identified at the time of removal and/or whether or not safety interventions are available to develop a safety plan to **contain or mitigate** current safety threats.

1. The CFS Specialist will determine the following:
   a) The child is **SAFE**. No safety concerns are present. **Safety threats that resulted in the child's removal** (as documented on the initial safety assessment) **are no longer present,** and no current safety threats were identified. The CFS Specialist will **document how initial safety issues were resolved.**
   b) The child is **CONDITIONALLY SAFE.** One or more safety threats are present. The CFS Specialist will **briefly describe the specific safety plan** that has been written with the family **to immediately** address the safety threats(s).
   c) The child is **UNSAFE.** One or more safety threats are present. **The only intervention to ensure safety is continued out-of-home placement.** The CFS Specialist will document why other interventions could not be implemented to reunify the child at the present time.
2. The CFS Specialist will also document in the Reunification Safety Assessment the following:
   a) Evidence and observations of caregiver behaviors used to answer safety assessment items; and
   b) The supports provided by the CFS Specialist to the family during the review period to help address safety threats.

M. **Section 4: Permanency Plan Recommendation Summary:**

1. The CFS Specialist will complete the decision tree for each child being considered for reunification and document the results.
2. Reunification is recommended when:
   a) Risk is low or moderate, parenting time for the child is acceptable, and the home is safe or conditionally safe, reunification is recommended. If any of these three conditions is not met, the CFS Specialist should indicate if the child has been in care for 15 of the previous 22 months. If so, a new permanency goal should be recommended. If not, efforts toward reunification should be continued.
   b) The recommendation of the assessment will be evaluated by the CFS Specialist. The CFS Specialist will determine if the outcome of the permanency plan recommendations summary decision tree is the appropriate action for this case. If there are unique circumstances in this family that justify a different recommendation, the CFS Specialist may exercise a discretionary override. If the CFS Specialist chooses to override the tool recommendation, he or she should indicate a reason for this override and seek supervisor approval.
      (1) The CFS Specialist, may, for example, override a tool recommendation to change the permanency goals if the family has made good progress on case plan goals and the CFS Specialist believes reunification may be achieved in the next review period. The CFS Specialist should carefully document the evidence that supports this view.



The CFS Specialist will utilize the Reunification Assessment tool in N-FOCUS to document the following recommendations for each child.

3. The CFS Specialist will utilize the Reunification Assessment tool in N-FOCUS to document the following recommendations for each child.

Child Name	Parenting Time	In care for 15 of 22 months?	Permanency Plan Recommendation Summary Outcome	Discretionary Override	New Goal Recommendation
	☐ Acceptable ☐ Unacceptable	☐ Yes ☐ No	☐ Reunify ☐ Maintain in care ☐ Change permanency goal	☐ No override ☐ Reunify ☐ Maintain in care ☐ Change permanency goal	☐ Reunification ☐ Adoption ☐ Permanent Guardianship ☐ I.L. ☐ Self-sufficiency with support

4. The CFS Specialist will summarize in N-FOCUS Narrative the following:
   a) Briefly describe the permanency plan recommendation for each child and why this recommendation was selected for the child; and
   b) Explain why a discretionary override was needed for the child (if applicable).
5. The Reunification Assessment can be completed at any time the situation changes. **NOTE:** Reports of concern of abuse or neglect or other care concerns regarding a licensed or approved foster or relative foster care provider will be assessed using the Assessment for Safety and Suitability.

XIII. **CASE PLANNING:** *Refer to Program Guidance Memo "Permanency and Case Planning.*

A. **Case Plans for Wards who are 16 Years of Age or Older:** *Refer to Program Guidance Memo #30-2015 – Transitional Living Planning.*

XIV. GENOGRAMS AND ECO-MAPS: All CFS Specialists are required to develop a genogram and eco-map with each family receiving ongoing services, whether court or non-court involved. The genogram and eco-map will be started at the assessment stage for any family whose child has been determined to be conditionally safe or unsafe, or for whom the risk of future maltreatment is high or very high. Documentation will be completed using the standardized format. [ii] Genograms and eco-maps are reviewed and updated by the CFS Specialist throughout the family's involvement with DHHS. Genograms and eco-maps will be documented and placed in the most current volume of the case file. The genogram and ecomap should be a part of every team meeting and updated as new information is obtained.

XV. SDM CASE REVIEWS: At a minimum, the CFS Supervisor will conduct the following reviews of SDM Assessments. The CFS Supervisor will utilize discretion and the work performance of individual CFS Specialists to determine the frequency of additional SDM Reviews.

A. The CFS Supervisor will review every SDM Assessment in which an Override is utilized;
B. The CFS Supervisor will review every SDM Assessment for CFS Trainees for the first 6 months or until the CFS Trainee has been promoted to CFS Specialist;
C. The CFS Supervisor will conduct a random sample of SDM Assessments. One SDM Assessment will be selected each month for each CFS Specialist. The CFS Supervisor will conduct an in-depth review of one SDM Assessment for each CFS Specialist.

XVI. CASE CLOSURE

A. The decision on recommending case closure in abuse, neglect, dependency, and 3 (c) cases is based on information gathered for the SDM® Risk Reassessment and the Safety Assessment.
B. The child, parent/caregiver (when parental rights are intact), family, and family team members are all involved when considering making a recommendation to the court to close a case. In all court involved cases, in addition to the family team members, all legal parties including the Guardian ad Litem, CASA and county attorney will provide input in the decision to recommend case closure.
C. Building Support Systems. Stabilizing the changes which have been made by the family is important. The CFS Specialist and the Family Team must identify changes and develop a plan that will enable the family to be successful without DHHS involvement. This process may be completed with case plans prior to requesting discharge. The use of informal supports is a key to stabilizing and maintaining change after DCFS involvement.
D. If referrals for services have not been made for children and families prior to discharge, the CFS Specialist will assist the ward and family by making referrals to DHHS programs such as AABD, medical assistance, Developmental Disabilities or other programs such as Social Security.
E. The CFS Specialist will inform the parent, guardian, or young adult to apply for a change in payee with the Social Security Administration, Veterans Administration or Railroad Retirement Board, as appropriate.
F. Safety Plan in Place: The CFS Specialist cannot close a case with a safety plan in place. If a safety plan is still needed, the child is not safe and the case cannot be closed. If the safety plan depends on the case monitoring or resources of agencies DCFS contracts with, the case cannot be closed. The CFS Specialist must ensure the family has developed and/or implemented strategies to keep the child safe over the long term.
G. In order to recommend discharge one of the following must be in place:

1. Non-Court Involved Cases: The CFS Specialist will take action to close a case when:
    a) All children in the family are determined to be safe **and** the determination of risk is low or moderate;
    b) All children in the family are determined to be safe **and** a high or very high risk family refused services **and** the supervisor have determined that the county attorney should not be contacted **or** the County Attorney has determined that there will be no court intervention; or
    c) The child, parent/caregiver, or family in a non-court case cannot be located after all reasonable efforts have been made.
2. Court Cases: The CFS Specialist will take action to close a court case when:
    a) A Court of competent jurisdiction has dismissed the involvement of the Department in the case;
    b) Reunification has occurred and the child is determined to be safe;
    c) The child's adoption is finalized;
    d) The child's guardianship is finalized (court appoints a guardian and terminated Department custody);
    e) The sending state through the Interstate Compact for the Protection of Children closes the case;
    f) The child has reached the age of majority. See guidance on the Transitional Living Plan Program;
    g) The child enlists in the armed services and completes basic training;
    h) The child marries;
    i) The child has been a runaway for 12 consecutive months and cannot be located;
    j) The child dies; or
    k) The child is convicted and sentenced as an adult.

XVII. **CLOSED CASE FILES:** Files that are closed must contain the following information, as applicable. All information except for the following, will be in N-FOCUS:

A. Original certified documents containing a raised seal or certified documents;
B. Signed relinquishment of Parental Rights;
C. Original documents necessary for an adoption or evidence in the court room;
D. Any document that is not readily and easily readable once imaged;
E. Photographs, cards or other keepsakes that may be valuable to the family should be given to the appropriate person when appropriate to do so, or if not appropriate, they should be maintained in the hard file.

XVIII. **CLOSED CASE RETENTION:** For information on maintenance of closed child welfare files, see the Children and Family Services retention and disposal schedule which can be accessed at www.sos.state.ne.us/records-management.

XIX. **PERSONAL PROPERTY AND INFORMATION AT CASE CLOSURE:** The following information and documents will be provided to the legal custodian of the child at the time of case closure or the child if they have reached the age of majority upon discharge and case closure for children who were in out of home care.

A. The original birth certificate: a copy must be retained in the case record;
B. The original Social Security card: a copy must be retained in the case file;
C. A written summary of medical history or a copy of medical records to include:
   1. Immunizations; and
   2. Names, addresses, and phone numbers of primary medical providers;
D. Copies of report cards or transcript of grades;
E. A written summary of the family background including
   1. Relatives and Kin;
   2. Birthdates; and
   3. Medical history
F. A written summary of the child's out-of-home placement history;
G. Photo(s) of the child and family;
H. Any personal records such as baptism or confirmation certificate;
I. Information regarding trust accounts and amounts; and
J. Any records of tribal affiliations, including tribal identification cards or Certificates of Degree of Indian Blood. (Copies must be maintained in the case record.)

XX. **DISPOSITION OF GUARDIANSHIP FUNDS AT DISCHARGE:** When a ward is discharged from the Department, all of the funds that are held by the Department in a guardianship "trust fund" account must be transferred immediately to the most appropriate individual or agency. The CFS Specialist will complete a "Request and Authorization for use of State Ward Guardianship Funds" on N-FOCUS. Finance and Accounting will ensure correct distribution of funds. The CFS Specialist should contact their local Income Maintenance Foster Care Worker if they have specific questions.

GLOSSARY

Abandonment means a parent's intentionally withholding from a child, without just cause or excuse, the parent's presence, care, love, protection and maintenance and the opportunity for the display of parental affection for the child.

Abandoned Child means a child who is without an appropriate caregiver due to the intentional act and conscious decision of the parent not to care for the child.

Active efforts means and includes and includes, but is not limited to:

1. A concerted level of casework, both prior to and after the removal of an Indian child, exceeding the level that is required under reasonable efforts to preserve and reunify the family described in section 43-283.01 in a manner consistent with the prevailing social and cultural conditions and way of life of the Indian child's tribe or tribes to the extent possible under the circumstances;
2. A request to the Indian child's tribe or tribes and extended family known to the department or the state to convene traditional and customary support and services;
3. Actively engaging, assisting, and monitoring the family's access to and progress in culturally appropriate and available resources of the Indian child's extended family members, tribal service area, Indian tribe or tribes, and individual Indian caregivers;
4. Identification of and provision of information to the Indian child's extended family members known to the department or the state concerning appropriate community, state, and federal resources that may be able to offer housing, financial, and transportation assistance and actively assisting the family in accessing such community, state, and federal resources;
5. Identification of and attempts to engage tribally designated Nebraska Indian Child Welfare Act representatives;
6. Consultation with extended family members known to the department or the state, or a tribally designated Nebraska Indian Child Welfare Act representative if an extended family member cannot be located, to identify family or tribal support services that could be provided by extended family members or other tribal members if extended family members cannot be located; and
7. Exhaustion of all available tribally appropriate family preservation alternatives.

Adjudication means the process of rendering a judicial decision as to whether the facts alleged in a petition or other pleadings are true.

Administrative Hearing is a due process hearing held to appeal a decision made by a state agency.

Adoption means the method provided by law to establish the legal relationship of parent and child with the same mutual rights and obligations that exist between children and their birth parents.

Adoption Disruption means termination of an adoptive placement prior to finalization of the adoption.

Adoption Dissolution means legal termination of an adoption that has been finalized, including legal termination of the adoptive parent(s)' rights.

Adoption Exchange means a listing of children with special needs for whom an adoptive family is being sought, and of families approved for adoption of special needs for children. Some exchanges also list children needing a legal risk placement.

Adoption Registry means a central repository of profiles for all families approved for adoption or fos-adopt by the Department and available for such a placement.

Adoptive Placement means a type of placement that has not been finalized by a Decree of Adoption issued by a county or juvenile court.

Adult means an individual 19 years or older.

Affidavit is a written statement of facts signed under penalty of perjury, often before a court clerk or notary public who administers the oath to the signing party, who is called the affiant or declarant. Affidavits are routinely required for the procurement of warrants and are used in some jurisdictions to initiate juvenile court proceedings. They may be admitted into evidence.

Aftercare means the control, supervision, and care exercised over youth who have been paroled. It also means the outpatient treatment program for persons who have completed inpatient substance abuse treatment.

Age of Majority means the age at which, by statute, an individual is considered an adult and responsible for his/her own care, support and actions.

Agency Substantiated means that the Department's determination of child abuse or neglect against the subject of the report of child abuse or neglect was supported by a preponderance of the evidence and based upon an investigation pursuant to Neb. Rev. Stat. 28-713.

Allegation means a charge or claim of fact in a petition or other pleading which must be proven if the petition or other pleading is to be found true.

Approval study means a process which includes results of a home visit, a Child Protective Services check, a law enforcement check, and responses from references completed by the Department of a relative or person known to a child prior to placement occurring.

Beginning of foster care means the first 60 days after a placement in out-of-home care is made.

Beyond a reasonable doubt means the highest standard of proof, most often used in criminal cases. The evidence must, by virtue of their probative force, prove guilt. This standard of proof is applied when a court terminates the parental rights of Indian and non-Indian parents to an Indian child.

Caregiver means a parent or guardian, or in some cases, other adult in the household who provides care and supervision for the child. The primary caregiver provides the most child care. The primary caregiver is considered to provide at least 51% of care. The secondary caregiver is the other legal parent or another adult in the household who cares for the children.

Case Closure
Case closure means the 1) safety and risk does not rise to the need for court intervention; or the children are safe and the risk is low to moderate; or the family is unable to be located or 2) decision and process on the successful achievement of goals and outcomes of a child/family that eliminate the need for services and supervision.

Case Plan means a written agreement developed by the CFS Specialist with input from the family

members and other team members that identifies the agreed upon goals and objectives. Case Plans are developed for both court involved and non-court involved families.

Case Planning means the family-centered strengths-based process of engaging family members to ensure services are tailored to best address the family's strengths and needs. For Indian children/youth, case planning includes contacting and involving the tribe at the earliest opportunity.

Central Registry means the list of records maintained by the Department containing records of all reports of child abuse or neglect opened for investigation which have been classified as Court Substantiated or Agency Substantiated.

Child means an individual who by reason of minority, is legally subject to parental, guardianship, or similar control. In the state of Nebraska child means an individual less than 19 years of age.

Child and Families Services Specialist means the case manager, initial assessment or ongoing case manager assigned to work with a child or their family who is employed by the Department of Health and Human Services.

Child Caring Agency means an agency incorporated to provide care for children in residential settings maintained by the organization for that purpose.

Child custody proceeding for an Indian child means and includes:

1. "Foster care placement" means any action removing an Indian child from its parent or Indian custodian for temporary or emergency placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, but where parental rights have not been terminated;
2. "Termination of parental rights" means any action resulting in the termination of the parent-child relationship;
3. "Preadoptive placement" means the temporary placement of an Indian child in a foster home or institution after the termination of parental rights, but prior to or in lieu of adoptive placement;
4. "Adoptive placement" means the permanent placement of an Indian child for adoption, including any action resulting in a final decree of adoption; and
5. "Voluntary foster care placement" means a non-court-involved proceeding in which the department or the state is facilitating a voluntary foster care placement or in-home services to families at risk of entering the foster care system. **This includes cases that are identified as non-court involved and Alternative Response.** An Indian child, parent, or tribe involved in a voluntary foster care placement shall only be provided protections as provided in Neb. Rev. Statute 43-1505(4) and sections 43-1506 and 43-1508

Child Placing Agency means an organization authorized by its articles of incorporation to place children with a foster family or in adoptive homes.

Child Pornography means any visual depiction (live performance or photographic representation) and includes undeveloped film or video tape or data stored on a computer disk or by other electronic means which is capable of conversion into a visual image and also includes any photograph, film, video, picture, digital image or computer-displayed image, video or picture, whether made or produced by electronic, mechanical, or other means of an individual under 18 years of age of sexually

explicit conduct.

Clear and convincing evidence means the amount of evidence needed to convince ordinarily prudent minded people that the evidence is strongly in favor of one of the parties. It is more than a preponderance of evidence. Clear and convincing evidence is the standard of proof needed to place an Indian child in foster care.

Closed Adoption means an adoptive situation in which there is no contact or exchange of information between birth relatives(s) and adoptive parent(s) after a decree of adoption.

Commitment means an order by the court committing a child to the care and custody of the Department of Health and Human Services.

Commitment Date means the date that a child is made a Department ward via court order or voluntary relinquishment.

Concurrent Planning means the process of developing and implementing plans simultaneously to reach the primary permanency objective and an alternative objective. Concurrent planning may occur at any time in a case regardless of adjudication, including status offense and delinquency.

Conditionally Safe means that one or more safety threats are present, and protective safety interventions have been identified and agreed to by caregiver(s). An in-home safety plan is required.

Continuance means the postponement of a hearing, trial or other scheduled court proceeding, at the request of one or both parties, or by the judge without consulting them.

Conviction means the finding that an individual is guilty beyond a reasonable doubt of committing a crime.

Court Appointed Special Advocate (CASA) means a lay volunteer appointed by the court to assist in representing the child's interest in a juvenile court proceeding.

Court Involved Case means a case in which the County Attorney has filed a petition in the interest of the child and the court has assigned responsibility of the child to DHHS or the court has taken jurisdiction of the child and family to address identified safety threats, risk of harm to the child or community safety.

Court Pending means that a criminal complaint, indictment, or information or a juvenile petition under Neb. Rev. Stat. § 43-247(3)(a) has been filed in District Court, County Court, or separate Juvenile Court, and that the allegations of the complaint, indictment, information, or juvenile petition relate or pertain to the same subject matter as the report of abuse or neglect.

Court Report means a written document that contains information about the child and the family and the progress towards achieving the goals in the case plan.

Court–Substantiated means that a district court, county court, or separate juvenile court has entered a judgment of guilty on a criminal complaint, indictment, or information, or an adjudication of jurisdiction on a juvenile petition pursuant to Neb. Rev. Stat. § 43-247(3) (a), and the judgment or adjudication relates or pertains to the same subject matter as the report of abuse or neglect.

Courtesy Assessment means an assessment completed at the request of another state jurisdiction without continuing involvement of DHHS.

Courtesy Supervision means a cooperative arrangement between two or more counties, states or tribes to provide, or continue to provide, services to children and their families who are the subject of a dispositional order.

Criminal History means a county, state, or federal criminal history of conviction or pending indictment of a misdemeanor or felony.

Cruel Punishment means any type of discipline that results in injury, cuts, extreme bruising; withholding food, water, or required care, or requiring child to consume non-food items or inappropriate amounts of food, water or non-food items; a parent/caregivers' use of sadistic measures or weapons.

Cultural Plan means a written plan to ensure a life-long process of encouraging and fostering the Indian child's awareness and understanding of their Native American and tribal heritage and the development of a positive cultural identity. Key components of this plan include, but are not limited to, educating the child about his/her tribal history; initiating and maintaining connections and contact with extended family and other tribal members; exposing the child to positive Native American role models, literature, music, and art; recognizing and addressing racism at the child's current age and in the future, planning for the child to be a part of tribal events and ceremonies, etc.

Custody means the right to or responsibility for a child's care and control, carrying with it the duty of providing food, shelter, medical care, education and discipline.

Dependent Child means a child whose parent is or will be unable to care for the child through no fault of the parent, when no maltreatment has been identified. The parent may be incapacitated or absent due to illness, death, incarceration, or otherwise unavoidably unable to provide care, the child has extraordinary mental health, emotional, or physical needs which the parent does not have the ability or capacity to meet.

Discharge means the termination of Department guardianship or custody of the child.

Disposition means the court's determination of a case in which there is an issuance of a final order or opinion.

Dispositional Hearing means the hearing used for the purpose of determining what will occur with or by a child and/or parents who have been adjudicated within the juvenile court's jurisdiction. A dispositional hearing is when the juvenile court judge will order implementation of a treatment plan.

Domestic Violence means the establishment of control and fear in a relationship through the use of violence and other forms of abuse between spouses, persons living as spouses or adult members of the same household. The offender may use physical abuse, emotional abuse, sexual abuse, economic oppression, isolation, threats, intimidation, and maltreatment of the children to control the other person. Relationships involving domestic violence may differ in terms of the severity of the abuse, but control is the primary goal of all offenders.

Emotional Abuse means the parent/caregiver demonstrates a pattern of criticizing, rejecting,

insulting, isolating, terrorizing, or humiliating the child, resulting in serious emotional or behavioral issues.

Emotional Neglect means a parent/caregiver's pattern of failure to seek ongoing or emergency mental health services for a child who has suicidal, homicidal, or severe self- harming behaviors. Severe self-harming behaviors include cutting, burning, or other self- mutilation that requires medical treatment OR risk-taking behaviors likely to result in serious physical harm.

Escapee means a youth who has made an unauthorized flight from a facility to which he/she has been committed by the court or placed by lawful authority.

Evidence means any sort of proof submitted to the court for the purpose of influencing the court's decision on a case.

Expungement Review means the process for an individual, whose name has been entered on the Child and/or Adult Abuse Central Registry, to request that their name be removed.

Failure to Thrive means a serious medical condition in which a child's weight and motor development are significantly below average for his/her age. Usually, though, not always, found in children less than one year old, the syndrome may have an organic cause or it may be caused by severe emotional or physical neglect.

Family means a biological, adoptive or self-created unit of people residing together consisting of adult(s) and child(ren) with the adults(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, cultural practices and a significant relationship. Biological parents, siblings, and others with significant attachments to a child living outside of the home are included in the definition of a family.

Family/Person Centered Practice means a process that is based on a core set of values, beliefs, and principles that recognize that families can and should contribute to all aspects of services through their active participation.

Family Preservation means the efforts being made to safely keep the family together. Family Preservation is also the permanency objective whenever a decision is made that indicates the child can be safely maintained in the home

Family Strength means areas of a family's life where they exhibit power and decision making that is an asset to the family. Identified family strengths are used when developing safety interventions and strategies to achieve case plan goals.

Family Team means a group comprised of individuals selected by the family (including children), including, but not limited to family, friends, relatives, peers, providers, teachers, etc. who come together both formally and informally to form a circle of support around a person and/or family. . Children must be involved in all family team meetings unless they are younger than age 9 or not developmentally appropriate to participate.

Family Team Meeting: A meeting that is convened for the purpose of creating, implementing, evaluating, and updating a Safety Plan and/or Case Plan that furthers an individual's/family's achievement of their goals and the child safety concerns. The team meeting must include the family (unless reunification is not the permanency goal), the Case Manager, and may include other formal

and informal supports selected by the family (or others if the family is no longer involved).

Formal Resource People/Participants/Supports means individuals who participate as members of the Family Team due to their paid relationship with the child and family. Examples of this include foster parents, teachers, therapists, community treatment aides, family organization advocates (mentors paid to provide support who are not chosen by the family), and agency staff.

Foster Care means engaged in the service of exercising 24-hour daily care, supervision, custody, or control over children, for compensations or hire, in lieu of the care of supervision normally exercised by parents in their own home. Foster care will not include casual care at irregular intervals or programs as defined in Neb. Rev. Stat. §71-1910. The Indian Child Welfare Act expands the definition of foster care to include guardianships and placements in which the parent or Indian custodian cannot have the child returned upon demand.

Foster Care Placement means (a) all types of placements of juveniles described in Neb. Rev. Stat. 43-245 and 43-247, (b) all types of placements of neglected, dependent, or delinquent children, including those made by the Department of Health and Human Services, by the court, by parents, or by third parties, (c) all types of placements of children who have been voluntarily relinquished pursuant to Neb. Rev. Stat. 43-106.01 to the department or any child-placing agency as defined in Neb. Rev. Stat. 71-1926 licensed by the department, and (d) all types of placements that are considered to be a trial home visit, including those made directly by the department or office.

Foster family means the placement in which a child is residing other than with their biological parent(s) or legal guardians.

Foster Home means a private single-family living unit, under one roof, housing no more than nine children/youth under the age of 19 including foster children and children of the provider that provides 24-hour parenting to all of the children. No more than six children can be under the age of 12.

Group Home means a home operated under the auspices of an organization that is responsible for providing social services, administration, direction, and control for the home and that is designed to provide 24-hour care for twelve or fewer foster children in a residential setting.

Guardian means an individual appointed by a court who has the powers and responsibilities of a parent. The guardian is empowered to facilitate education, authorize medical care, consent to marriage or adoption of the ward. Under Nebraska law a guardian is not legally required to provide financial support for the ward and is not liable for acts of the ward.

Guardian ad Litem means an attorney appointed by the court to act in the minor's or an incompetent adult's behalf in a lawsuit and protect the minor's or adult's best interests in court.

Guardianship means that the court has appointed an individual to become a child's guardian. Guardianship is one of the permanency objectives available to children if reunification or adoption cannot occur.

Household means all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. A person considered as a member of the household if he/she spends 50% or more of his/her time in the home OR if the home is his/her only permanent residence (e.g., deployed members of the military, temporarily

incarcerated individuals).

Household Violence means violence within the household which can include child to child; child and parent; parent to parent; or other caretakers or relatives in the home.

Independent Living means the establishment of a residence for a foster youth to reside outside of a foster placement or his/her family. The youth would reside in an apartment, house, dorm or other type of living arrangement and is responsible for taking care of their needs i.e., paying rent, buying and preparing food, managing a budget). It is also a term used as a permanency objective or concurrent plan for a youth 16 years of age or older when it appears reunification may not occur and adoption or legal guardianship are not appropriate and the youth's best interest is served by self-sufficiency.

Indian Child Welfare Act means the federal and state law that provides direction in working with Indian Children and their families. Refer to the Indian Child Welfare Act Operations Manual for specific direction in working with children and families that may be Indian.

Informal Living Arrangement means that the parent has made arrangements prior to or after DCFS involvement for a temporary and alternative place for their child to reside until child safety can be managed in the parental home.

Informal Resource People/Participants/Supports means individuals who participate as members of the Family Team and do not receive payment for their responsibility with respect to the family. Examples of this may be relatives, neighbors, spiritual leaders, volunteer mentors, friends, etc.

Initial Assessment means the process the Department utilizes to assess for child safety, risk and to determine if maltreatment occurred.

Injury means tissue damage such as welts, bruises, or lacerations that last more than 24 hours, resulting from trauma.

Intake means the stage of the CPS case process where the CPS caseworker screens and accepts reports of child maltreatment.

Interstate Compact on Juveniles (ICJ) means the law which provides (1) for the return from one state to another of delinquent juveniles who have absconded; (2) for the return of non-delinquent juveniles who have run away from home; (3) for the cooperative supervision of delinquent juveniles on probation or parole; and, (4) for additional cooperative measures to the protection of juveniles and of the public.

ICJ Compact Administrator means the individual in each compacting state appointed by the appropriate state authority for the administration and management of the state's supervision and transfer of juvenile delinquents.

Interstate Compact on the Placement of Children (ICPC) means the law which controls the movement of children from one state to another for the purposes of placement.

ICPC Administrator or designee means a person designated by the executive head of each jurisdiction that is party to this compact who shall be general coordinator of activities under this compact in his/her jurisdiction and who, acting jointly with like persons of other party

jurisdictions, shall have the power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact. In Nebraska this person is located in the Policy Unit of the Division of Children and Family Services. Interstate Compact on ICPC and ICPC Administrator designee definitions are out of alphabetical order and should be moved to where Interstate Compact on Juveniles definition is located.

Juvenile Offender means (1) any juvenile who has committed an act other than a traffic offense which would constitute a misdemeanor or an infraction under the laws of the state or violation of a city or village ordinance; or (2) any juvenile who has committed an act which would constitute a felony under the laws of this state; or (3) any juvenile who has committed an act which would constitute a traffic offense as defined in Neb. Rev. Stat section 43-245.

Kinship Home means a home where a child or children receive foster care and at least one of the primary caretakers has previously lived with or is a trusted adult that has a pre-existing, significant relationship with the child or children or is a sibling of such child or children pursuant to Neb. Rev. Stat. 43-1311.02.

Law Enforcement means the police department or town marshal in incorporated municipalities, the office of the sheriff in unincorporated areas, the Nebraska State Patrol, or tribal law enforcement.

Law Enforcement Check means a review of computer information or contact with a law enforcement agency to determine all felony or misdemeanor filings, including any charges filed, the dates filed, the level of charges, disposition date and final disposition.

Least restrictive means a child in a placed in a setting that is most comparable to his/her home.

Legal custody means a legal relationship that is established by court order, in which one individual, referred to as the Custodian, if given legal authority over, and the corresponding legal responsibility for, another individual. Physical custody may or may not be simultaneous with legal custody.

Maltreatment means parenting behavior that is harmful or destructive to a child's (age birth through age seventeen (17)) cognitive, social, emotional, and/or physical development,

Medical Neglect means the parent/caregiver's pattern of refusing or failing to seek/obtain medical treatment or rehabilitative care for the child's conditions that have potential life-threatening or long-term health effects, including failure to thrive. This includes appropriate medication, medical or dental care, or speech or physical therapy when there is potential for lifelong negative impact.

Medical Neglect of Handicapped Infant means the withholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from disabled infants with life-threatening conditions. Exceptions include those situations in which:

1. The infant is chronically and irreversibly comatose;
2. The provision of this treatment would merely prolong dying or not be effective in improving or correcting all the life-threatening conditions; or
3. The treatment would be virtually futile in terms of the survival of the infant and the treatment itself in such a situation be inhumane. Food and water must always be provided regardless of the extent of disabilities, and "quality of life" cannot be used as a criterion for deciding upon appropriate medical treatment.

Missing Child/Family Alert means the process whereby CFS agencies can attempt to locate families

who have left their jurisdiction by notifying other parts of the state or other state CFS agencies that the children are under the jurisdiction of the court or may be in danger.

Near Fatality means a case in which an examining physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment (Neb. Rev. Stat. 81-3126).

Non-Court Involved Case means a case in which the family agrees to work with DHHS without involving the juvenile court system, to address the identified safety threats and/or reduce the potential for risk of future maltreatment to children. Non-court involved cases are also described as Voluntary Cases.

Non-custodial Parent means any individual recognized as the parent legally through marriage, adoption, or biology; a man named by the mother or other relative as the father, who agrees he is the father; or in some cases, an individual who has acted in the role of parent for a significant period of time who does not have placement of the child the majority of the time.

Parenting Time means the quality and quantity of time a parent spends with their child who is in out of home care.

Permanency is both a process and a result that includes involvement of the child as a participant or leader in finding a permanent connection with at least one committed adult who provides a safe, stable and secure parenting relationship, love, unconditional commitment and lifelong support in the context of reunification, a legal adoption, or guardianship, where possible, and in which the child/youth has the opportunity to maintain contacts with important persons including brothers and sisters.

Permanency Plan means the systematic process of carrying out (within a brief, time-limited period) a set of goal-directed activities designed to help children live in permanent families. This process has the goal of providing the child continuity of relationships with nurturing parents or caretakers and the opportunity to establish lifetime family relationships.

Permanency Objective means an anticipated result of all efforts and services, which will result in permanency for the child or his/her discharge from Department custody.

Petition means a document filed by a county attorney in a juvenile court at the beginning of a maltreatment, status offense, and/or delinquency case. The petition states the allegations that, if true, form the basis for court intervention.

Physical Abuse means the non-accidental infliction of injury or an act the poses substantial likelihood of inflicting bodily injury.

Physical Custody means the individual with whom the agency places a child for provision of physical care, or in the case of children who are not wards of DHHS, or the individual(s) physically caring for the child.

Physical Neglect means the failure of the caregiver to provide basic needs, for example food, clothing, shelter, medical care, supervision and a safe and sanitary living environment for the child.

Placement means the arrangement for the care of a child in a licensed or approved foster family or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic or any institution primarily education in character, and any hospital or other medical facility. For purposes of the Indian Child Welfare Act, the definition of placement can include an institution caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character, and any hospital or other medical facility.

Prevention Assessment means a process to evaluate the probability (likelihood, chance, potential, prospect) that a family involved with DHHS for Dependency or Status Offense will experience maltreatment in the next 12 to 18 months.

Primary Caregiver means the person in the household who provides the most child care. The primary caregiver is considered to provide at least 51% of the care.

Preponderance of Evidence means that an event is more likely to have occurred than not by a greater weight of the evidence. As the term "preponderance of the evidence" suggests, there must be credible evidence of maltreatment documented in the case record to support a finding of agency substantiated.

Protective Placement means that safety threats are identified and no interventions are possible, the child is unsafe and must be taken into protective placement. Protective placement is defined as: 1) the family voluntarily placing their child out of the home in a residence approved by the Department; or 2) the Department initiating court action.

Putative Father: A person alleged to be the biological father with no legal establishment of paternity. Also referred to as the alleged parent.

Reasonable efforts mean those supports and services both informal and formal that may allow the child to remain in his/her home safely or to be returned home.

Relative means a person connected to the child by blood, marriage, adoption or tribal law or custom. A person related through legal guardianship will be deemed to be a relative for the purpose of these regulations. For Native American children, relative will be defined either by the law or custom of the tribe, or, in the absence of tribal law or custom, as defined by the Indian Child Welfare Act.

Reunification means a permanent plan for the child that involves the return of the child to any individual who retains parental or legal rights to the child after removal for child abuse, neglect, or both, regardless of the custody arrangement prior to the child entering out-of-home care.

Reunification Assessment means a process to assess whether a child(ren) can be safely returned to the family home based on an evaluation of safety, risk and parenting time.

Risk means the probability (likelihood, chance, potential, prospect) that any harm will occur in the next year to two years.

Risk Assessment means an objective appraisal of the likelihood that children in a household will experience abuse or neglect in the future.

Risk Re-assessment means the process of reassessing for risk to determine if change has been made

in the family that has reduced or increased the probability of future harm.

Runaway means there is reasonable evidence to suggest that the child has runaway or has been absent from home for at least 12-14 hours without parent/caregiver consent, and the parent/caregiver does not know where to locate the child.

Safe child means no safety threats were identified at the present time. Based on currently available information, there are no children likely to be in imminent danger of serious harm.

Safety means actions of protection, demonstrated by a caregiver, that mitigate the danger, demonstrated over time.

Safety Assessment means an immediate (here and now) observation and investigation of whether there are serious and imminent threats to a child. Safety is about the short term.

Safety Intervention means involvement to mitigate safety threats which utilizes family strengths whenever possible through the use of family, kin, neighbors or other individuals in the community as safety resources. It may also include direct services by the case manager and community and agency resources. Action to remove a child from the home may be necessary to ensure child safety through court action, a Voluntary Placement Agreement or the family and DHHS agreement to an informal out-of-home placement with relatives.

Safety Plan means there is a written agreement created with the family that describes the safety threats and how those safety threats will be managed to ensure child safety. The plan may remain in effect as long as needed and must be continuously evaluated and modified as long as it is in effect.

Safety Threat means there are circumstances in the family situation that could result in serious harm to the child. "Serious" means that the harm would require medical or mental health attention or emergency services, and that if DHHS staff do not think they could contain the threat, staff could not leave the child in the home. Imminent means that there is a reasonable expectation that the harm will occur in the next week or month.

Secondary Caregiver is a person residing in the household and provides care for children. They are usually a legal parent or another adult that provides less than 50% of care to the child.

Sexual Abuse means any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

Sexual Exploitation means, but is not limited to, causing, allowing, permitting, inflicting or encouraging, or forcing a minor child to solicit for or engage in voyeurism, exhibitionism, or prostitution, or in the production, distribution or acquisition of pornographic photography, films or depictions of the child when the child is unable to give consent due to the child's age or incapacity.

Status Offender means any juvenile who, by reason of being wayward, or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who deports himself or herself so as to injure or endanger seriously the morals or health of himself, or others; or who is habitually truant from home or school.

Torture means the infliction of intense pain to punish, coerce, or afford sadistic pleasure.

Trial Home Visit means a placement of a court-involved juvenile who goes from a foster care placement back to his or her legal parent or parents or guardian but remains as a ward of the state.

Transitional Living Proposal means there is a Transitional Living Proposal/Plan developed by identifying knowledge and skills of a youth related to their ability to live on their own with limited supports and providing them with education, support and training to develop and improve those skills and knowledge. This term has also been referred to as an Independent Living Plan

Unable to Locate means the subjects of the maltreatment report have not been located after a good faith effort on the part of the Department.

Unfounded means all reports not classified as court substantiated, court pending, agency substantiated, or unable to locate.

Unreasonable use of Confinement/Restraints means the use of restraints without a physician's order; the parent/caregiver using confinement to a chair, bed, corner or similar environment for unreasonable periods of time is considered physical abuse.

Unsafe child means a child for whom one or more safety threats are present and placement is the only protective intervention possible. Without placement, the children will likely be in imminent danger of serious harm.

Violence means the exertion of physical force so as to injure, abuse, or control.

Vulnerable Child means a child/youth that does not have sufficient capacity for self-protection.

References:

[i] See attached. Physical and Cognitive Developmental Milestones – Adapted from "Developmental Milestones Summary," Institute for Human Services, (1990); "Developmental Charts" provided by Jeffery Lusko, Orchards Children's Services, Southfield, MI; "Early Childhood Development from two to six years of age," Cassie Landers, UNICEF HOUSE, New York.

ACTIVE EFFORTS

DHHS.PSPolicyandGuid@nebraska.gov

The CFS Specialist must follow Active Efforts in any case as soon as the CFS Specialist knows or has reason to believe ICWA could apply.

I. ACTIVE EFFORTS.

1. The Indian Child Welfare Act (ICWA) establishes a minimum standard for preventing the breakup of the family, removal of an Indian child from their home and guidelines for placement in foster or adoptive homes. Active efforts must be made to keep the Indian family together. Active efforts means that ***everything possible*** must be performed to help the family resolve the problems that led to neglect or abuse, including referral to services that are sensitive to the family's culture. The CFS Specialist must involve and use the available resources of the extended family, the tribe, Indian social service agencies and individual Indian caregivers.
2. The CFS Specialist will provide active efforts to provide remedial services and rehabilitative programs to prevent the breakup of the Indian family. The CFS Specialist must consider services available through tribal social services, Native American service providers, and service providers with appropriate cultural components, experience or knowledge as well as individual Indian caregivers (traditional healers, spiritual leaders, etc.) and extended family members.
3. The CFS Specialist will provide Active efforts as described below. This list is not exhaustive and the CFS Specialist can and should take any action necessary to prevent removal and to help the family resolve the problems that led to the alleged abuse or neglect.
    1. Collaborative casework that includes the family and the tribe(s), both prior to and after the removal of an Indian child, exceeding the level that is required under reasonable efforts to preserve and reunify the family that is consistent with the current social and cultural conditions and way of life of the Indian child's tribe or tribes to the extent possible under the circumstances;
    2. A request to the Indian child's tribe or tribes and extended family known to DCFS to convene traditional and customary support and services;
    3. Actively engaging, assisting, and monitoring the family's access to and progress in culturally appropriate and available resources of the Indian child's extended family members, tribal service area, Indian tribe or tribes, and individual Indian caregivers;
    4. Identification of and provision of information to the Indian child's extended family members concerning appropriate community, state, and federal resources that may be able to offer housing, financial, and transportation assistance and actively assisting the family in accessing such community, state, and federal resources;
    5. Identification of and attempts to engage tribally designated Nebraska Indian Child Welfare Act representatives;
    6. Exhaustion of all available tribally appropriate family preservation alternatives.

4. At every court hearing involving an ICWA child, the CFS Specialist will provide a written report of DCFS attempts to provide or provision of active efforts based on Neb. Rev. Stat. 43-1503. This report will be sent to the Indian child's tribe or tribes within three (3) days after being filed with the court regardless of the decision of the tribe to intervene or efforts made to be involved in the case. The CFS Specialist may contact the DCFS ICWA Program Specialist to consult on the provision of Active Efforts.
   When the Court or Court Order does not find that active efforts have been made, the CFS Specialist and CFS Supervisor will contact the DCFS ICWA Program Specialist for consultation.

References:

Program Guidance on ICWA.
ICWA Case Management Desk Aid

SUMMARY OF REVISIONS	
DATE	REVISION
11/08/2017	Effective

OUT OF HOME ASSESSMENT

DHHS.PSPolicyandGuid@nebraska.gov

I. <u>CONDUCTING THE OUT-OF-HOME ASSESSMENT</u>.

A. To obtain the most accurate information it is the procedure of the Department to proceed in the following order. The CFS Specialist will:

1. Review relevant Department and law enforcement records.
2. Notify all CFS Specialists of children in care to discuss relevant case information and coordinate decision-making about the child(ren).
3. In cases involving a licensed child caring agency, the investigating CFS Specialist request incident reports from the agency and documentation from the licensed facility that describes the action the facility has taken to ensure child safety. In cases involving foster homes, the licensing agent in consultation with his/her supervisor will determine when a Safety Plan is developed. The Out-of-Home Assessment is only conducted on foster homes when the foster family has no current placements and the allegations involve foster children previously placed in the foster home.
4. Coordinate contact and consultation, as appropriate, with law enforcement, licensing, contracting, and resource development regarding placement and safety status.
5. Conduct interviews in the following order:
   a. Reporting party to confirm details;
   b. Identified child victims;
   c. Other children in care who might have knowledge related to allegations;
   d. Anyone identified as present during incidents or who have knowledge of incidents;
   e. In the case of foster parents, the non-maltreating foster parent; and
   f. Alleged perpetrator
6. If law enforcement is conducting a criminal investigation, the involved law enforcement officer will be responsible to determine how and when the interviews with the alleged perpetrator will occur. The Department will not interview the alleged perpetrator until approved by law enforcement.

B. **<u>Notification of Parents of Children</u>**.

1. When conducting an assessment of alleged neglect, physical abuse or sexual abuse of a child in a child care home or facility, the CFS Specialist will make every effort to contact the parent or legal guardian of any suspected victims before interviewing the child.
   a. If attempts to contact the parent or legal guardian are unsuccessful and there is reason to believe that interviewing the child is necessary to protect the child or other children, the CFS Specialist will interview the child without parental consent. Contact with the parent or legal guardian will occur as soon as possible following the interview with the child.
   b. The following information will be provided to the parents or legal guardians of children alleged to have been abused or neglected in a child care home or facility:
      (1) Notice that a report alleging neglect, physical abuse or sexual abuse has been received and information on the nature of the maltreatment;
      (2) Notice that the DCFS is conducting an assessment of the allegations;
      (3) The safety/protective or corrective measures taken; and
      (4) The conclusions of the assessment along with any recommendations that will help protect the child from future maltreatment in the facility.

C. **<u>Case Status Determination in a facility</u>**.

1. The CFS Specialist will follow the Program Guidance on Central Registry Entries to determine whether there is preponderance of evidence that child abuse, neglect or sexual abuse occurred.
2. The CFS Specialist will determine if there is risk to other children in care will determine if child abuse and neglect occurred and whether there is preponderance of the evidence.
3. The CFS Specialist may determine that risk of maltreatment to children exists without a substantiated finding that actual incidents of child abuse, neglect or sexual abuse has actually occurred. Recommendations about changes in practice or conditions that will reduce the likelihood of maltreatment will be made. Once these determinations have been made the following will occur:
   a. The case status determination will be entered into the Child Abuse and Neglect Central Registry utilizing the Program Guidance on Central Registry Entries.
   b. A summary of the assessment, findings and recommendations for action will be sent to the appropriate licensing staff, resource development staff, CFS Specialists with children in placement and the county attorney.
   c. The case findings will be shared with the alleged perpetrator and facility director.
4. Recommendations about changes in practice and conditions that would reduce the likelihood of maltreatment will be provided to the child care provider, the parents involved and the child care director in cases of a child care facility.

D. **Substantiated Reports.**
1. When reports of child maltreatment are substantiated, the Department will:
   a. Assess present risk to the child(ren) involved and assure steps are taken to protect the child(ren).
   b. Inform the child's parent or legal guardian as soon as possible.
   c. Notify the agency responsible for the child's placement when an incident involves a child placed by another child caring agency.
   d. Immediately notify the appropriate licensing and contracting authorities of the substantiated abuse or neglect.
2. When neglect or abuse is substantiated the parents of the victim(s) and subject of the report in that home or child care facility will be notified.
3. Information on the status of the investigation cannot be shared with the parent/caretakers of children who are not identified victims or witness of abuse/neglect in the facility.
4. Requests for information from others who are not subjects in the report will be referred to Law Enforcement to make a request for information.

When Licensing determines that children are not safe in the care of home or facility, licensing staff will make recommendations to the parent or legal guardian to make alternative child care arrangements.

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-17	Effective

SDM ASSESSMENT OF PLACEMENT SAFETY AND SUITABILITY

DHHS.PSPolicyandGuid@nebraska.gov

SDM Assessment of Placement Safety and Suitability (APSS) is the tool that is used to assess safety and care concerns in a foster home placement. Foster home placements include agency based, traditional, relative, ~~DD Family homes~~kinship, or adoptive homes.

The process for completion of the APSS will be consistent across the state. Individual Service Areas may assign ~~staff~~ CFS Specialists or Resource Development to complete the APSS process ~~differently~~, based on Service Area needs and resources. The APSS will be completed by ~~staff~~ CFS Specialist or Res~~u~~ource Development in the service area in which the home is located, even though there may be children placed in a foster home from other Service Areas. CFS Specialists for the child will share any information they may have about the child and the home with the worker completing the assessment.

An Initial Assessment CFS Specialist will assess the foster home related to allegations of abuse or neglect using the APSS.

The APSS **will not** be used for congregate care placements (i.e., group homes and institutions) or for foster homes with no current placement. If a report of abuse/neglect is made on a licensed/approved foster home with no placements the CFS Specialist will investigate the alleged maltreatment and document all information in the Organization Related Investigation narrative. The Organization Related Investigation on N-FOCUS will be used to assess and document complaints on these types of homes and facilities. This is also known as the Out-of-Home Care Assessment. The assigned worker will coordinate with the Licensure Unit, Medicaid, Managed Care Association(s), Behavioral Health, and Developmental Disabilities divisions as appropriate. The Out of Home Assessment will be documented using the Organization Related Investigation icon on N-FOCUS.

The APSS is to be used at the following times:

- When an Intake report is ~~received accpeted~~ accepted on a licensed or approved foster home where foster children are placed;
- When there are placement concerns related to child safety regarding behaviors among children in a foster home; or
- When there are significant changes in a placement that impacts child safety.

SDM ASSESSMENT OF PLACEMENT SAFETY AND SUITABILITY

Completion of the assessment is done in two parts. Information gathered must be comprehensive so that both parts of the assessment can be completed accurately.

1. The investigation component must be done to determine if there was maltreatment, which is important in assessing safety and risk, and so the appropriate case status determination or finding can be made.
2. The second part is completion of the APSS and consideration of the placement decision.

   The APSS looks at possible safety threats to the child and care concerns for the child in placement. Placement resources are held to a higher standard of care than a parental home. A situation in the foster home does not have to rise to the level of a safety threat before an intervention is put in place. The APSS placement decision guides the worker(s) to the final decision of assuring safety and suitability of the placement for the child. If a safety or care concern is identified, the worker assigned will assess if an intervention can be put in place to improve safety and care. The placement decision is based on identified concerns and available interventions.

While completing assessments based on intakes with allegations and intakes with only care concerns, workers involved will assess the suitability of the placement resource for future placements. Any and all concerns will be documented.

The APSS will be documented on N-FOCUS on the Organization in Home Details by completing the SDM Assessment for Placement Safety and Suitability. Family Functioning Narratives are available for documentation for Intakes with allegations, but can also be used for documentation by other CFS Specialist and RD staff cooperating with the assigned worker while the case is in draft status. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the APSS. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding the decisions on each of the items. Although the CFS Specialist completing the initial assessment will take the lead in completing the investigation of abuse/neglect allegations, the CFS Specialist will collaborate with the ongoing worker(s), RD staff and agency staff supporting the placement.

It is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some can be deliberately hidden from the CFS Specialist. Based on reasonable efforts to obtain information necessary to

respond to each item, the CFS Specialist will review each of the concerns and accompanying definitions

I. COMPLETING THE APSS.

A. **Section 1A: Safety Concerns** – Safety concerns are circumstances in the placement that make a child less safe. They may or may not rise to the level of being a safety threat, but, because the child is in state custody, would represent a reason to consider changing the placement if the concern cannot be contained through a plan to increase safety.

1. **Care provider caused physical harm to the child or made a plausible threat to cause physical harm in the current incident, as indicated by any of the following:**
    a. Any non-accidental injury or abuse to any child in the household.
    b. Care provider fears he/she will physically harm the child and/or requests removal.
    c. Threat to cause harm or retaliate against the child: Threat of action that could result in harm, or plans to retaliate against the child for CPS investigation.
    d. Excessive discipline: Care provider has acted in a way that bears no resemblance to appropriate discipline, considering the previous experiences of child. Consider any discipline that is not in compliance with DHHS or agency policy.
    e. Use of physical force or corporal punishment.

2. **Current circumstances, combined with prior allegations of abuse/neglect and/or incident reports, suggest that the child's safety may be of immediate concern.** There must be both current concerns **and** related previous allegations/incidents that represent an emerging or unresolved pattern.

Current circumstances include any behaviors or conditions that diminish child safety without rising to the level of concern as defined here. Examples include but are not limited to the following: • Child sometimes does not have sufficient nutrition, but malnourishment is not yet a concern.	**AND** Previous incidents may include any of the following: • Prior incident reports, including any licensing complaints or citations. • Prior referrals of abuse/neglect to the child. • Evidence of prior unreported injuries or incidents.

• Child sometimes has imperfect hygiene that does not rise to the level of a concern.	

3. **Child sexual abuse is suspected <u>and</u> circumstances suggest that the child's safety may be of immediate concern.** To select this threat, two conditions must be present: suspicion and circumstances.

Suspicion of sexual abuse may be based on indicators such as the following: • The child discloses sexual abuse either verbally or behaviorally (e.g., age-inappropriate, sexualized behavior toward self or others). • Medical findings consistent with sexual abuse. • Care provider or others in household have been convicted, investigated, or accused of sexual misconduct with the child. • Indications of poorly defined or questionable sexual boundaries between household members, and/or care provider engages in or permits other household members to engage in behaviors that infringe upon appropriate sexual boundaries. Based on age, gender, and developmental status of household members, examples of inappropriate and/or poorly defined sexual boundaries may include such things as non-gender-specific sleeping	**AND** • Access to the child by possible or confirmed sexual abuse perpetrator exists.

arrangements or showering/bathing practices, exposure to nudity or sexually explicit materials, etc.	

4. **Care provider does not/is unable to protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, neglect, or emotional abuse.** The CFS Specialist will select this item when there is current harm or an identified current threat of harm to a child **and** the care provider does not take action.

Current harm or an identified threat may be indicated by the following: • An individual(s) with known violent criminal behavior/history resides in the household or frequents the home, and care provider allows access to the child. • The care provider does not or cannot comply with orders to prevent contact between the child and birth parent or other family members. • Include homes where gang activity occurs or where there is criminal activity in the home.	**AND** Care provider does not/is unable to protect the child from harm or threatened harm as a result of physical abuse, neglect, sexual abuse, or emotional abuse by other family members, other household members, or others having regular access to the child. Based on the child's age or developmental stage, care provider does not provide supervision necessary to protect the child from potential harm by others.

5. **Care provider's explanation for the injury to the child is questionable or inconsistent with the type of injury.** Factors to consider include age and vulnerability of the child, location of injury, exceptional needs of the child and chronicity of injuries.
   a. Medical evaluation indicates injury is consistent with abuse; care provider denies, or attributes injury to accidental causes.
   b. Care provider's explanation for the observed injury is inconsistent with the type of injury.
   c. Care provider's description of the injury or cause of the injury minimizes the extent of harm to the child.

6. **Care provider actively impedes assessment by denying access to the child, coercing or coaching the child, or fleeing with the child.** Do not include care providers who are uncooperative or non-compliant with assessment requests and/or court orders or if the care provider is uncooperative with safety planning. In such cases, consider other safety concerns.
   a. Care provider currently hinders or refuses access to the child.
   b. Care provider has removed the child from a hospital against medical advice.
   c. Care provider keeps the child at home, away from peers, school, and other outsiders for extended periods of time.
   d. Care provider intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

7. **Care provider does not, cannot, or will not meet the child's need for supervision, food, clothing, and/or medical or mental health care.**
   Note: If the care provider's limitations in this regard are directly related to substance abuse, select item 8.
   a. Care provider does not attend to the child to the extent that the child's need for care goes unnoticed or unmet (e.g., care provider is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).
   b. Care provider leaves the child alone (time period varies with age, developmental state, and vulnerability).
   c. Care provider is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) or incapacitated (e.g., injured, ill).
   d. Care provider makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.
   e. Nutritional needs of the child are not met, resulting in danger to the child's health and/or safety; the child appears malnourished; or there is insufficient food in the home.
   f. The child is without appropriate clothing for the weather.
   g. Care provider does not seek treatment for the child's medical/dental/vision conditions(s) or does not follow prescribed treatment for such conditions.

h. The child has a special need, such as being medically fragile, which care provider does not or cannot meet.
i. The child has serious emotional symptoms, lack of behavioral control, or psychosomatic symptoms (e.g., sleep/appetite disturbance) and care provider will not/cannot seek or provide appropriate interventions.

8. **Care provider's current use of a legal or illegal substance impairs his/her ability to supervise, protect, or care for the child.**
   Care provider uses legal or illegal substances, including alcohol, to the extent that control of his or her actions is impaired. As a result, care provider was/is unable to care for the child, has harmed the child, or is likely to harm the child.

9. **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.**
   Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:
   a. Leaking gas from stove or heating unit.
   b. Substances or objects accessible to the child that may endanger the health and/or safety of the child (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities).
   c. Lack of water or utilities (heat, plumbing, electricity) and no alternate, safe provisions have been made.
   d. Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows.
   e. Exposed electrical wires.
   f. Excessive garbage or rotted or spoiled food that threatens health.
   g. Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).
   h. Evidence of human or animal waste throughout living quarters.
   i. Guns and other weapons are not locked.
   j. Unrestricted access to pool or other body of water.
   k. Blocked exits or unmarked exit routes.
   l. Missing or non-functioning smoke detectors.
   m. Un-gated stairways in home with young children, as licensing regulations apply.

n. Unsafe sleeping arrangements (e.g., infants sleeping on their stomachs, sleeping arrangements for infants that include pillow and comforters that may present a SIDS risk).

10. **Child behaviors raise concerns regarding child safety, in spite of appropriate response by care provider(s).**

To mark this threat, the following three conditions MUST be present:		
The child is currently engaging in or habitually engages in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from placement and place themselves in unsafe living/sleeping situations, children who engage in prostitution, and children who engage in self-harming behaviors, such as cutting, that require medical intervention.	**AND** The care provider(s) have responded appropriately and made reasonable efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child, and increasing direct supervision and monitoring of the child.	**AND** The care provider's current efforts, although appropriate, are insufficient to prevent the child from engaging in the behavior in the future

11. **Other.** If, after careful review of the definitions for the other 10 safety threats, the CFS Specialist feels there is something unique in this care provider that was not captured in any other safety threat, the CFS Specialist should select "other" and document the identified unique safety threat that, if not resolved immediately, would lead to removal of a child in this home.

B. **Section 1B: Care Concerns**

Care concerns are circumstances that do not diminish child safety, but that may indicate that a placement change should be considered if the concern cannot be addressed through a plan.

12) **Care provider's overall functioning impairs his/her current ability to supervise, protect, or care for the child.**

a. Care providers refusal to take prescribed medications impedes his/her ability to care for the child.
b. Care provider's inability to control his/her emotions impedes his/her ability to care for the child.
c. Care provider acts out or exhibits distorted perception that impedes his/her ability to care for the child.
d. Care provider's emotional stability, developmental status, or cognitive deficiency impedes his/her ability to care for the child.
e. Care provider expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, be still for extended periods, be toilet trained, eat neatly, or older children expected to care for younger siblings or stay alone).
f. Care provider lacks the basic knowledge related to parenting skills:
   (1) Does not know that infants need regular feedings;
   (2) Fails to access and obtain basic/emergency medical care;
   (3) Does not understand what constitutes proper diet; or
   (4) Does not understand what constitutes adequate supervision.

13) **Care provider routinely describes the child or family of origin in negative terms or acts toward the child in negative ways.**
a. Care provider describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
b. Care provider curses and/or repeatedly puts the child down.
c. Care provider scapegoats a particular child in the household.
d. Care provider blames the child for a particular incident or household problems.
e. Care provider treats the child in markedly different ways that may stigmatize the child.
f. Care provider interferes with the child's reunification or adoption (e.g., interferes with visitation or communication with birth parent, makes negative comments about the child's birth/adoptive family).
g. Care provider undermines the child's identity (e.g., mocking the child for his/her background).

14) **Domestic violence currently exists in the household.**
a. The child is or has been exposed to domestic violence in the household; OR
b. Domestic violence among adults in the household is ongoing, and the child may or may not be aware of or involved in recent incidents.

C. **Section 2. Interventions to improve safety and care**

1. This section is completed only if one or more concerns are identified. If one or more concerns are present, it does not automatically follow that a child must be removed from the placement. In many cases, it will be possible to initiate a temporary plan that will mitigate the concern(s) sufficiently so that the child may remain in the home.
2. When there are safety concerns, the CFS Specialist completing the assessment must complete the interventions section.
3. The intervention list contains general categories of interventions rather than specific programs. The CFS Specialist should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the concern(s), and whether there is reason to believe the placement will follow through with a planned intervention. The CFS Specialist may determine that even with an intervention, the child would be unsafe, or the CFS Specialist may determine that an intervention would be satisfactory, but has reason to believe the placement would not follow through. The CFS Specialist must keep in mind that any single intervention may be insufficient to mitigate the concern(s), but a combination of interventions may provide adequate safety and care. Interventions are not intended to solve the household's problems or provide long-term answers. A plan permits a child to remain in the home while further issues are resolved.
4. The process of writing a plan to improve safety and care and selecting interventions should be a collaboration between the CFS Specialist and placement family, starting with consideration of the least intrusive interventions that make use of the family's strengths, and ending with a plan that is both feasible and effective while taking into account the family's view.
5. Interventions marked with an asterisk (*) should be used in combination with monitoring by the CFS Specialist or another person who has passed suitability.
   a. **Interventions that utilize the families strengths:**
      (1) **Use of family, neighbors or other individuals in the community as safety resources.** Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbors, or other individuals to mitigate safety concerns; agreement by a neighbor or relative to serve as a safety net for the child. An Assessment of Safety Plan Participants is REQUIRED for each person who will be engaged in this safety intervention.

(2) ***The care provider will appropriately protect the victim from the alleged perpetrator.** Care provider has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator.

(3) ***The alleged perpetrator will leave the household, either voluntarily or in response to legal action.** Removal of the allege perpetrator. Examples include arrest of alleged perpetrator, "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agrees to leave.

b. **Interventions that utilize community or agency resources.**

(1) **Intervention or direct services by CFS Specialist.** Actions taken or planned by the CFS Specialist or other agency/DHHS staff that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, the child's developmental needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definition of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE services provided to respond to family needs that do not directly affect safety.

(2) **Use of community agencies or services as safety resources.** Involving community-based organizations, faith-related organization, or other agency in activities to address safety concerns. DOES NOT INCLUDE long-term therapy or treatment or being put on a waiting list for services.

(3) **Other.** The family or CFS Specialist identified a unique intervention for an identified safety concern that does not fit within the items above.

c. **Placement change intervention.**
Removal from current placement is necessary because interventions above do not adequately ensure the child's safety. One or more children are removed from the current placement resource.

D. **Section 3: Placement Decision**

1. The placement decision is the result of careful consideration of the safety concerns and care concerns present and any available interventions taken or immediately planned by the care provider, community partners, or agency to protect the child. The CFS Specialist will collaborate with Resource Development on licensing and

placement and will identify the placement decision based on the CFS Specialist's independent assessment of all safety concerns, care concerns, interventions, and any other information known about the case.

2. The CFS Specialist will determine if the home is:
   a. **Safe and suitable**. Based on currently available information, there are no child concerns in this placement.
   b. **Conditionally safe and suitable.** Based on interventions, the child will remain in the household at this time. An intervention plan is required.
   c. **Unsafe or unsuitable; removal from the household is the only protective intervention possible for one or more children.** Without removal, one or more children will likely be in danger of serious harm or in an unsuitable care arrangement.
3. The CFS Specialist will document their conclusion to include the following in N-FOCUS in the APSS narrative:
   a. **Concerns:** The CFS Specialist will identify the safety and/or care concerns identified and briefly describe the specific individuals, behaviors, conditions, and/or circumstances associated with each particular concern.
   b. **Interventions:** The CFS Specialist will identify all interventions identified and how the intervention(s) will adequately and effectively mitigate all identified concerns.
   c. **Placement Decision:** The CFS Specialist will identify the placement decision made and briefly describe why this decision was selected.

E. **Intervention Plan:**

1. An intervention plan is required whenever the decision is conditionally safe and suitable. The following should be included in any plan which is written in a family friendly manner:
   a. A description of each safety and care concern.
   b. A detailed description for each planned intervention.
   c. A description of how the plan will be monitored (e.g., who is responsible for each intervention action).
   d. The plan should be signed by the family members, the CFS Specialist, and his/her supervisor.

The intervention plan MUST be completed with the care provider and a copy should be left with the family. The Intervention Plan is located on the last page(s) of the APSS, the CFS Specialist must print off the APSS in N-FOCUS in order to provide a copy with the family.

SDM ASSESSMENT OF PLACEMENT SAFETY AND SUITABILITY

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-2017	Effective

SDM HOUSEHOLDS

DHHS.PSPolicyandGuid@nebraska.gov

SDM Assessments are completed on households. Do not consider employees (babysitter, nanny, etc.) to be household members. When a child's caregivers do not live together, the child may be a member of two households. If both households are involved in the report, both households should be assessed. In a situation in which multiple families share a home, consider the group to be one household if there is shared child care and/or shared access to children. For example, if two families share a house, and adults in both family groups have access to children in both families, assess the group as one household. However, if two families share a house with clear partitions of space and the ability to restrict access to children (e.g., locked doors between living area, separate entrances to the home, etc.), consider the families to comprise two separate households.

The CFS Specialist should keep in mind that during the course of a case, the number and configuration of households may change. For example, a case may begin with both parents living together with the child in the same household. At that point in time, they would be assessed as a single household, and the primary and secondary caregiver would be identified. If the parents separated while the child was in placement, and both parents were considered for reunification, then *two* assessments would become necessary, one for each household, with the legal parent as primary caregiver in each household.

There can be many family units in one household. When considering safety you assess everyone in the household.

Caregivers: The CFS Specialist should use the matrix below to assist in determining the primary and secondary caregivers.

Circumstance	Primary Caregiver	Secondary Caregiver
Two legal parents living together	Provides the most child care. May be 51% of care. • If care is divided precisely 50/50, select the alleged perpetrator. • If both are alleged perpetrators, select the caregiver contributing the most to abuse/neglect.	The other legal parent

	• If there is no alleged perpetrator or both contributed equally, pick either.	
Single legal parent, no other adult in the household	The only parent	None
Single legal parent and any other adult living in the household	The only legal parent	Another adult in the household who contributes the most to care of the child. If none of the other adults contribute to child care, there is no secondary caregiver.
No legal parents Assess only if this household will be engaged in services or is the subject of initial assessment.	The household adult who provides the most child care.	Another adult in the household who contributes the most to care of the child. If there are no other adults, or none contributes to child care, there is no secondary caregiver.

When a **minor parent** is living with his/her parent and the minor parent retains legal care and custody of the child, the minor parent should be considered the primary caregiver of his/her child. The minor parent's parent may be considered a secondary caregiver of the infant/young child.

If both the CP and the NCP have allegations of abuse or neglect the CFS Specialist will open separate households. If there are no allegations against the non-custodial parent there is no reason to open a household to conduct SDM Assessments on the non-custodial parent.

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-2017	Effective

SDM PREVENTION ASSESSMENT

DHHS.PSPolicyandGuid@nebraska.gov

I. COMPLETING THE PREVENTION ASSESSMENT.

A. The prevention assessment is completed based on conditions that exist at the start of the initial assessment or referral to ongoing services. An SDM prevention assessment must be completed on each household that is involved in the referral

B. The CFS Specialist should refer to the policy definitions to determine his/her selection for each item.

C. **Section 1: Neglect/Abuse Index**

1. **P1. Prior investigations of any household adult**
   Assess prior DHHS or other CPS history. Determine if there are any prior intakes, excluding those accepted as dependency, Alternative Response, duplicate/multiple reports, information only, and law enforcement only, involving any adult members of the current household as alleged perpetrators for any type of neglect or abuse, regardless of finding. Keep in mind that one intake may involve multiple allegations and/or multiple children, but will still be counted as one intake. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect. Where possible, history from other jurisdictions should be included.
   Answer both P1a and P1b, indicating the number of prior neglect investigations and the number of prior abuse investigations.
   a. Neglect includes general neglect or abandonment, and if the caregiver is absent or incapacitated.
   b. Abuse includes physical abuse, emotional abuse, and sexual abuse/sexual exploitation.

P1. Prior investigations of any household adult	Neglect Score	Abuse Score
[ ] a. No	-1	0
[ ] b. Yes	0	0
P1a. Prior neglect (select one)		
[ ] a. None	0	0
[ ] b. One or Two	2	0
[ ] c. Three or More	3	0
P1b. Prior Abuse (select one)		
[ ] a. None	0	0
[ ] b. One	1	1
[ ] c. Two or More	1	2

2. **P2. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)**
The CFS Specialist will mark “Yes” if this household previously had or currently has an open family preservation or foster care case as a result of a prior investigation. Include voluntary or court-ordered family services or foster care services; do not include delinquency, Alternative Response, status offense or dependency cases.

P2. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	3	2

3. **P3. Number of children in the household.**
Determine the number of children under 19 years of age who live in the home, related or not. Include the following:
a. An unborn child if the mother is in the last trimester of pregnancy;
b. Children who have been removed from the home in the current referral;
c. The legal children of any caregiver, even if that caregiver does not have full custody (e.g., if those children reside in the household less than 50% of the time).
Do not include children who are not the legal responsibility of a household caregiver if they do not reside in the home full-time (e.g., an unrelated child who frequently stays in the home but has a permanent residence elsewhere).

P3. Number of child children in the Household.	Neglect Score	Abuse Score
[ ] a. One, two, or three	0	0
[ ] b. Four or more	2	0

4. **P4. Prior substantiated physical abuse**
The CFS Specialist will mark “Yes” if any prior physical abuse investigation was substantiated for any current adult member of the household. The CFS Specialist will mark “No” if there is no history of substantiated physical abuse.

P4. Prior substantiated physical abuse	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	2

5. **P5. Age of youngest child in the home**
The CFS Specialist will determine the current age of the youngest child presently in the household. If a child was removed as a result of the current referral, count the child as residing in the home.

P5. Age of youngest child in the home	Neglect Score	Abuse Score
[ ] a. 2 or older	0	0
[ ] b. Under 2	1	0

6. **P6. Characteristics of children in the household**
The CFS Specialist will assess each child in the household and determine the presence of any of the following characteristics:
   a. **Medically fragile/failure to thrive.** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention (include also infants under six months of age with physical conditions requirement medical intervention if the condition is likely to persist for six months or more), or is diagnosed as failure to thrive. Requires medical documentation or credible report of professional diagnosis.

The following characteristics may be present during the initial assessment, or may have been true for any child in the household at any time in the past.
   b. **Drug or alcohol exposure.** A child was affected by drugs or alcohol in utero or at birth as evidenced by maternal alcohol or drug use during pregnancy, OR any child had a positive toxicology report for alcohol or another drug at birth or at any time in the past.
   c. **Physical disability,** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include any credible information).
   d. **Developmental disability,** as evidenced by intellectual disability, learning disability, or other developmental problem including ADHD, that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
   e. **Delinquency history.** A child has been referred to juvenile court for delinquent or status offense behavior. Status offenses that are not brought to court attention but that create stress within the household should also be scored, such as children who run away or are habitually truant.
   f. **Current or previous mental health/behavior problems.** These are problems not related to a physical or developmental disability. This could be indicated by a current Diagnostic and Statistical Manual (DSM) diagnosis, received or receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking psychotropic medication. Exclude ADHD and use of related medications, which would be included in item “d”.
   g. **None of the above.** No characteristics are exhibited by any child in the household.

P6. Characteristics of children in the household	Neglect Score	Abuse Score
[ ] a. Medically fragile/failure to thrive	1	0
[ ] b. Drug or alcohol exposure	1	0
[ ] c. Physical disability	1	0
[ ] d. Developmental disability	0	1
[ ] e. Delinquency history	0	1
[ ] f. Current or previous mental health/behavior problems	0	1
[ ] g. None of the Above	0	0

7. **P7. Primary caregiver provides physical care consistent with each child's needs**

   The CFS Specialist will mark "Yes" if the caregiver is providing age-appropriate physical care that meets minimal standards for all children in the household. Examples may include the following:

   a. Obtaining standard immunizations. Do not mark cases in which the caregiver has made a choice not to immunize due to religious or philosophical convictions.
   b. Obtaining medical care for severe, chronic, or recurrent illness. Mark as "No" missed well-baby/child visits where there are concerns for infant/child health.
   c. Providing the child with adequate food.
   d. Providing the child with adequately clean, weather-appropriate clothing.
   e. Preventing or addressing rodent or insect infestations.
   f. Providing adequate housing with operative plumbing and electricity (heating and cooling).
   g. Ensuring that poisonous substances or dangerous objects are not within reach of a small child.
   h. Supporting or providing age/developmentally appropriate hygiene (bathing, brushing teeth, changing diapers).

P7. Primary caregiver provides physical care consistent with each child's needs service case due to child abuse or neglect (voluntary or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	1	0
[ ] b. Yes	0	0

8. **P8. Primary caregiver characteristics**

   Assess the primary caregiver for each characteristic and mark all that apply.

   a. **Provides insufficient emotional/psychological support** to the child, such as persistently berating/belittling/demeaning the child, not attempting to bond with the child, or depriving the child of affection or emotional support.
   b. **Employs excessive/inappropriate discipline** that caused or threatened harm to the child because the actions were excessively harsh physically or emotionally

and/or inappropriate to the child's age or development. Examples may include the following:
(1) Locking the child in a closet or basement;
(2) Holding the child's hand over fire;
(3) Hitting the child with dangerous instruments; or
(4) Depriving a young child of physical and/or social activity for extended periods.

c. **Domineering parent,** indicated by controlling, abusive, overly restrictive, bullying, or over-reactive rules. This may be characterized by a caregiver seeing his/her own way as the only way or by little two-way communication between the caregiver and child.

d. **None of the above** characteristics are exhibited by the primary caregiver.

P8. Primary caregiver characteristics	Neglect Score	Abuse Score
[ ] a. One or more apply	0	1
[ ] Provides insufficient emotional/psychological support		
[ ] Employs excessive/inappropriate discipline		
[ ] Domineering parent		
[ ] b. None of the above	0	0

9. P9. Primary caregiver has a past or current mental health problem

The CFS Specialist will mark "Yes" if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:

a. Current DSM diagnosis by a mental health clinician;
b. Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; or
c. Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.

Do not include diagnoses of ADHD or learning disabilities (e.g., dyslexia).

P9. Primary caregiver has a past or current mental health problem	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes (mark all that apply)	1	0
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

10. P10. Primary caregiver has past or current alcohol or drug problem that interferes with family functioning

The CFS Specialist will assess whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Include abuse of alcohol and/or illegal substances, and abusive use of prescription drugs. Legal, non-abusive prescription drug or alcohol use should not be considered

an alcohol or drug problem. Assess for the following characteristics and mark all that apply:
Interference in function may be evidenced by the following:

a. Substance use that affects or affected the following:
   i. Employment;
   ii. Criminal involvement;
   iii. Marital or family relationships; or
   iv. Ability to provide protection, supervision, and care for the child.
b. An arrest or citation in the past for driving under the influence of drugs and/or alcohol, refusing breathalyzer testing, possession of a controlled substance or paraphernalia;
c. Self-report of a problem;
d. Treatment received currently or in the past;
e. Multiple positive toxicology screens;
f. Health/medical problems resulting from substance use; or
g. The child was diagnosed with fetal alcohol syndrome or exposure (FAS or FAE), or the child had a positive toxicology screen at birth and the primary caregiver was the birthing parent.

The CFS Specialist will select the following based on whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

P10. Primary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes	**2**	**1**
[ ] Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] Drugs (mark all that apply		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

11. **P11. Secondary caregiver has past or current alcohol or drug problem**
Applying the definition in P10 to the secondary caregiver, the CFS Specialist will select the following based on whether the secondary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

P11. Secondary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No secondary caregiver	**0**	**0**
[ ] a. No	**0**	**0**

[ ] b. Yes	0	1
[ ] Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] Drugs (mark all that apply		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

12. P12. Primary caregiver has a history of abuse or neglect as a child

The CFS Specialist will mark "Yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. Include disclosure of incidents that would be screened in for assessment now.

P12. Primary caregiver has a history of abuse or neglect as a child	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	2	1

13. P13. Primary caregiver has a criminal arrest history

The CFS Specialist will indicate whether the primary caregiver has ever been arrested or convicted either as adult or as a juvenile. This includes DUI but exclude all other traffic offenses (e.g., willful-reckless driving, speeding, parking tickets; consider citations for window tint, driving without insurance and other non-moving violations as traffic offenses).

P13. Primary caregiver has a criminal arrest history	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	1	1

14. P14. Two or more incidents of domestic violence in the household in the past year.

The CFS Specialist will mark "Yes" if credible statements by caregivers or others indicate that there have been two or more physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult in the past year. Include domestic violence involving minor parents if they are the primary or secondary caregiver. Do not include violence among other household members that does not involve primary and/or secondary caregivers. The CFS Specialist will use collaterals and/or supporting evidence in describing the item.

P14. Two or more incidents of domestic violence in the household in the past year.	Neglect Score	Abuse Score
[ ] a. No	0	0

[ ] b. Yes	0	1

15. **P15. Housing**
The CFS Specialist will assess and determine the presence of any of the characteristics below and mark all that apply. If the agency or DHHS has already provided emergency services to address housing, assess housing as it was prior to the intervention. If the agency or DHHS helps the family move to a DV shelter as part of a Safety Plan, do not mark this item.
   a. **Current housing is physically unsafe,** such that it does not meet the health or safety needs of the child (e.g., exposed wiring; structurally unsafe conditions; unsafe/insufficient heating and cooling, and alternative safe arrangements have not been made; unsanitary plumbing; roach/rat infestations; human/animal waste on floors or other household surfaces; rotting food); **or family is homeless** or has received an eviction notice at the time of the referral. Include families who are living in temporary shelter. If the caregiver is unsure of the family's living situation or family considers themselves homeless, endorse this item.
   b. **Family has housing that is physically safe.**

P15. Housing	Neglect Score	Abuse Score
[ ] a. Current housing is physically unsafe or family is homeless	2	0
[ ] b. Family has housing that is physically safe	0	0

D. **Section 2: Scoring and Overrides**

- **Scoring Individual Items**:
   a. A score for each assessment item is derived from the CFS Specialist's observation of the characteristics it describes. Some characteristics are objective (such as prior child abuse/neglect history or the age of the child). Others require the CFS Specialist to use discretionary judgment based on his/her assessment of the family.
   b. Sources of information used to determine the CFS Specialist's endorsement of an item may include statements made by the child, caregiver, or collateral persons; CFS Specialist observations; reports; or other reliable sources. The CFS Specialist should refer to the definitions to determine his/her selection for each item.
   c. After all index items are scored, the CFS Specialist totals the scores and indicates the corresponding prevention level of each index. Next, the scored prevention level (whichever is higher of the abuse or neglect index) is entered.

Neglect Score	Abuse Score	Prevention Level
-1-0	0-1	Low
1-3	2-4	Moderate
4-8	5-8	High

9+	9+	Very High

- **Overrides:**
  a. After completing the prevention assessment, the CFS Specialist determines if any of discretionary overrides exist. The prevention assessment does not have any policy overrides.
  b. A discretionary override is applied by the CFS Specialist to increase the prevention level in any case in which the CFS Specialist believes that the prevention level set by the prevention assessment is too low. This may occur when the CFS Specialist is aware of conditions affecting the likelihood of future harm that are not captured within the items on the prevention assessment. Discretionary overrides may increase the prevention level by one unit (for example, from low to moderate OR moderate to high, but NOT from low to high).
  c. After completing the Override section, the CFS Specialist will indicate the final prevention level, which is the highest of the scored level, or discretionary override level.
  d. The prevention level informs the decision to open an ongoing services case.

Note: Alternative Response policy will be used in Alternative Response Cases regarding recommendations.

Final Prevention Level	**Recommendation**
Low	Recommend for referral*#
Moderate	Recommend for referral*#
High	Ongoing services needed
Very High	Ongoing services needed
**Low and moderate risk cases must be recommended for ongoing services if the most recent SDM safety assessment finding was conditionally safe or unsafe.*	

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-17	Effective

I. COMPLETING THE RISK ASSESSMENT.

A. The risk assessment is completed based on conditions that exist at the start of the initial assessment.

B. The CFS Specialist will refer to the definitions to determine his/her selection for each item.

C. **Section 1: Neglect/Abuse Index**

1. **R1. Current report is for.**
   The CFS Specialist will determine if the report that led to the current referral or DHHS investigation is for abuse, neglect, or both. Neglect includes general neglect, abandonment, and caregiver absence/incapacity. Abuse includes physical abuse, emotional maltreatment and/or exploitation, or sexual abuse/sexual exploitation. *Neither category includes dependency.*

   Include reported allegations as well as allegations added by DHHS during the course of the initial assessment.

R1. Current report is for	Neglect Score	Abuse Score
[ ] a. Neglect	1	0
[ ] b. Abuse	0	1
[ ] c. Both	1	1

2. **R2. Prior investigations of any household adult**
   Assess prior DHHS or other CPS history. Determine if there are any prior intakes, excluding those accepted as dependency, alternative response, duplicate/multiple reports, information only, and law enforcement only, involving any adult members of the current household as alleged perpetrators for any type of neglect or abuse, regardless of finding. One intake may involve multiple allegations and/or multiple children, but will still be counted as one intake. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect. Where possible, history from other jurisdictions should be included.

   If yes, answer both R2a and R2b, indicating the number of prior neglect investigations and the number of prior abuse investigations.
   a. Neglect includes general neglect or abandonment, and if the caregiver is absent or incapacitated.
   b. Abuse includes physical abuse, emotional abuse, and sexual abuse/sexual exploitation.

R2. Prior investigations of any household adult	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	1	0

R2a. Prior Neglect		
[ ] a. None	**0**	**0**
[ ] b. One	**1**	**0**
[ ] c. Two	**1**	**0**
[ ] d. Three or more	**2**	**0**
R2b. Prior Abuse		
[ ] a. None	**0**	**0**
[ ] b. One	**0**	**1**
[ ] c. Two or more	**0**	**2**

3. **R3. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)**
   The CFS Specialist will mark "Yes" if this household previously had or currently has an open family preservation or foster care case as a result of a prior investigation. Include voluntary or court-ordered family services or foster care services; do not include delinquency, status offense, alternative response or dependency cases.

R3. Household previously had an open ongoing service case due to child abuse or neglect (non-court (voluntary) or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	**0**	**0**
[ ] b. Yes	**1**	**1**

4. **R4. Number of child victims involved in the current child abuse or neglect incident**
   Determine the number of children under 19 years of age for whom abuse or neglect was alleged or substantiated in the current investigation. Only include the number of children listed on the intake who have allegations. If it is discovered that other children are victims, they would need to be added to the intake and counted.

R4. Number of child victims involved in the current child abuse or neglect incident	Neglect Score	Abuse Score
[ ] a. One, two, or three	**0**	**0**
[ ] b. Four or more	**1**	**0**

5. **R5. Prior injury to any child in household resulting from child abuse or neglect**
   The CFS Specialist will mark "Yes" if any child sustained an injury resulting from abuse and/or neglect prior to the referral that resulted in the current investigation. Injury sustained as result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn. Prior injury may or may not have been subject to a child protection investigation. Include prior substantiated injuries and credible report of prior injuries, but exclude accidental injuries.

R5. Prior injury to any child in household resulting from child abuse or neglect	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	1

6. **R6. Age of youngest child in the home**
   The CFS Specialist will determine the current age of the youngest child presently in the household where the child abuse or neglect incident reportedly occurred. If a child was removed as a result of the current investigation, count the child as residing in the home.

R6. Age of youngest child in the home	Neglect Score	Abuse Score
[ ] a. 2 or older	0	0
[ ] b. Under 2	1	0

7. **R7. Characteristics of children in the household**
   The CFS Specialist will assess each child in the household and determine the presence of any of the following characteristics. These characteristics are separate and distinct from the child vulnerabilities on the safety assessment. Diagnoses are required where indicated. Diagnoses must be listed as a current Diagnostic and Statistical Manual (DSM) diagnosis.
   1. **Medically fragile/failure to thrive.** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention, or is diagnosed as failure to thrive. Requires medical documentation or credible report of professional diagnosis.

   The following characteristics may be present during the initial assessment, or may have been true for any child in the household at any time in the past.
   b. **Positive toxicology,** any child had a positive toxicology report for alcohol or another drug at birth or at any time in the past. The child need not have been born in the current incident or during the initial assessment.
   c. **Physical disability,** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include any credible information).
   d. **Developmental disability,** as evidenced by intellectual disability, learning disability, or other developmental problem including ADHD, that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
   e. **Delinquency history.** A child has been referred to juvenile court for delinquent or status offense behavior. Status offenses that are not brought to court attention but that create stress within the household should also be scored, such as children who run away or are habitually truant.
   f. **Current or previous mental health/behavior problems.** These are problems not related to a physical or developmental disability. This could be indicated by a current Diagnostic and Statistical Manual (DSM) diagnosis, received or receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking psychotropic medication. Exclude ADHD and use of related medications, which would be included in item "d".

g. **None of the above.** No characteristics are exhibited by any child in the household.

R7. Characteristics of children in the household	Neglect Score	Abuse Score
[ ] a. Medically fragile/failure to thrive	1	0
[ ] b. Positive toxicology screen at birth	1	0
[ ] c. Physical disability	1	0
[ ] d. Developmental disability	0	1
[ ] e. Delinquency history	0	1
[ ] f. Current or previous mental health/behavior problems	0	1
[ ] g. None of the above	0	0

8. **R8. Primary caregiver's assessment of incident**
   The CFS Specialist will assess for each characteristic and mark all that apply.
   a. **Blames child.** Blaming refers to caregiver's statement that the maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced him/her, or the child's misbehavior forced caregiver to beat him/her). Exclude situations in which the caregiver claims that one child injured another child or in which the caregiver claims that the child injured him/herself.
   b. **Justifies maltreatment of the child.** Justifying refers to caregiver's statement that his/her action or inaction, which resulted in harm to the child, was appropriate and constitutes good parenting (e.g., claiming that this form of discipline was how the caregiver was raised, so it is all right).
   c. **None of the above** characteristics are applicable.

R8. Primary caregiver's assessment of incident	Neglect Score	Abuse Score
[ ] a. Blames child	0	1
[ ] b. Justifies maltreatment of the child	0	2
[ ] c. None of the above	0	0

9. **R9. Primary caregiver provides physical care consistent with each child's needs**
   The CFS Specialist will mark "Yes" if the caregiver is providing age-appropriate physical care that meets minimal standards for all children in the household. Examples may include the following:
   a. Obtaining standard immunizations. Do not mark cases in which the caregiver has made a choice not to immunize due to religious or philosophical convictions.
   b. Obtaining medical care for severe, chronic, or recurrent illness. Mark as "No" missed well-baby/child visits where there are concerns for infant/child health.
   c. Providing the child with adequate food.
   d. Providing the child with adequately clean, weather-appropriate clothing.
   e. Preventing or addressing rodent or insect infestations.
   f. Providing adequate housing with operative plumbing and electricity (heating and cooling).

g. Ensuring that poisonous substances or dangerous objects are not within reach of a small child.
h. Supporting or providing age/developmentally appropriate hygiene (bathing, brushing teeth, changing diapers).

R9. Primary caregiver provides physical care consistent with each child's needs	**Neglect Score**	**Abuse Score**
[ ] a. No	**1**	**0**
[ ] b. Yes	**0**	**0**

10. **R10. Primary caregiver characteristics**
Assess the primary caregiver for each characteristic and mark all that apply.
a. **Provides insufficient emotional/psychological support** to the child, such as persistently berating/belittling/demeaning the child, not attempting to bond with the child, or depriving the child of affection or emotional support.
b. **Employs excessive/inappropriate discipline** that caused or threatened harm to the child because the actions were excessively harsh physically or emotionally and/or inappropriate to the child's age or development. Examples may include the following:
(1) Locking the child in a closet or basement;
(2) Holding the child's hand over fire;
(3) Hitting the child with dangerous instruments; or
(4) Depriving a young child of physical and/or social activity for extended periods.
c. **Domineering parent,** indicated by controlling, abusive, overly restrictive, bullying, or over-reactive rules. This may be characterized by a caregiver seeing his/her own way as the only way or by little two-way communication between the caregiver and child.
d. **None of the above** characteristics are exhibited by the primary caregiver.

R10. Primary caregiver characteristics	**Neglect Score**	**Abuse Score**
[ ] a. Provides insufficient emotional/psychological support	**0**	**1**
[ ] b. Employs excessive/inappropriate discipline	**0**	**1**
[ ] c. Domineering parent	**0**	**1**
[ ] d. None of the above	**0**	**0**

11. **R11. Primary caregiver has a past or current mental health problem**
The CFS Specialist will mark "Yes" if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
a. Current DSM diagnosis by a mental health clinician;
b. Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; **or**

c. Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.

Do not include diagnoses of ADHD or learning disabilities (e.g., dyslexia).

If the CFS Specialist selects “Yes”, documentation must reflect details as to how the CFS Specialist made their determination (i.e., parent reported specific diagnosis and was able to provide information on the doctor, medications, treatment etc.)

If the CFS Specialist selects “No”, documentation must include references to collaterals or supporting evidence (e.g., spouse, parent, children, friends, NDEN) that no one indicated that mental health has been an issue.

R11. Primary caregiver has a past or current mental health problem	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes (mark all that apply)	1	0
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

12. **R12. Primary caregiver has past or current alcohol or drug problem that interferes with family functioning**

The CFS Specialist will assess whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family’s functioning. Include abuse of alcohol and/or illegal substances, and abusive use of prescription drugs. Legal, non-abusive prescription drug or alcohol use should not be considered an alcohol or drug problem. The CFS Specialist will assess for the following characteristics using the definitions and mark all that apply:

Interference in function may be evidenced by the following:

a. Substance use that affects or affected the following:
   i. Employment;
   ii. Criminal involvement;
   iii. Marital or family relationships; or
   iv. to provide protection, supervision, and care for the child.
b. An arrest or citation for driving under the influence of drugs and/or alcohol, refusing breathalyzer testing, possession of a controlled substance or paraphernalia (this includes situations when the individual was not charged or the charge was dismissed);
c. Self-report of a problem;
d. Treatment received currently or in the past;
e. Multiple positive toxicology screens;
f. Health/medical problems resulting from substance use; or
g. The child was diagnosed with fetal alcohol syndrome or exposure (FAS or FAE), or the child had a positive toxicology screen at birth and the primary caregiver was the birthing parent.

The CFS Specialist will select the following based on whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

R12. Primary caregiver has past or current alcohol or drug problem	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Alcohol (mark all that apply)	1	0
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] c. Drugs (mark all that apply)	1	0
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

13. **R13. Secondary caregiver has past or current alcohol or drug problem**
    Applying the definition in R12 to the secondary caregiver, assess for the following characteristics and mark all that apply.

R13. Secondary caregiver has past or current alcohol or drug problem	Neglect Score	Abuse Score
[ ] a. No secondary caregiver	0	0
[ ] b. No	0	0
[ ] c. Yes	0	1
Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
Drugs (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

14. Primary caregiver has a history of abuse or neglect as a child
The CFS Specialist will mark "Yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. The alleged abuse or neglect does not need to have happened by the adult's caregiver/parent. Include disclosure of incidents that would be screened in for assessment now.

R14. Primary caregiver has a history of abuse or neglect as a child	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	1

15. R15. Two or more incidents of domestic violence in the household in the past year
The CFS Specialist will mark "Yes" if credible statements by caregivers or others indicate that there have been two or more physical assaults and/or periods of intimidation/threats/harassment between caregivers, or between a caregiver and

another adult, in the past year. Instances of domestic violence that occur outside the physical household structure (i.e. bar) or with any of the current household members will be included in the count. The CFS Specialist will use collaterals and/or supporting evidence in describing the item.

R15. Two or more incidents of domestic violence in the household in the past year	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	2

16. R16. Housing

The CFS Specialist will assess and determine the presence of any of the characteristics below and mark all that apply. If the agency or DHHS has already provided emergency services to address housing, assess housing as it was prior to the intervention. If the agency or DHHS helps the family move to a DV shelter as part of a Safety Plan, do not mark “a” or “b” in this item.

a. **Current housing is physically unsafe,** such that it does not meet the health or safety needs of the child (e.g., exposed wiring; structurally unsafe conditions; unsafe/insufficient heating and cooling, and alternative safe arrangements have not been made; unsanitary plumbing; roach/rat infestations; human/animal waste on floors or other household surfaces; rotting food).

b. **Homeless at time the investigation began,** or about to be evicted at the time the investigation began. Include families who are living in temporary shelter. If the caregiver is unsure of the family’s living situation or family considers themselves homeless, endorse this item.

c. **Family has housing that is physically safe.**

R16. Housing (mark all that apply)	Neglect Score	Abuse Score
[ ] a. Current housing is physically unsafe	1	0
[ ] b. Homeless at time the investigation began	2	0
[ ] c. Family has housing that is physically safe	0	0

D. **Section 2: Scoring and Overrides**

1. **Scoring Individual Items**:

a. A score for each assessment item is derived from the CFS Specialist’s observation of the characteristics it describes. Some characteristics are objective (such as prior child abuse/neglect history or the age of the child). Others require the CFS Specialist to use discretionary judgment based on his/her assessment of the family.

b. Sources of information used to determine the CFS Specialist’s endorsement of an item may include statements made by the child, caregiver, or collateral persons; CFS Specialist observations; reports; or other reliable sources. The CFS Specialist should refer to the definitions to determine his/her selection for each item.

c. After all index items are scored, the CFS Specialist totals the scores and indicates the corresponding risk level of each index. Next, the scored risk level (whichever is higher of the abuse or neglect index) is entered.

Neglect Score	Abuse Score	Risk Level
0-1	0-1	Low
2-4	2-4	Moderate
5-8	5-7	High
9+	8+	Very High

2. **Policy Overrides:** After completing the risk assessment, the CFS Specialist determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns, and have been determined to warrant a risk level designation of very high regardless of the risk level indicated by the assessment. **Note: Mark each policy override that is present:**
   a. Sexual abuse case AND the perpetrator is likely to have access to the child. This override only applies if it happened within the review period.
   b. Non-accidental injury to a child under age 2. This override only applies if it happened within the review period.
   c. Severe non-accidental injury. This override only applies if it happened within the review period.
   d. Caregiver action or inaction resulted in death of a child due to abuse or neglect. This policy override is considered over the lifetime of the case. If the caregiver ever caused a child death either by action or inaction this policy override will be selected.

3. **Discretionary Override:** A discretionary override is applied by the CFS Specialist to increase the risk level in any case in which the CFS Specialist believes that the risk level set by the risk assessment is too low.
   a. This may occur when the CFS Specialist is aware of conditions affecting risk that are not captured within the items on the risk assessment.
   b. Discretionary overrides may increase the risk level by one unit (for example, from low to moderate risk OR moderate to high risk, but NOT from low to high risk).
   c. After completing the Override section, the CFS Specialist will indicate the final risk level, which is the highest of the scored risk level, policy override risk level (which is always very high), or discretionary risk level.
   d. The risk level informs the decision to open an ongoing services case.

Final Risk Level	Recommendation
Low	Close Case*
Moderate	Close Case*
High	Ongoing services needed
Very High	Ongoing services needed

**Low and moderate risk cases must be recommended for ongoing services if the most recent SDM safety assessment finding was conditionally safe or unsafe.*

II. DETERMINING RISK ASSESSMENT RESPONSE.

Following the completion of the safety and risk assessments, the CFS Specialist determines the DCFS response. The response by DCFS must be the least intrusive, most appropriate level of service necessary to meet the identified needs of the family.

A. An on-going case will be opened based on the following:
   1. Families with an unsafe or conditionally safe child; and/or
   2. Families at high or very high risk for future child abuse or neglect of their children; and/or
   3. Families with court ordered DHHS involvement regardless of Safety/Risk Assessment determinations.

Ongoing cases may be court or non-court involved. All ongoing cases will be assessed to determine if a child or family is Native American. If a child is identified or is believed to be Native American, the CFS Specialist will send Non-Court or Court Notice to the Tribe(s) and follow all ICWA procedures described in the Indian Child Welfare Act Operations Manual.

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-2017	Effective

SDM SAFETY ASSESSMENT

DHHS.PSPolicyandGuid@nebraska.gov

I. SDM Safety Assessment Overview.

A. The purpose of the safety assessment is to assess whether a household presents imminent **danger of serious harm** to any child, and if so, to determine what interventions should be initiated or maintained to provide appropriate protection or if protective placement is necessary.

B. **Safety versus risk assessment:** It is important to keep in mind the difference between safety and risk when completing this assessment. The safety assessment focuses on the serious and imminent threat of harm to the child in the household and the interventions currently needed to protect the child. The risk assessment looks at the likelihood of **future** maltreatment in the next year to two years.

C. The CFS Specialist will conduct the safety assessment when a report of child abuse or neglect has been accepted for assessment. If both the Custodial Parent (CP) and the Non-Custodial Parent (NCP) have allegations of abuse or neglect the CFS Specialist will open separate households and complete the safety and risk assessment for each home and provide services as necessary. The first safety assessment is completed by the CFS Specialist assigned to conduct the initial assessment with the family. If subsequent new reports are accepted for assessment the Service Area will develop protocols to determine if an Initial Assessment worker or the CFS Specialist responsible for the case will conduct a safety assessment. Safety reassessments are completed by the CFS Specialist responsible for the case at any time a change in safety status is noted.

D. During an initial assessment and throughout the case, more than one safety assessment may be required, due to changes in family circumstances. The safety assessment *process is required:*

1. At the first face-to-face contact with the family in the initial assessment;
2. When a new allegation of abuse or neglect involving the caregiver's household is received on an open case;
3. Whenever new information becomes available or family conditions change;
4. Prior to recommending case closure when the initial safety finding was unsafe or conditionally safe.

II. Completing the Safety Assessment:

A. **Child Vulnerabilities**. The CFS Specialist will consider the vulnerability of each child throughout the assessment. Young children cannot protect themselves. For older children, the inability to protect themselves could result from diminished mental or physical capacity, or repeated victimization. The following conditions may result in a child's inability to protect self. The CFS Specialist will select all vulnerabilities that apply to any child.

1) Age 6 and under: Any child in the household is under the age of 7 years. Younger children are considered more vulnerable, as they are less verbal and less able to

protect themselves from harm. Younger children also have less capacity to retain memory of events. Infants are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protection.

2) Significant diagnosed medical or mental disorder that significantly impairs ability to protect self: Any child in the household who has a diagnosed medical or mental disorder that significantly impairs their ability to protect self from harm, or diagnosis may not yet be confirmed but preliminary indications are present and testing/evaluation is in process. Examples may include but are not limited to severe asthma, severe depression, severe ADHD, medically fragile (e.g., requires assistive devices to sustain life), etc. For developmental disabilities, mark the item for "diminished developmental/cognitive capacity."
3) Isolated or less visible in the community: Examples of children who are isolated or less visible in the community include but are not limited to any child of school age who is not currently enrolled in school or is enrolled but habitually absent, a child whose family lives in an isolated or remote community, a child who is not routinely involved in other activities within the community, etc.
4) Extreme allegiance to the alleged perpetrator: Any child in the household would be unable to protect him/herself or to assist others in acts of protection due to allegiance to the alleged perpetrator. Examples include children who prioritize protecting the caregiver over protecting themselves.
5) Diminished developmental/cognitive capacity: Any child in the household has diminished developmental/cognitive capacity, which impacts ability to communicate verbally or to care for and protect self from harm. Examples include but are not limited to autism, language disability, fetal alcohol effect, etc.
6) Diminished physical capacity: Any child in the household has a physical condition/disability that impacts ability to protect self from harm (e.g., cannot run away or defend self, cannot get out of the house in an emergency situation if left unattended).
7) Prior history of abuse/neglect as a victim that impacts child's ability to protect self: Any child in the household has previously been the victim of abuse or neglect AND this prior experience negatively affects that child's ability to protect him/herself in the current situation. Include both substantiated prior assessments or credible report.

B. **Section 1: Safety Threats:** The CFS Specialist will use the definitions below to assess the following behaviors or conditions in the household that may place a child in immediate danger of serious harm. **The CFS Specialist will analyze and answer each safety threat as it relates to the most vulnerable child.**

1) **Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm, as indicated by any of the following:**
   a. Current serious injury or abuse to the child other than accidental. Caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health

or well-being of the child (e.g., suffocating, shooting, bruises/welts, bite marks, choke marks) and requires medical treatment. Medical treatment is defined as going to a doctor or hospital. Include serious child injuries that result from domestic violence.
Treatment that can be accomplished by a lay person in the home such as bandaging or icing should not be included as medical treatment. This threat is not met if the parent takes the child to the doctor/hospital but it was not necessary (such as the child has a scratch).

b. Caregiver fears he/she will physically harm the child and/or requests placement.
c. Current threat to cause serious harm or retaliate against the child. Threat of action that would result in serious harm, or household member plans to retaliate against the child for DHHS investigation or intervention.
d. Current excessive discipline or physical force. Caregiver has used torture or physical force, or has acted in a way that bears no resemblance to reasonable discipline; or he/she punished the child beyond the child's endurance. Examples include but are not limited to having the child kneel on rice or hold phone books with extended arms as punishment.
e. Drug-exposed infant. There is evidence that the mother used alcohol or other drugs during pregnancy AND this has created imminent danger to the infant.
   (1) Indicators of drug use during pregnancy include drugs found in the mother's or child's system, mother's self-report, diagnosed high risk pregnancy due to drug use, efforts on mother's part to avoid toxicology testing, withdrawal symptoms in mother or child, and pre-term labor due to drug use.
   (2) Indicators of imminent danger include the level of toxicity and/or type of drug present; the infant is diagnosed as medically fragile as a result of drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy.
f. Domestic violence likely to physically injure child. Domestic violence involves physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult. Include situations in which a child has already been injured, even if the intended victim of harm was not the child. Threat of physical harm to a child includes child behaviors that increase the risk of injury (e.g., attempting to intervene during violent dispute, participating in a violent dispute, clinging to an adult involved in the violent dispute), and the use of weapons or other instruments in a violent, threatening, and/or intimidating manner.

2) **Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern.** To mark this safety threat, TWO conditions must be present: 1) suspicion and 2) circumstances. Consider the vulnerability of the alleged child victim, vulnerability of other children in the home, and the relationship of alleged perpetrator to other children in the home.

Suspicion of sexual abuse may be indicated by any of the following:	**AND** An immediate concern for child safety may be characterized or indicated by the following:
• The child discloses sexual abuse either verbally or behaviorally (e.g., age-inappropriate sexualized behavior toward self or others). • Medical findings are consistent with molestation. • A possible or confirmed sexual perpetrator has access to any child in the household. Include any person (household member or not) who has been convicted, investigated, or accused of any sexual crime, or who has had other sexual contact with any child. • Caregiver or another household member has forced or encouraged any child in the household to engage in or observe sexual performances or activities.	• Non-offending caregiver has expressed disbelief that sexual abuse occurred and appears unable or unwilling to prevent access to child by alleged perpetrator. • Alleged perpetrator refuses to leave the home or limit contact with alleged victim and siblings. • Child expresses fear that maltreatment will recur.

3) **Caregiver does not/is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.** The CFS Specialist will select this threat when there is current harm or an identified current threat of harm to a child **and** the caregiver does not take action.

Current harm or an identified threat may be indicated by the following:	**AND** Caregiver does not or is unable to protect the child from serious harm or threatened harm by other family members, other household members, or others having access to the child. Caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age, emotional or physical disability, or developmental stage.
• An alleged perpetrator of abuse who is not the caregiver. • An individual with known violent criminal behavior/history resides in the home, or caregiver allows access to the child. Caregiver may or may not know about the individual's history.	

• Include homes where gang activity occurs or where there is criminal activity in the home.	

4) **Caregiver's explanation for current injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.**

Evidence of questionable or inconsistent explanation includes the following: • Medical evaluation indicates that the injury is a result of abuse; however, caregiver denies, or attributes injury to accidental causes. • Caregiver's explanation for the observed injury is inconsistent with the type of injury. • Caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child. • Caregiver does not or cannot explain injury when there is a reasonable expectation that the caregiver should know (e.g., caregiver is sole person caring for the infant; caregiver states that child has not been out of his/her supervision during time that injury occurred).	**AND** When determining if the nature of the injury suggests that safety is of immediate concern, consider the vulnerability of the child, location and/or severity of injury, physical or emotional disability of the child, and chronicity of injuries.

5) **The family actively impedes assessment by denying access to the child, coercing or coaching the child, or fleeing with the child.** Do not include families who are uncooperative or non-compliant with assessment requests and/or court orders or a caregiver who is uncooperative with safety planning. In such cases, consider other threats to child safety.
   a. Family currently refuses or does not provide access to the child, or cannot or will not provide the child's location.
   b. Family has removed the child from a hospital against medical advice to avoid assessment/investigation.

c. Family has previously fled in response to a CPS investigation, or has previously fled with a child during visitation.
d. Family has a history of keeping the child at home or away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding assessment.
e. Caregiver intentionally coaches or coerces the child or allows others to coach or coerce the child in an effort to hinder the assessment.

If the family will not allow the CFS Specialist to see the child at all or if the family coaches the child to give false information, the threat is present.

The threat is NOT present if:

a. The caregiver denies that maltreatment is occurring (despite evidence to the contrary);
b. The caregiver is reluctant to allow the child to be interviewed but relents during the contact and permits it;
c. The caregiver refuses to allow the CFS Specialist to take a follicle sample for testing;
d. The caregiver refuses to participate in safety planning regarding another safety threat;
e. The caregiver repeatedly delays efforts to contact and/or evaluate the family but the child is seen.

6) **Caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. Needs may be basic or exceptional.**
   a. Caregiver does not attend to the child to the extent that the need for care goes unnoticed or unmet (e.g., caregiver is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).
   b. Caregiver leaves the child alone (time period varies with age, physical or emotional disability, and developmental stage).
   c. Caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.
   d. Minimal nutritional, clothing, and/or supervisory needs of the child are not met, resulting in danger to the child's health and/or safety.
   e. Child appears malnourished (e.g., child is listless and has difficulty concentrating; child or caregiver discloses inadequate nutritional practices).
   f. The child is without minimally acceptable clothing for the weather and environment.
   g. Caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical/mental health condition(s) or does not follow prescribed treatment for such conditions, and lack of treatment presents an imminent and serious threat to child safety.
   h. The child has exceptional needs, such as being medically fragile, which caregiver does not or cannot meet.

i. The child is violent, assaultive, or suicidal and caregiver will not/cannot take protective action.
j. The child shows effects of maltreatment such as serious emotional symptoms, lack of behavioral control, or serious physical symptoms.

Situations of abandonment or desertion are included in safety threat 7 and should not be marked as part of item 6.

7) **Caregiver is not available, is unwilling to provide care, or has deserted the child.** Examples of desertion include but are not limited to the following:
   a. Caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).
   b. The caregiver left a child unattended, the child is unable to identify him/herself, and there is no evidence with which to identify the child's family.
   c. The caregiver left the child unattended or in the temporary care of an adult caregiver, and it is not known where the caregiver is or if the caregiver will return.
   d. There is evidence that the caregiver will no longer parent and will not assume further responsibility for the child (e.g., does not pick up child who is ready to be discharged from hospital or juvenile detention, the caregiver demands a child removal, child "evicted" from family home). For whatever reason, the parent ceases parental responsibilities.

   This threat does not include educational neglect.

8) **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.** Based on the child's vulnerability, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:
   a. Leaking gas from stove or heating unit;
   b. Substances or objects accessible to the child that may endanger his/her health and/or safety (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities; unsecured weapons);
   c. Lack of water or utilities (heat, plumbing, electricity), and no alternate, safe provisions are made;
   d. Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows;
   e. Exposed electrical wires;
   f. Excessive garbage or rotted or spoiled food that threatens health;
   g. Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites, severe infestation of pests including cockroaches and bedbugs causing negative medical/health effects);
   h. Evidence of human or animal waste throughout living quarters.

9) **Child shows signs of significant emotional harm that present an imminent threat to child safety <u>and</u> concerning caregiver behaviors are currently present.**
Note: Child behaviors that indicate mental health or disability concerns that are not being addressed should be addressed under safety threat 6.

Indicators of significant emotional harm to the child include the following:	**AND** Examples of caregiver behaviors include the following (indicate all that apply):
• The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations in household. • The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of conditions in the home. • Child is a danger to self or others, is acting out aggressively, is suicidal, or otherwise exhibits severe emotional disturbance.	• <u>Domestic violence among adults is present in the household.</u> Domestic violence may involve physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult. • <u>Caregiver behavior towards the child.</u> The caregiver may do any of the following: • Describe the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly); • Curse at the child and/or repeatedly put the child down; • Scapegoat a particular child in the family; • Blame the child for a particular incident or for family problems; • Place the child in the middle of a custody battle; or • Choose his/her own relationships with an intimate partner above child's emotional safety.

10) **Child behaviors place the child at imminent threat of serious harm, in spite of appropriate response by caregiver(s).**
To mark this threat, all three of the following conditions **<u>must</u>** be present:

The child is currently engaging in or habitually engages in behaviors that place him/her at	**AND** The child's caregiver(s) have responded appropriately and made reasonable	**AND** The caregiver's current efforts, although appropriate, are insufficient to prevent

imminent risk of serious harm. Examples include but are not limited to children who run away from home and place themselves in unsafe living/sleeping situations, children who engage in prostitution, and children who engage in self-harming behaviors, such as cutting, that require medical intervention.	efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child, and increasing direct supervision and monitoring of the child.	the child from engaging in the behavior in the future.

11) **There is a pattern of prior CPS investigations of household members as alleged perpetrators, protective placements, or caregiver behavior <u>and</u> current circumstances are near the definition for any other safety threat.**

A pattern may be established by any of the following: • Prior death of a child as a result of action or inaction of current household members. • Prior serious harm to a child: Previous maltreatment by caregiver or other household adult that was serious enough to cause severe injury (e.g., fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, and/or physical findings consistent with sexual abuse based on medical exam). • Termination of parental rights: Caregiver had parental rights terminated as a result of a prior CPS investigation. • Prior removal of the child from caregiver: Removal/placement of the child by DHHS or other responsible party was	**AND** Current circumstances are concerning, but not sufficiently imminent or serious to warrant the marking of another safety threat. Examples include but are not limited to the following: • Child has a physical injury that is not serious or that does not warrant medical attention. • Child sometimes does not have sufficient nutrition, but malnourishment is not yet a concern.

necessary for the safety of the child. • Prior CPS substantiation: Prior CPS investigation involving current household adults substantiated for maltreatment. • A pattern of unsubstantiated CPS investigations for any household adult. • Prior threat of serious harm to child by any household adult: Previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against the child for previous incidents; or prior domestic violence that resulted in serious harm or threatened harm to a child. • Prior service failure: Caregiver previously failed to successfully complete court-ordered or previously recommended services.	

12) Other. If, after careful review of the definitions for the other 11 safety threats, the CFS Specialist feels there is something unique in this family that was not captured in any other safety threat, the CFS Specialist should select “other” and document the identified unique safety threat that, if not resolved immediately, would lead to removal of a child in this home.

The CFS Specialist will utilize “other” when methamphetamine use by the parent or caregiver has been identified. The CFS Specialist will document the supporting evidence for selection of this safety threat.

If the CFS Specialist is unable to identify the perpetrator and there is a severe injury there is an active safety threat. The CFS Specialist should start to rule out people that they know did not cause the injury and then safety plan from there.

Safety Assessment decisions are based on what the CFS Specialist knows at a point in time, so the CFS Specialist will make the best informed decision they can with the

information they have available to them. Safety decisions can/may change as more information becomes available.

C. Section 2: Safety Interventions

1) If no safety threats are present, the CFS Specialist can proceed to Section 3 of the Safety Assessment. The CFS Specialist will complete Section 2 – Safety Interventions whenever one or more safety threats are present. For each safety threat identified, the CFS Specialist will consider the resources available in the family and the community that might help to keep the child safe. This section is intended to assist the family and the CFS Specialist in developing a strategy to allow a child to remain safely in the home.
2) Safety interventions are actions that will be taken by the family to allow the child to remain safely in the home. The interventions, either singly or in combination/sequence, will allow a safety plan to be written that will adequately and effectively mitigate all identified safety threats.
3) The process of writing a Safety Plan and selecting safety interventions should be a collaboration between the CFS Specialist and the family, starting with consideration of the least intrusive interventions that make use of the family's strengths, and ending with a plan that is both feasible and effective while taking into account the family's view. In furtherance of the Child Protection Act, the CFS Specialist may contact the non-custodial parent or the parent with shared custody when it has been determined that there is an active safety threat and the non-custodial or shared custodial parent may be able to provide for the child's safety.
4) The CFS Specialist will identify all types of safety interventions that will be implemented. If there are no available safety interventions that would allow the child to remain in the home, the CFS Specialist will indicate the need for protective placement.

D. Interventions that utilize family strengths:

Interventions marked with an asterisk (*) **must** be combined with frequent monitoring and oversight by the CFS Specialist or a person who has passed suitability.

1) **Use of family, kin, neighbors or other individuals in the community as safety resources.** Applying the family's strengths as resources to mitigate safety concerns, or using extended family members, kin, neighbors, or other individual to mitigate safety concerns. An Assessment of Safety Plan Participants is REQUIRED for each person who will be engaged in this safety intervention.
2) ***The caregiver will appropriately protect the child from the alleged perpetrator.** A non-offending caregiver has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator.
3) ***The non-offending caregiver will move to a safe environment with the child.** A caregiver not suspected of harming the child has taken or plans to take the child to an alternate location where the alleged perpetrator will not have access to the child.
4) ***The alleged perpetrator will leave the home, either voluntarily or in response to legal action.**
   Another caregiver is available and the alleged perpetrator will be temporarily or

permanently removed from the home. Examples include non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agreeing to leave. When there are concerns about the reliability of either caregiver or perpetrator, this intervention should be used in combination with other interventions and increased monitoring of the Safety Plan.

E. Intervention's that utilize community and agency resources:

1) **Intervention or direct services by worker.**
   Actions taken or planned by the CFS Specialist that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; and advocacy and support in obtaining restraining orders. DOES NOT INCLUDE the assessment itself or services provided to respond to family needs that do not directly affect safety.
2) **Use of community agencies or services as safety resources.**
   Involving a community-based organization, faith-related organization, or other agency in activities to address safety concerns, e.g., using a local food pantry, community mental health crisis intervention.
3) **Legal action planned or initiated; the child may remain in the home.**
   A legal action has already commenced or will commence that effectively mitigates identified safety concerns. This includes family-initiated (e.g., restraining orders, protection orders, mental health commitments, change in custody/visitation/guardianship) and/or DHHS/agency-initiated (file petition and the child remains in the home) actions. When there are concerns about enforcement, this intervention should be combined with another intervention.
4) **Other.** The family and/or CFS Specialist identified a unique intervention for an identified safety concern that does not fit within the items above, and this intervention allows child(ren) to return to the home or remain in the home.

F. Intervention to remove a child from the home is necessary to adequately ensure the child's safety.

Indicate the removal action taken:

1) The parent or legal guardian has chosen to utilize an Informal Living Arrangement;
2) Request emergency protective custody;
3) Other court action.

G. <u>Safety Concerns:</u>

1) At the initial contact and every subsequent contact with the family, CFS Specialists must recognize immediate safety concerns. The CFS Specialist must start with a review of child vulnerabilities. No child is responsible for creating safety, but some children may have limited capacity to ask for help or escape maltreatment.
2) The CFS Specialist will then consider threats to safety. When the CFS Specialist identifies a threat to safety using the definitions on the safety assessment, there is imminent risk of serious harm to a child, the CFS Specialist cannot leave the home without taking action to ensure the child will be safe.

3) When safety threats are identified, the CFS Specialist must assess the parent's ability to protect the child and consider if any safety interventions will keep the child safe in the home. The safety decision is the interaction of threats and interventions. If the family and CFS Specialist can develop and implement a Safety Plan that will keep the child safe from the identified threats, the child is conditionally safe and may remain in the home. The CFS Specialist must follow up and monitor the family to ensure that the Safety Plan is followed.
4) If safety threats are identified and no interventions are possible, the child is unsafe and must be placed in out of home care.

SUMMARY OF REVISIONS	
DATE	REVISION
11/08/2017	Effective

Attachment Thirteen
Nebraska Caregiver Responsibilities
(NCR)

Child's Name: ____________________________ Child's Master Case # ________________

Today's Date: ___________ Last Assessment Date: ___________ Previous Score: ___________

Assessment Type:

- ☐ Initial
- ☐ Reassessment (6 months from date of previous tool)
- ☐ Request of Foster Parent
- ☐ Request of Agency/Department
- ☐ Change of Placement
- ☐ Permanency Plan Change
- ☐ Change of Child Circumstance

Worker Completing Tool: ________________________________ Service Area: _______________

Caregiver(s): ____

Child Placing Agency: ______________________ CPA Worker: _____________________________

The Nebraska Caregiver Responsibility (NCR) document is to be completed within the **first 30 days of a child's placement in out-of-home care or when there are changes that may impact the responsibilities of the caregiver as defined above.**

Forms should be filled out during a face-to-face meeting with the foster parent, the assigned worker, and the child placing agency worker (if applicable). Foster parents and the child placing agency worker (if applicable) should receive copies of the tool. If the foster parent disagrees with the results of the NCR document, he/she should notify the case worker and/or child placing agency worker as applicable.

In accordance with the Strengthening Families Act (SFA) caregiver should exercise reasonable and prudent parenting standards. REASONABLE PRUDENT PARENT STANDARD (RPPS) means a standard characterized by careful and sensible parental decisions which maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities. The first level (LOR1) is considered essential for all placements and the minimum expectation of all caregivers. **For each of the responsibilities, indicate the level of responsibility (LOR)_currently required to meet the needs of the child (based on results of the current assessment model). The focus is on the caregiver's responsibilities, not on the child's behaviors**. Each level is inclusive of the previous one. Outline caregiver responsibilities in the box

provided for any area checked at a 2 or higher.

CIRCLE ONE ONLY

LOR1 Medical/Physical Health & Well-Being	
L1	Caregiver arranges and participates, as appropriate in routine medical and dental appointments; Provides basic healthcare and responds to illness or injury; administers prescribed medications; maintains health records; shares developmentally appropriate health information with child. Definition: Caregiver follows established policies to ensure child's physical health needs are met by providing basic healthcare and response to illness or injury. Caregiver contributes to ongoing efforts to meet the child's needs, by arranging, transporting* and participating in doctor's appointments that is reflected in required ongoing documentation. Caregiver will administer medications as prescribed, keep a medication log of all prescribed and over-the-counter medication, understand the medications administered, and submit the medication log monthly.
L2	Caregiver arranges and participates with additional visits with medical specialists, assists with treatment and monitoring of specific health concerns, and provides periodic management of personal care needs. Examples may include treating and monitoring severe cases of asthma, physical disabilities, and pregnant/parenting teens. Definition: Additional health concerns must be documented and caregiver's role in meeting these additional needs will be reflected in the child's case plan and/or treatment plan. Caregiver will transport* and participate in additional medical appointments, including monthly medication management, physical or occupational therapy appointments, and monitor health concerns as determined by case professionals.
L3	Caregiver provides hands-on specialized interventions to manage the child's chronic health and/or personal care needs. Examples include using feeding tubes, physical therapy, or managing HIV/AIDS. Definition: Any specialized interventions provided by the caregiver should be reflected in the child's case plan and/or treatment plan. Case management records should include narrative as to the training and/or certification of the caregiver to provide specialized levels of intervention specific to the child's heath needs. Caregiver will provide specific documentation of specialized interventions utilized to manage chronic health and/or personal care needs.
Outline the caregiver responsibilities:	

*Please detail transportation arrangements in responsibilities section. If the caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

CIRCLE ONE ONLY

LOR2	**Family Relationships/Cultural Identity**
L1	Caregiver supports efforts to maintain connections to primary family including siblings and extended family, and/or other significant people as outlined in the case plan; prepares and helps child with visits and other contacts; shares information and pictures as appropriate; supports the parents and helps the child to form a healthy view of his/her family. Definition: Caregiver follows established visitation plan and supports ongoing child-parent and sibling contact as outlined in case plan. Caregiver provides opportunities for the child to participate in culturally relevant experiences and activities including transportation*. Caregiver works with parents and youth in ongoing development of youth's life book.
L2	Caregiver arranges and supervises ongoing contact between child and primary family and/or other significant people or teaches parenting strategies to other caregivers as outlined in the case plan. Definition: Caregiver provides and facilitates parenting time in accordance with the established parenting time plan and case plan. Caregiver provides regular instruction to parent outlining parenting strategies. This feedback must be reflected in Caregiver's required ongoing documentation.
L3	Caregiver works with primary family to co-parent child, sharing parenting responsibilities, OR supports parent who is caring for child AND works with parent to coordinate attending meetings AND appointments together. Examples include attending meetings with doctors, specialists, educators, and therapists together. Definition: Caregiver partners and collaborates with parents to ensure both caregiver and parent attends child's appointments and activities. Caregiver allows parental interaction in the foster home and provides support to the parent while the child is in the parent's home. Caregiver allows the parent to participate in daily routine of the child in the foster home (i.e. dinner, bedtime routine, morning routine). Documentation should illustrate caregiver's efforts to engage parent and shows examples of a transfer of learning to the parent.
Outline the caregiver responsibilities:	

*Please detail transportation arrangements in responsibilities section. If the caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

CIRCLE ONE ONLY

LOR 3 Supervision/Structure/Behavioral & Emotional	
L1	Caregiver provides routine direct care and supervision of the child, assists child in learning appropriate self-control and problem solving strategies; utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change, adapts schedule or home environment to accommodate or redirect occasional outbursts. Definition: Caregiver provides age and developmentally appropriate supervision, structure, and behavioral and/or emotional support. Caregiver utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change. Caregiver can provide examples of strategies and interventions implemented.
L2	Caregiver works with other professionals to develop, implement and monitor specialized behavior management or intervention strategies to address ongoing behaviors that interfere with successful living as determined by the family team. Definition: Caregiver provides beyond age and developmentally appropriate supervision, structure, and behavioral and/or emotional support in accordance with a formal treatment or behavioral management plan as identified by the child's needs. Caregiver can provide examples of strategies and interventions implemented.
L3	Caregiver provides direct care and supervision that involves the provision of highly structured Interventions such as using specialized equipment and/or techniques and treatment regiments on a constant basis. Examples of specialized equipment include using alarms, single bedrooms modified for treatment purposes, or using adaptive communication systems, etc.; works with other professionals to develop, implement and monitor strategies to intervene with behaviors that put the child or others in imminent danger or at immediate risk of serious harm. Definition: Caregiver follows established treatment plan to ensure child's safety and well-being. Treatment plan requires immediate and ongoing (more than once daily) monitoring and interaction. Strategies and interventions are developed in accordance with treatment plan and in consultation with case manager and must be followed to ensure child's immediate and ongoing safety and well-being. If plan is not followed child is at risk of imminent danger. Caregiver maintains frequent contact with mental health professionals and actively participates in services and monitoring. Caregiver can provide examples of therapeutic interventions and demonstrates ongoing monitoring.
Outline the caregiver responsibilities:	

CIRCLE ONE ONLY

LOR 4 Education/Cognitive Development	
L1	Caregiver provides developmentally appropriate learning experiences for the child noting progress and special needs; assures school or early intervention participation as appropriate; supports the child's educational activities; addresses cognitive and other educational concerns as they arise, participation in the IEP development and review. Definition: Caregiver ensures child meets established education goals. Routine educational support includes providing transportation* to and from school, providing a structured homework routine and help with homework; maintaining regular, ongoing contact with school to ensure age-appropriate performance and progress. This includes participation in regularly scheduled parent- teacher conferences with the parents (as appropriate). For non-school age children, the caregiver will ensure the child is working on developmental goals (i.e. colors, ABCs, counting, etc.)
L2	Caregiver maintains increased involvement with school staff to address specific educational needs that require close home/school communication for the child to make progress AND responds to educational personnel to provide at-home supervision when necessary; or works with others to implement program to assist youth in alternative education or job training. Definition: Educational goals may include both school-based as well as job training goals (for older youth). Caregiver implements monitoring in the home to reflect established learning plan objectives or collaborates with professionals to ensure child's educational goals are met. Caregiver provides examples of efforts to support education. Caregiver provides support and structure for child if suspended or expelled from school.
L3	Caregiver works with school staff to administer a specialized educational program AND carries out a comprehensive home/school program (more than helping with homework) during or after school hours. Definition: Caregiver implements interventions per an established alternative education plan, IEP or 504 plan which involves specialized activities and/or strategies outside of the educational setting. Implementation of this plan requires regular communication with school and is not considered routine educational support. Caregiver may require specialized training or certification in order to meet the child's educational and cognitive needs.
	Outline the caregiver responsibilities:

*Please detail transportation arrangements in responsibilities section. If the caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

CIRCLE ONE ONLY

LOR 5 Socialization/Age-Appropriate Expectations	
L1	In keeping with Reasonable and Prudent Parenting standards, Caregiver works with others to ensure child's successful participation in communityactivities; ensures opportunities for child to form healthy, developmentally appropriate relationships with peers and other community members, and uses everyday experiences to help child learn and develop appropriate social skills. Definition: Caregiver encourages and provides opportunities for child to participate in age-appropriate peer activities at least once per week. Caregiver can give examples of the child's participation the activity. Caregiver transports* to activity if needed. Caregiver monitors negative peer interactions. Examples may include: school-based activities, sports, community-based activities, etc.
L2	Caregiver provides additional guidance to the child to enable the child's successful participation in Community and enrichment activities AND provides assistance with planning and adapting activities AND participates with child when needed. Examples include shadowing, coaching social skills, sharing specific intervention strategies with other responsible adults, etc. Definition: Caregiver's intervention and participation further ensures child's participation in the activity. The child may not be able to participate without adult support. Caregiver can give examples of the child's participation in the activity.
L3	Caregiver provides ongoing, one-to-one supervision and instruction (beyond what would be age appropriate) to ensure the child's participation in community and enrichment activities AND caregiver is required to participate in or attend most community activities with other responsible adults, etc. Definition: Caregiver must participate and fully supervise child during all community and enrichment activities. Participation in the community and enrichment activities provides a normalized child experience. Caregiver can provide examples of child's normalized involvement in the activity.
	Outline the caregiver responsibilities:

*Please detail transportation arrangements in responsibilities section. If the caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

CIRCLE ONE ONLY

LOR 6 Support/Nurturance/Well-Being	
L1	Caregiver provides nurturing and caring to build the child's self-esteem; engages the child in constructive, positive family living experiences; maintains a safe home environment with developmentally appropriate toys and activities; provides for the child's basic needs and arranges for counseling or other mental health services as needed. Definition: Caregiver meets child's established basic needs to assure well-being. Caregiver understands and responds to the child's needs specific to removal from their home. Caregiver transports* and participates in mental health services as needed.
L2	Caregiver consults with mental health professionals to implement specific strategies of interacting with the child in a therapeutic manner to promote emotional well-being, healing and understanding, and a sense of safety on a daily basis. Definition: Caregiver follows established treatment plan to ensure child's safety and well-being are addressed. Strategies and interventions are developed in accordance with the treatment plan and in consultation with case manager. Caregiver has regular contact with mental health professionals and participates in mental health services for the child. Caregiver can provide examples of therapeutic interventions and demonstrates ongoing monitoring.
L3	Caregiver works with services and programs to implement intensive child-specific in-home strategies of interacting in a therapeutic manner to promote emotional well-being, healing, and understanding, and sense of safety on a constant basis. Definition: Treatment plan requires immediate and ongoing (more than once daily) monitoring and interaction. Therapeutic strategies and interventions are developed in accordance with treatment plan and in consultation with case management staff and must be followed to ensure the child's well-being. If plan is not followed child is at risk of imminent danger. Caregiver maintains frequent contact with mental health professionals and actively participates in services and monitoring. Caregiver can provide examples of therapeutic interventions and demonstrates ongoing monitoring.
	Outline the caregiver responsibilities:

*Please detail transportation arrangements in responsibilities section. If the caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

CIRCLE ONE ONLY

LOR 7 Placement Stability	
L1	Caregiver maintains open communication with the child welfare team about the child's progress and adjustment to placement and participates in team meetings, court hearings, case plan development, respite care, and a support plan. Definition: Caregiver works to ensure placement stability. Caregiver communicates openly and regularly with case manager, provides required monthly documentation and participates in family team meetings. Caregiver must actively participate in developing a support plan to eliminate placement disruption.
L2	The child's/youth's needs require caregiver expertise that is developed through fostering experience, participation in support group and/or mentor support, and consistent relevant in-service training. Definition: Caregiver must utilize specialized knowledge, skills, and abilities to maintain child's placement. Child's needs warrant specialized knowledge, skills, and abilities. Interventions provided by caregiver must be in collaboration and consultation with other professions and case managers. Caregiver should provide examples of their specialized knowledge, skill, and abilities to ensure placement and participation in in- service training.
L3	The child's/youth's needs require daily or weekly involvement/participation by the caregiver with intensive in-home services as defined in case plan and/or treatment team. Definition: Caregiver must collaborate with external supports in order to maintain placement. These external supports provide intensive interventions within the caregiver's home, without which child could not safety be maintained. Interventions must be selected and implemented in collaboration with the case manager. Caregiver collaborates with intensive service interventions and demonstrates specialized knowledge, skills, and abilities to maintain child's placement. Caregiver provides examples of their role in the intensive in-home service provision. Caregiver may require additional training to eliminate placement disruption.
	Outline the caregiver responsibilities:

CIRCLE ONE ONLY

LOR 8 Transition To Permanency and/or Living Independently as an Adult	
L1	For all children/youth regardless of their permanency objective, Caregiver provides routine ongoing efforts to work with biological family and/or other significant adults to facilitate successful transition home or into another permanent placement. Caregiver provides routine assistance in the on-going development of the child/youth life book. Definition: Caregiver collaborates with case manager and other community resources to ensure child's/youth's permanency goal is met. Caregiver works with child/youth in ongoing development of life book in preparation for permanency. Caregiver addresses developmentally appropriate daily life skills with the child/youth to include assistance with budgeting, education, self care, housing, transportation, employment, community resources, and lifelong connections.
L2	Caregiver actively provides age-appropriate adult living preparation and life skills training for child/youth. For children/youth age 14 and above, training should be outlined in the written transition plan and determined through completion of a life skills assessment. **For children/ youth whose permanency objective is adoption or guardianship**, the caregiver (with direction from their agency and in accordance with the case plan), cooperates and works with team members, potential adoptive parents, therapists and specialists to ensure the child/youth achieves permanency. Definition: **For children 8 and above** caregiver develops and monitors daily life skills activities. For children/youth 14 and above, caregiver assists the youth in completing a life skills assessment and uses the results to inform daily activities that promote development of life skills to include assistance with budgeting, education, self care, housing, transportation, employment, accessing community resources and lifelong connections. Caregiver also supports efforts to maintain family relationships where appropriate. **For children/youth whose permanency objective is adoption or guardianship**, the caregiver regularly collaborates with team members to ensure child's permanency goals are met. If the caregiver will be providing permanency for the child, the caregiver actively participates in adoption preparation activities (examples include training, support groups, mentor support, respite care).
L3	Transition to Adulthood Focus: Caregiver supports active participation of youth age 14 or above in services to facilitate the development of life skills and the transition to living independently as an adult. Definition: Caregiver partners with life skills resources to ensure youth is prepared for transition to live independently as an adult. Caregiver provides assistance and interventions on an ongoing basis and in accordance with established transition plan to include assistance with budgeting, education, self-care, housing, transportation, employment, community resources and lifelong connections. Additionally, caregiver regularly collaborates with youth's team (i.e. caseworker, agency staff, PALS Specialist) to ensure a smooth transition out of care. Caregiver demonstrates role in preparing youth for living independently as an adult by providing concrete examples of provided intervention and youths skill acquisition.

CIRCLE ONE ONLY

	Outline the caregiver responsibilities:

Transportation: Foster Parents are responsible for the first 100 miles per month of direct transportation for foster children in their home and are eligible for reimbursement for every 50 mile increment beyond the initial 100 miles. (Title 479 2-002.03E1. Administrative Memo #1-3-14-2005)

Liability Insurance: Federal and state law mandate eligibility coverage for Foster Parents. For more information speak with your child's case worker and/or agency representative (Program Memo-Protection and Safety-.#11-201

SIGNATURES:

NAME: ______________________________

Foster Parent

DATE: ______________________________

NAME: ______________________________

Foster Parent

DATE: ______________________________

NAME: ______________________________

CFS/FPS Worker

DATE: ______________________________

NAME: ______________________________

CFS/FPS Supervisor

DATE: ______________________________

NAME: ______________________________

CPA Representative (if involved)

DATE: ______________________________

NAME: ______________________________

Other Participant

DATE: ______________________________

NCR TOOL