Service Coordination and High-Fidelity Wraparound Purpose

The purpose of Service Coordination and High-Fidelity Wraparound through the Clermont County Wraparound Program* is to provide a neutral setting for families requiring services where their needs have not been adequately addressed in traditional agency systems. Service Coordination and High-Fidelity Wraparound are collaborative, coordinated, cross-system team-based planning processes implemented to address the needs of youth and families where those needs are multiple and complex. These processes build upon the strengths of services in the community that are currently working for families, and when needed, propose new services, supports, and/or strategies to be added to address unmet needs.

The following is a list of values that are integral to the Service Coordination and High-Fidelity Wraparound process, resulting in a more effective service delivery system:

- Services are delivered using a family-centered approach.
- Services are responsive to the cultural, racial, and ethnic characteristics of the population being served.
- Service outcomes are evaluated.
- Available funding resources are fully utilized or integrated.
- Home and community supports are utilized as needed.
- Specialized treatment for difficult-to-serve populations and evidence-based treatments are encouraged.
- Duplicative or competing efforts among agencies are reduced or eliminated.
- Most importantly, families and youth are fully involved in decision-making and are offered a referral for family advocacy and support options.

Eligibility Criteria

Any child, youth or young adult, age birth to 21, who has multi-systemic needs and whose needs have not been adequately addressed in traditional agency systems are eligible for the Clermont County Wraparound Program. Multi-systemic needs include the following:

- Developmental Disabilities
- Child Neglect
- Drug and/or Alcohol
- Delinquent Charges
- Special Education
- Mental Health
- Unruly Charges
- Physical Health
- Poverty
- Truancy
- Child Abuse

CLARIFICATION FOR SPECIFIC POPULATIONS

As stated above any youth, age birth to 21, with multi-systemic needs is eligible for services. This also includes youth who are involved with the following agency systems:

- ***Children's Protective Services (CPS) (Youth in Custody or CPS Family Involvement)*** - The Clermont County Wraparound Program can be accessed for any youth with needs across multiple systems, including those youth whose families are involved with Children's

Protective Services. Services may be provided to youth in out of home placement in an effort to expedite reunification with family.

- ***Juvenile Justice System –*** The Clermont County Wraparound Program is available for any youth that is suspected or adjudicated unruly or delinquent, or considered to be truant, and presents needs across multiple systems.
- ***Early Intervention Service Coordination –*** If a child is being served by the Clermont County Wraparound Program and a referral is made to Early Intervention Service Coordination, upon determination of eligibility, the lead provider of service will be Early Intervention Service Coordination. For these children, the Clermont County Wraparound Program will support and assist the Early Intervention Service Coordination team as needed. Also, the Clermont County Program Supervisor and Early Intervention Service Coordination Supervisor will meet as needed to discuss collaboration efforts concerning children who will be aging out of Early Intervention Service Coordination on their third birthday. The purpose of these meetings will be to ease the transition of lead service agency from Early Intervention Service Coordination to the Clermont County Wraparound Program for those families who will need additional services and supports moving forward.

Access to Wraparound Program

Referrals for the Clermont County Wraparound Program may come from any agency serving a Clermont County family who has a child, youth or young adult, age birth to 21, in their home; or is working with a youth, age 21 or younger, who is living independently. Referrals can also come from local community agencies (i.e. churches, Big Brothers Big Sisters, food pantries, etc.) or a family can self-refer. Referrals for Clermont County youth in an out of home placement will be considered when the goal is family reunification.

Referral forms (Attachment 1) are located on the Clermont County Family & Children First (FCF) website *www.clermontfcf.org* and can be faxed to the Clermont County Wraparound Program at *513-732-7491* or emailed to *agulley@pressleyridge.org.* Referrals can also be taken over the phone by contacting the Clermont County Wraparound Program at *513-498-4195.*

All referrals will be contacted within 1 business day of being received. Both the family and the referral source will receive notification from the Clermont County Wraparound Program that the referral has been processed, and, if applicable, who is the assigned Care Coordinator. Once a family has been assigned to a Coordinator's caseload, the Coordinator will contact the family within 2 business days to set up a face-to-face meeting in order to complete appropriate forms, begin gathering the family's story, and discuss next steps. A follow-up face to face meeting will be scheduled with the family within 7 days of the initial meeting to begin implementing the appropriate level of coordination.

Levels of Care Coordination and Assessments

The Clermont County Wraparound Program provides various levels of care coordination within the Wraparound Program. Level of care coordination provided to a family will be determined by the *Ohio Comprehensive Child and Adolescent Needs and Strengths* (CANS) assessment# (Attachment 2) (http://praedfoundation.org). This tool will be utilized by a trained Care Coordinator within 7 days after the initial face to face with the family, unless the assessment has recently been completed by an outside agency. It is the goal of Clermont County Wraparound Program to always offer families the most appropriate, least intensive level of care coordination first; then, work up to more intensive levels of care coordination and interventions as needed.

The levels of care coordination provided to families include:

- ***Information and Referral***
- ***Service Coordination***
- ***High-Fidelity Wraparound***

The Ohio Comprehensive CANS will be conducted every 90 days or if a significant change occurs to continually evaluate and modify the most appropriate level of service being provided. Also, the Ohio Comprehensive CANS will be used to assist in tracking outcome measures, such as an increase in Child's Strengths and a decrease in Child Behavioral/ Emotional Needs, for families involved in the Clermont County Wraparound Program.

#Level of care coordination determination by the Ohio CANS can be overturned if other external factors surrounding the family lead assigned Care Coordinator and Program Supervisor to believe another level of care coordination is more appropriate. Justification for decision will be documented in agency's electronic health record.

Information and Referral

Information and Referral will be offered to families who meet the recommendation for Information and Referral based on the CANS Decision Support Model (Attachment 3) for care coordination. This level of care coordination will include a referral (if desired) to a Parent Peer Support Partner (PSP), as well as information and referrals to various other community resources that are available to help meet the needs discussed during the Coordinator's initial face to face meeting with a family. In addition, the Coordinator will offer "follow-up" contacts for the proceeding 90 days to offer additional supports and help determine if the information and referrals are meeting the family's needs. At the end of 90 days, another CANS assessment will take place to conclude if the level of coordination needs to be moved to Service Coordination, or if the family is ready to be discharged from the program. At any point during the process a family can be discharged from the program upon request.

Service Coordination

Service Coordination will be offered to families who meet the recommendation for Service Coordination based on the CANS Decision Support Model for care coordination. Service Coordination is a broad-based, neutrally positioned, youth and family-driven, cross-system (team) planning process by which previously identified and existing resources and supports are

coordinated to determine the least restrictive plan of success for youth with complex needs. During the Service Coordination process, a trained Coordinator will work with the team, which will include the family and service providers and school personnel, to create a plan that focuses on the following areas in order to help foster success for a youth and family:

1. Formatting the *alignment* of services provided.
2. Ordering the *sequence* of services provided.
3. Eliminating the *duplication* of services provided.
4. Monitoring the *depth/intensity* of services provided.

In addition to team facilitation, families will be offered a referral for a PSP, follow-up phone calls and contact from their assigned Coordinator, and face to face meetings as needed. Also, as deemed appropriate, families may be eligible to access FCF Pooled Funds, Family Centered Services & Support Funds, and Multi-System Youth Funds (Attachments 4, 5 and 6).

High Fidelity Wraparound

High Fidelity Wraparound will be offered to families who meet the recommendation for High Fidelity Wraparound based on the CANS Decision Support Model for care coordination. High Fidelity Wraparound is a specific evidence-supported intensive planning and facilitation process, utilizing a comprehensive team to develop a uniquely designed helping plan based on the youth and family's unmet needs, and is inclusive of uniquely designed resources linked to youth and family strengths. During the High-Fidelity Wraparound process, a trained Coordinator will work with a team, which will include the family, extended family and friends, community supports, school personnel and formal services, to create a plan that will meet a family's unmet needs. The goal of this process is to:

1. Change the way people look at the family.
2. Change the way people look at the problem.
3. Change what help may look like for the family.

The purpose of High-Fidelity Wraparound is not the elimination or ending of formal supports and services, but rather the increased capacity of a family and those around them to get their needs met without the reliance on an on-going intensive team-based planning and adaptation process.

In addition to team facilitation, families will be offered a referral for a PSP, follow-up phone calls and contact from their assigned Coordinator, and face to face meetings as needed. Also, as deemed appropriate, families may be eligible to access FCF Pooled Funds, Family Centered Services & Support Funds, and Multi-System Youth Funds (Attachments 4, 5 and 6).

On-Going Family Team Meetings

Families who are receiving Service Coordination or High-Fidelity Wraparound will work with their assigned Coordinator in the development of their child and family team (CFT). CFTs are a group of individuals (who the family approves of) that work with the Care Coordinator and the

family in creating and implementing a plan to meet the family's needs. CFTs can include paid professionals, community members, Parent Peer Support Partners, parent advocates, school personnel, extended family members, friends, or any individual that a family would like to participate (with guardian consent if the parent is not the guardian).

Potential CFT members will be invited to participate in the Service Coordination or High-Fidelity Wraparound process by the assigned Coordinator. The Coordinator will prepare both team members and the family for the initial team meeting, which will be scheduled within 30 calendar days from the initial face to face meeting with the family.

The intent of CFT meetings is the creation and monitoring of a family's individualized Child and Family Centered Plan of Care (POC) (Attachment 7). During team meetings, a trained Coordinator will lead the CFT in an appropriate discussion that coincides with the level of care being provided. After an initial family team meeting, on-going family team meetings will be used to monitor and update the POC.

On-going CFT meetings will take place every 1 to 8 weeks (at least monthly is preferred) depending on the level of care, needs of the family and scheduling preferences of the family and team members. The Care Coordinator will send reminders for all upcoming CFT meetings to team members, via email or phone, no later than 2 business days before the meeting is to take place. Also, the Coordinator will work with the family to add new team members, as needed, throughout the process. Finally, all notes from CFT meetings will be sent out via email to all team members within 3 business days of a meeting.

At any point families can request additional or emergency team meetings by contacting their assigned Care Coordinator.

Family Team Meetings for Youth at Risk of Out-of-Home Placement

At any point in time, a service agency, community agency, or family can request an emergency meeting for a youth is who is at risk of out-of-home placement. This also includes youth who are not enrolled in the Clermont County Wraparound Program. These meetings will be facilitated by either the Program Supervisor or Clermont County FCF Program Director, for the purpose of exploring whether all less restrictive options have been exhausted within Clermont County and the surrounding areas.

The intent of the Clermont County Wraparound Program is to safely maintain youth in their family homes and communities. The Clermont County Wraparound Program and its staff do not recommend out of home placement for youth. The decision to place a youth outside of their home is typically the decision of Clermont County Children's Protective Services or Juvenile Court. Additionally, Multi-System Youth funds may be an option when custody relinquishment is being considered in order to meet the youth's needs (Attachment 6). If the decision is made for a youth to be placed in an out-of-home placement through Children's Protective Services or Juvenile Court, a Care Coordinator can be assigned to the family and team, if desired, to begin planning for community supports for the family during placement and for the child's return to

the community. Youth/families receiving Multi-System Youth funding must be actively engaged in Service Coordination or High-Fidelity Wraparound.

If an emergency placement is made for a youth who is enrolled in the Clermont County Wraparound Program, the assigned Coordinator will work with the family and team to schedule an emergency CFT meeting within 10 business days of the placement. The intent of this meeting will be to plan for community supports for the family and to begin planning for the child's return to the community.

Any recommendations and plans developed by the Clermont County Wraparound Program will not override decisions and policies of Juvenile Court, Children's Protective Services or Board of Developmental Disabilities (BDD).

Discharge from Program

The goal of the Clermont County Wraparound Program is to help families move from crisis to stable, and to help the families and the community develop skills to maintain stability for the long-term. Stability is determined by the following factors:

1. **Ohio CANS Assessments** – Every 90 days, or if a significant change occurs, the assigned Coordinator will complete a new Ohio Comprehensive CANS for each family enrolled in the program. Progress documented by the Ohio CANS will be used to help determine whether a family has reached stable functioning.
2. **Child and Family Centered Plan of Care (POC)** – Each family involved in either Service Coordination or High-Fidelity Wraparound will have a POC that will focus on helping the family accomplish goals and/or meeting unmet needs. Outcome measures will be included in every POC to help determine when goals and needs are met. Results of outcome measures documented in the POC will be used to help determine whether a family has reached stable functioning.
3. **Family and/or Team Self-Report –** A family or entire CFT can report at any time to the assigned Care Coordinator that they believe they have reached stable functioning.

All these factors will be taken into consideration if/when the Coordinator begins having a conversation with the family and team about preparing for the next level of care after the Clermont County Wraparound Program. If appropriate, the Coordinator will work with the family and team to plan around future hopes and concerns they may have. Also, the Coordinator will work to create a set of documents that summarizes the progress made while participating in the Clermont County Wraparound Program such as, all Plans of Care, lists of future resources, self-care tools and letters of introduction that families can present to future care-providers.

Families who have been discharged from the Clermont County Wraparound Program will be documented in an Electronic Health Record (EHR) (the Wraparound database) as being discharged for one of following reasons:

- Completed Plan
- Family terminated services
- Transition to adult services
- Youth enrolled in OhioRISE
- Custody Relinquishment
- Family unable to be located
- Not participating in plan
- Youth has moved
- Youth in IV-E agency custody
- Youth in placement

The Clermont County Wraparound Program is voluntary, so at any point while enrolled, a family can request to be discharged from the program.

Crisis Planning and Safety Programming

The Clermont County Wraparound Program will look at crisis planning and safety programming (Attachment 8) for families as components to a Family and Child Centered Plan of Care.

Crisis Planning

The purpose of crisis planning is to help families and teams better manage single events that can be anticipated and are unpleasant. Potential crisis will be continually discussed with the families and teams; and appropriate crisis plans will be documented.

The assigned Care Coordinator will work with the family and team in the development of a plan that is both proactive and reactive. The Coordinator will work with the team on practicing the crisis plan to test its validity. In the event of an actual crisis where a crisis plan is implemented, the Coordinator will call a family team meeting to discuss the effectiveness of the plan and restructure it as needed.

Safety Programming

The purpose of safety programming is to help reduce the overall likelihood and impact of risk events in families' lives. If appropriate, the Coordinator will lead the CFT in a conversation that focuses on increasing protective factors in the family's life and not on managing or containing behaviors.

The protective factors that will be focused on are:

1. **Community Building –** Discover who cares about the youth and family and find ways for those individuals to become involved in their lives.
2. **Confidence Building –** Discuss who was harmed and how to address it.
3. **Capacity Building –** Decide what skills need to be developed amongst the family, team, and community.
4. **Context Building –** Determine what could have been done differently.

Conversations and planning around these factors will be interwoven throughout CFT meetings and will be included in a family's POC.

Program Monitoring

Quality, consistency, and fidelity of the program will be monitored by the Program Supervisor. Individual supervision will be held for each Coordinator on a regular basis, with group supervision taking place once a month. Shadowing of family team meetings and other activities will also take place on a regular basis. The Program Supervisor will review families' POC, Ohio CANS assessments, and families' team meeting notes to determine whether a Coordinator is delivering consistent, high quality service to all families on his/her case load.

In addition, all activity of Care Coordinators will be documented in the approved data system within 2 business days of the activity taking place. Documented activities will include, but not be limited to, the following:

- Child and Family Team Meetings
- In person or virtual meetings with families
- In person or virtual meetings CFT members
- Email or phone communication with families
- Email or phone communication with CFT members
- Completion of assessments
- Development and documentation of crisis plans
- Preparation for CFT meetings
- Development of CFT meeting notes
- Research and referral for services for families
- Development and monitoring of families' safety plans

Reports to Family and Children First Council

All families enrolled in the Clermont County Wraparound Program will be subject to data collection while enrolled. Data will be collected through the EHR data system, satisfaction surveys (Attachment 9), Ohio CANS, and parent self-report. This de-identified information will be shared with the Clermont County Family and Children First Council, and various other system partners, on a regular basis. De-identified information will be shared with Ohio Family & Children First and other State agencies as required. Data reported will include:

- **Process Outcomes –** Number of new referrals and referral sources, total number of families served, number of families discharged from program and reason for discharge, average length of enrollment, etc.
- **Demographics –** average age of youth served, gender, race, and ethnicity, TANF eligibility, local school district, special education, etc.
- **Needs Assessed and Services Accessed –** Needs present at intake and services accessed while enrolled
- **Family Self-Report –** results of satisfaction surveys at end of enrollment, summaries of success stories, etc.

Information collected and reported to the Clermont County Family and Children First Council will be used to inform the Council of possible "gaps" in county services, provide information on reoccurring or new needs arising in the community, and offer Council possible strategies to help fill service gaps and meet the community's needs. This information will also be used to inform the decision-making process and collaboration efforts outside of Council.

Monitoring of Out-of-Home Placements

As requested, youth who are in out-of-home placements through Juvenile Court, Children's Protective Services or Board of Developmental Disabilities will be reviewed by the Clermont County FCF Program Director. The purpose of these reviews is to work with the assigned Probation Officer, Caseworker or Service and Support Administrator, and their Supervisors and Directors to monitor the progress of residential treatment and work on developing strategies to help transition a youth back into the community as soon as possible.

All youth/families receiving Multi-System Youth funding, including funds for short term out-of-home placement, will be monitored by the Clermont County Wraparound Program. Youth/families receiving Multi-System Youth Funds must be actively engaged in Service Coordination or High-Fidelity Wraparound (Attachment 6).

Confidentiality

All information gathered by the Clermont County Wraparound Program pertaining to enrolled families is confidential and all communication will be compliant with HIPAA laws and policies. All families will be required to complete a Release of Information (Attachment 10, 11) form during their initial face to face meeting with their assigned Care Coordinator. The Coordinator will use the Release of Information to guide their communication with team members and service providers while the family is enrolled in the program. Also, all CFT meetings will begin with a sign-in sheet (Attachment 12) that prohibits a team member in attendance from sharing confidential information outside of team meetings unless they have an appropriate Release of Information from the family.

If needed, families can give written consent, via email, to allow a Coordinator to release personal information to possible team members and other service agencies. This written consent will be uploaded into the EHR. It will be the responsibility of the Coordinator to update the Release of Information at the following face to face meeting with the family.

Dispute Resolution

Please see Attachment 13, 14.

Community Awareness

Clermont County FCF makes every effort to ensure that the community is aware of FCF, the Clermont County Wraparound Program, and the services and supports available to children and their families.

- FCF hosts and participates in various county events, such as mobile food pantries and community events.
- FCF maintains a website listing local resources, Council information, and details regarding the referral process.
- FCF has developed a local resource flyer and school directory for assistance in locating appropriate resources/services. The directories are available on the FCF website and are provided at any time upon the request of a family.
- FCF does presentations to mental health specialists, superintendents, Children's Protective Services, BDD and Juvenile Court staff to inform them of FCF, the Wraparound Program, and services/supports available, as well as providing trainings to staff regarding changes or updates to the service coordination mechanism.
- FCF participates in various meetings to inform the community and agencies of FCF, Wraparound, and services/supports available. Examples are the Coalition for a Drug Free Clermont County, Coalition for Activity & Nutrition and the Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) Committee.
- The Service Coordination Mechanism is available on the FCF website and is provided in hard copy form at any time upon families' requests.

*The Clermont County Wraparound Program is provided by Pressley Ridge through a contract with Clermont County Family & Children First.

ATTACHMENT ONE

Clermont County Wraparound Referral Packet

Date: _____

Identified Youth's Name	Date of Birth	Adopted Y or N	School	Grade	Ethnicity/ Race	Gender

Education Placement (Check One)	☐ Regular School ☐ Home Instruction ☐ PH ☐ Alternative School ☐ Home Schooled ☐ Hearing Impaired ☐ Dropped Out School ID # _____
Referred By:	**Agency:**
Email:	**Phone:**

Does youth have Medicaid? ☐ Yes ☐ No
Medicaid Number _____ **Social Security Number (if known):** _____

Service Requested (leave blank if uncertain): ☐ High Fidelity Wraparound ☐ Service Coordination ☐ Information and Referral

Parties Involved:
☐ Board of Developmental Disabilities ☐ Children's Protective Services
☐ Juvenile Court ☐ Job and Family Services
☐ Mental Health Services ☐ Addiction Services
☐ School ☐ Physician/Hospital
☐ Early Intervention Service Coordination/Help Me Grow
☐ Other _____

Is the youth on an IEP? ☐ Yes ☐ No Preferred Language: _____

Guardian Name:	Guardian Name:
Relation: Marital Status: Date of Birth:	Relation: Marital Status: Date of Birth:
Address:	Address:
City: State:	City: State:
Zip: Home Phone:( )	Zip: Home Phone:( )
Employer:	Employer:
Work Phone:( ) Cell:( )	Work Phone:( ) Cell:( )
Email:	Email:

Is youth currently out of the home (hospital, detention, treatment facility)? ☐ Yes ☐ No If yes, complete the following:

Placement:	Contact:
Address:	Phone: ( )
City: State: Zip:	Email:

Other household members:	DOB	Relationship	Adopted Y or N	School	Grade

Current Personal or Community Supports and Service Providers

(Juvenile Court, Dev. Disabilities, School, Mental Health, Children's Services, Church, Family, Friends, Scouts, etc.)

NAME	AGENCY/ORGANIZATION (if applicable)	ROLE-RELATIONSHIP	PHONE (ext)	EMAIL ADDRESS

Mental Health Diagnosis: _____

Current Medications: _____

Prescribed by: Dr._____

Primary Physician's Name: _____

Check if History of Abuse: ☐ Physical ☐ Sexual ☐ Neglect ☐ Victimization

Reports of sexual and/or abuse of the youth, **past or present.** (Professional must follow duty to report mandate if this event has not already been reported)

Which if any of the following systems has your child been involved with in the past 12 months?

Could you briefly explain their involvement?

☐ JFS/Children's Services _____

☐ Mental Health Treatment _____

☐ Substance Use Treatment _____

☐ Developmental Disabilities _____

☐ Health Care _____

☐ Special and/or Alt. Education _____

☐ Juvenile Ct/Law Enforcement _____

Check if the court has found the youth: ☐ Unruly ☐ Delinquent (criminal offense if an adult)

Presenting Risks that occurred in the PAST 30 DAYS.

Behavior:

- ❑ Suicidal Ideation: Youth **states, talks, or thinks** about **hurting or killing self**.
- ❑ Suicidal Gestures: Youth engages in **non-life threatening behavior**, concurrent **with thoughts and/or talk about suicide**.
- ❑ Suicide Attempt: Serious **life threatening attempt with clear intent and desire to commit suicide**. (attempted hanging; potentially lethal overdose; involvement of a gun)
- ❑ Self-Injurious Behaviors: Self-harming behaviors that are not life threatening and may be of a chronic nature such as: **cutting, head banging, ingestion or insertion of objects**.
- ❑ Violent Behaviors: Behaviors that cause **serious harm,** injury, or damage to people, property or animals. Example: **domestic violence, animal torture**, extensive property damage **with intent to harm**.
- ❑ Aggressive Behaviors (Towards people or animals etc): Youth demonstrates behaviors that are potentially **dangerous or harmful to people or animals, without serious damage**. Examples: Bullying, pushing.
- ❑ Verbal or Written Threats to Others: Youth states or writes threats of harm toward people, places, or things.
- ❑ Availability of Weapons: Youth has access to obtaining weapons through self, family, friends, or neighbors.
- ❑ Impulsive Behaviors: Youth exhibits behaviors without thought or planning that are potentially **dangerous or harmful to self or others**.
- ❑ Limited Ability to Control Anger: Youth demonstrates difficulty in managing emotions with limited abilities in controlling or managing his or her anger.
- ❑ Runaway: History or recent episodes of youth being absent from home without the permission or the caregiver's knowledge of the youth's whereabouts.
- ❑ Negative peer involvement or gang activity: Peer or gang involvement that results in negative behaviors by the youth.
- ❑ Chargeable Sex Offense: Youth has admitted to or has been charged with a sexual offense, or is part of a current sexual offense investigation.
- ❑ Prejudicial thinking: Youth identifies or espouses hate group thinking or philosophy. Evidence of prejudicial thinking or views **pose a potential risk to others or property**.
- ❑ Known/Suspected Criminal Activity: Youth is suspected of, or admitted to, being **involved in activities that are chargeable offenses**; has current pending court charges for criminal behavior(s); or the youth has been found "guilty" of criminal charges.
- ❑ High Risk Sexual Behavior: Youth has a recent or current history of sexually active behaviors **without regard for personal safety** or negative outcomes.
- ❑ Youth uses drugs or alcohol: Youth admits to use of alcohol or drugs, or drug screen for youth tests positive.
- ❑ Anorexia or Bulimia: Youth exhibits or is known to have clear patterns of bingeing/purging or abnormal amounts of limiting food intake with significant weight loss which concerns the parent or caregiver.
- ❑ Anxiety: Youth has **intense anxiety**, avoidance, obsessions, compulsions, fearfulness or persistent and excessive worry.
- ❑ Fire Setting Behaviors: Fascination with fire, play with matches or objects that have the potential to **set fire and harm self or others**. Previous reports of fire setting or a pattern of concerns related to fire.

Family/Caregiver/Environmental

- ❑ Caregiver with chronic/acute mental illness, developmental delay, or mental retardation: Caregiver has significant mental illness, developmental disability, or mental retardation where the **disability compromises or limits his or her ability to care for the needs of youth** and family. Caregiver's disability may limit their ability to monitor and supervise the youth.

- ❑ Caregiver with Drug or Alcohol Problem: Caregiver has a substance abuse problem which **compromises or limits his or her ability to care for the needs of youth** and family. Such use may limit their ability to monitor and supervise the youth.

- ❑ Caregiver with severe chronic illness: Caregiver has significant chronic illness that is debilitating and **limits his or her ability to care for the needs of youth** and family. Caregiver's illness may limit their ability to monitor and supervise the youth.

- ❑ Resides in high crime neighborhood: Youth and/or caretaker report that neighborhood crime/violence is at a level that is a potential safety issue for the youth and family. Normal **daily activity and functioning is limited because of these safety concerns**.

- ❑ Unrestricted internet access: Evidence of access and/or exposure to internet sites **that pose a risk or danger to the youth**; online interactions without sufficient monitoring or computer safeguards; and/or unlimited access to internet usage.

- ❑ Lack of caregiver supervision or behaviors that overwhelm caregiver resources: Insufficient adult monitoring and supervision, given the youth's age and/or disability, and without regard for safety or negative outcomes or such severe behavior **caregiver cannot adequately address safety of youth**.

- ❑ Current Placement Suspected Child Abuse: Abuse is suspected or alleged by current caregiver/guardian, which places the child at imminent risk or danger.

- ❑ Acute Family Crisis: Family is experiencing a crisis, family defined, that **restricts or limits their resources or abilities to care for or supervise youth's safety or behaviors**.

- ❑ Family Conflict: Verbal or physical family disagreements that pose a real or potential risk or **safety concern to the youth and/or family**.

- ❑ Poverty, Youth's Lack of Stable Residence/Homelessness: Youth does not have consistent ongoing housing, which may lead to additional instability and safety concerns or caregiver lacks resources to meet basic needs of youth.

Emotional Disturbances

- ❑ Limited Developmental Capacity to Maintain Personal Safety: Youth's personal safety is at risk due to his or her inability to maintain personal safety and care for self independently.

- ❑ Severe social impairment: Youth has significant social interaction problems or misperceives social situations and **youth's behavior causes safety issues for self or others,** and/or youth has strong reaction to their environment or sensory input that **interferes with normal functioning**.

- ❑ Mood difficulties: Youth or parents state that the youth appears to be **depressed**, withdrawn, and/or shows marked diminished interest or pleasure in activities and/or period of **abnormally and persistently elevated or irritable mood**.

- ❑ Hears voices or sees things: Youth states hearing voices or seeing things that are not based in reality.

School

- ❑ Suspended, Expelled, or Dropped Out of School: Youth has **multiple suspensions from school that places him or her at risk of expulsion**, is expelled from school, or has dropped out of school.

- ❑ Held Back/Behind in Grade: Youth has been retained one or more years in school.
- ❑ Truancy: Admitted or reported failure to attend school on a regular basis, which may result in legal action.
- ❑ Emotional or Educational Disabilities: Youth has been assessed to have a **serious emotional, developmental, and/or learning disability,** which may cause functional impairment or limit daily activities, or educational progress.

*Adapted from Stark County Family Council *Community Wraparound*

Child's Strengths: _____

_____

Barriers to Treatment: _____

_____

What is the goal of this referral? What would you like to accomplish?

_____

_____

For FCF office use only

☐ Accepted ☐ Declined

Assigned to: _____

ATTACHMENT TWO

Ohio GOVERNOR'S CHILDREN'S INITIATIVE

OH Comprehensive Child and Adolescent Needs and Strengths • Rating Sheet

Date:	
Type: ☐ Initial ☐ Scheduled Update ☐ Major Life Event ☐ Exit	

Assessor ID:	Program:
Client Name:	Client ID: DOB
Gender: Ethnicity:	Grade: Zip Code:

Please Check All that Apply:

☐ There is no possible community living arrangement for the youth that is willing and able to support the intensive community treatment (e.g., wraparound) for the youth given their current needs.

☐ Youth was unsuccessful in intensive community treatment.

☐ Youth is in custody of, or on parole with, the Department of Youth Services.

For the **Strengths**, use the following categories and action levels:

0 – Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan

1 – Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength

2 – Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.

3 – An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

STRENGTHS DOMAIN (Ages 6+)

Items	N/A	0	1	2	3		0	1	2	3
Family Strengths		☐	☐	☐	☐	Community Life	☐	☐	☐	☐
Interpersonal		☐	☐	☐	☐	Relationship Permanence	☐	☐	☐	☐
Optimism		☐	☐	☐	☐	Resilience	☐	☐	☐	☐
Educational Setting	☐	☐	☐	☐	☐	Resourcefulness	☐	☐	☐	☐
Vocational	☐	☐	☐	☐	☐	Cultural Identity	☐	☐	☐	☐
Talents and Interests		☐	☐	☐	☐	Natural Supports	☐	☐	☐	☐
Spiritual/Religious		☐	☐	☐	☐	Youth Involvement in Care	☐	☐	☐	☐

Please write a rationale for Centerpiece ('0') and Useful ('1') Strengths, as well as Strengths to Build ('2' or '3').

For the **Needs Domains**, use the following categories and action levels:

0 – No evidence of any needs; no need for action.
1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
2 – Action is required to ensure that the identified need is addressed; need is interfering with functioning.
3 – Need is dangerous or disabling; requires immediate and/or intensive action.

LIFE FUNCTIONING DOMAIN (Ages 6+)

Items	0	1	2	3	Items	0	1	2	3
Family Functioning	☐	☐	☐	☐	Sexual Development	☐	☐	☐	☐
Living Situation	☐	☐	☐	☐	Sleep	☐	☐	☐	☐
Social Functioning	☐	☐	☐	☐	School Attendance	☐	☐	☐	☐
Recreational	☐	☐	☐	☐	School Behavior	☐	☐	☐	☐
Developmental/Intellectual (A)	☐	☐	☐	☐	School Achievement	☐	☐	☐	☐
Legal	☐	☐	☐	☐	Decision Making	☐	☐	☐	☐
Medical/Physical	☐	☐	☐	☐	Basic Activities of Daily Living	☐	☐	☐	☐

A. DEVELOPMENTAL NEEDS MODULE *(To complete when the Developmental/Intellectual item is rated '1', '2' or '3'.)*

Cognitive	☐	☐	☐	☐	*Sensory*	☐	☐	☐	☐
Developmental	☐	☐	☐	☐	*Motor*	☐	☐	☐	☐
Communication	☐	☐	☐	☐					

Please write a rationale for any item in the Life Functioning Domain and related modules rated actionable ('2' or '3').

BEHAVIORAL/EMOTIONAL NEEDS DOMAIN (Ages 6+)

Items	0	1	2	3	Items	0	1	2	3
Psychosis (Thought Disorder)	☐	☐	☐	☐	Anger Control	☐	☐	☐	☐
Impulsivity/Hyperactivity	☐	☐	☐	☐	*Substance Use (C)*	☐	☐	☐	☐
Attention/Concentration	☐	☐	☐	☐	*Autism Spectrum (D)*	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Eating Disturbances	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Attachment Difficulties	☐	☐	☐	☐
Oppositional Behavior	☐	☐	☐	☐	Behavioral Regressions	☐	☐	☐	☐
Conduct (Antisocial Behavior)	☐	☐	☐	☐	Somatization	☐	☐	☐	☐
Adjustment to Trauma (B)	☐	☐	☐	☐					

B. TRAUMATIC STRESS SYMPTOMS MODULE *(To complete when the Adjustment to Trauma item is rated '1', '2' or '3'.)*

Emotional and/or Phys. Dysregulation	☐	☐	☐	☐	*Avoidance*	☐	☐	☐	☐
Intrusions / Re-experiencing	☐	☐	☐	☐	*Numbing*	☐	☐	☐	☐
Traumatic Grief & Separation	☐	☐	☐	☐	*Dissociation*	☐	☐	☐	☐
Hyperarousal	☐	☐	☐	☐					

C. SUBSTANCE USE DISORDER MODULE *(To complete when the Substance Use item is rated '1', '2' or '3'.)*

Severity of Use	☐	☐	☐	☐	*Recovery Support in Community*	☐	☐	☐	☐
Duration of Use	☐	☐	☐	☐	*Acute Intoxication*	☐	☐	☐	☐
Stage of Recovery	☐	☐	☐	☐	*Withdrawal History*	☐	☐	☐	☐
Peer Influences	☐	☐	☐	☐	*Withdrawal Risks*	☐	☐	☐	☐
Parental/CG Influences	☐	☐	☐	☐	*Awareness of Relapse Triggers*	☐	☐	☐	☐
Environmental Influences	☐	☐	☐	☐					

D. AUTISM SPECTRUM MODULE *(To complete when the Autism Spectrum item is rated '1', '2' or '3'.)*

Regulatory: Body Ctrl/Emotional Ctrl	☐	☐	☐	☐	*Restricted Interests*	☐	☐	☐	☐
Repetitive Behaviors	☐	☐	☐	☐	*Sensory Responsiveness*	☐	☐	☐	☐

Please write a rationale for any item in the Behavioral/Emotional Needs Domain and related modules rated actionable ('2' or '3').

RISK BEHAVIORS DOMAIN (Ages 6+)

Items	0	1	2	3		0	1	2	3
Suicide Risk	☐	☐	☐	☐	*Runaway (G)*	☐	☐	☐	☐
Non-Suicidal Self-Injurious Behavior	☐	☐	☐	☐	Intentional Misbehavior	☐	☐	☐	☐
Other Self-Harm (Recklessness)	☐	☐	☐	☐	*Fire Setting (H)*	☐	☐	☐	☐
Danger to Others (E)	☐	☐	☐	☐	*Victimization/Exploitation (I)*	☐	☐	☐	☐
Delinquent Behavior (F)	☐	☐	☐	☐	*Sexually Problematic Behavior (J)*	☐	☐	☐	☐

E. DANGEROUSNESS/VIOLENCE MODULE *(To complete when the Danger to Others item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
Historical Risk Factors									
History of Violence	☐	☐	☐	☐	*Violent Thinking*	☐	☐	☐	☐
Emotional/Behavioral Risks					*Resiliency Factors*				
Frustration Management	☐	☐	☐	☐	*Aware of Violence Potential*	☐	☐	☐	☐
Hostility	☐	☐	☐	☐	*Response to Consequences*	☐	☐	☐	☐
Paranoid Thinking	☐	☐	☐	☐	*Commitment to Self-Control*	☐	☐	☐	☐
Secondary Gains from Anger	☐	☐	☐	☐	*Treatment Involvement*	☐	☐	☐	☐

F. JUVENILE JUSTICE MODULE *(To complete when the Delinquent Behavior item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
History	☐	☐	☐	☐	*Peer Influences*	☐	☐	☐	☐
Seriousness	☐	☐	☐	☐	*Parental Criminal Behavior*	☐	☐	☐	☐
Planning	☐	☐	☐	☐	*Environmental Influences*	☐	☐	☐	☐
Community Safety	☐	☐	☐	☐	*Legal Compliance*	☐	☐	☐	☐

G. RUNAWAY MODULE *(To complete when the Runaway item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
Frequency of Running	☐	☐	☐	☐	*Likelihood of Return on Own*	☐	☐	☐	☐
Consistency of Destination	☐	☐	☐	☐	*Involvement with Others*	☐	☐	☐	☐
Safety of Destination	☐	☐	☐	☐	*Realistic Expectations*	☐	☐	☐	☐
Involvement in Illegal Activities	☐	☐	☐	☐	*Planning*	☐	☐	☐	☐

H. FIRE SETTING MODULE *(To complete when the Fire Setting item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
History	☐	☐	☐	☐	*Community Safety*	☐	☐	☐	☐
Seriousness	☐	☐	☐	☐	*Response to Accusation*	☐	☐	☐	☐
Planning	☐	☐	☐	☐	*Remorse*	☐	☐	☐	☐
Use of Accelerants	☐	☐	☐	☐	*Likelihood of Future Fire Setting*	☐	☐	☐	☐
Intention to Harm	☐	☐	☐	☐					

I. COMMERCIALLY SEXUALLY EXPLOITED MODULE *(To complete when the Victimization/Exploitation item is rated '1', '2' or '3 for youth identified as sexually exploited'.)*

Items	0	1	2	3		0	1	2	3
Duration of Exploitation	☐	☐	☐	☐	*Exploitation of Others*	☐	☐	☐	☐
Age of Onset - Exploitation	☐	☐	☐	☐	*Reproductive Health*	☐	☐	☐	☐
Perception of Dangerousness	☐	☐	☐	☐	*Arrests for Loitering/Solicitation*	☐	☐	☐	☐
Knowledge of Exploitation	☐	☐	☐	☐	*Exploitation History*	☐	☐	☐	☐
Trauma Bond	☐	☐	☐	☐					

J. SEXUALLY PROBLEMATIC BEHAVIOR MODULE *(To complete when the Sexually Problematic Behavior item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
Hypersexuality	☐	☐	☐	☐	*Sexually Reactive Behavior*	☐	☐	☐	☐
High Risk Sexual Behavior	☐	☐	☐	☐	*Sexual Aggression*	☐	☐	☐	☐
Masturbation	☐	☐	☐	☐					

J1. SEXUALLY AGGRESSIVE BEHAVIOR MODULE *(To complete when the Sexual Aggression item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
Physical Force/Threat	☐	☐	☐	☐	*Type of Sex Act*	☐	☐	☐	☐
Planning	☐	☐	☐	☐	*Response to Accusation*	☐	☐	☐	☐
Age Differential	☐	☐	☐	☐	*Temporal Consistency*	☐	☐	☐	☐
Relationship	☐	☐	☐	☐	*History of Sexually Aggressive Behav.*	☐	☐	☐	☐

Please write a rationale for any item in the Risk Behavior Domain and related modules rated actionable ('2' or '3').

CULTURAL FACTORS DOMAIN (All Ages. For Children birth thru age 5, rate this section for the family.)

Items	0	1	2	3		0	1	2	3
Language	☐	☐	☐	☐	Cultural Stress	☐	☐	☐	☐
Traditions and Cultural Rituals	☐	☐	☐	☐	Cultural Diffs. within the Family	☐	☐	☐	☐

Please write a rationale for any item in the Cultural Factors Domain rated actionable ('2' or '3').

For the **Potentially Traumatic/Adverse Childhood Experiences**, use the following categories and action levels:
No – No evidence of any trauma of this type.
Yes – Child/youth has had experience, or there is suspicion that the child/youth has experienced this type of trauma —one incident, multiple incidents, or chronic, on-going experiences.

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES -- LIFETIME EXPOSURE (All Ages)

	No	Yes		No	Yes
Sexual Abuse	☐	☐	Witness to Family Violence	☐	☐
Physical Abuse	☐	☐	Witness to Community/School Violence	☐	☐
Neglect	☐	☐	War/Terrorism Affected	☐	☐
Emotional Abuse	☐	☐	Witness /Victim of Criminal Activity	☐	☐
Medical Trauma	☐	☐	Parental Criminal Behavior	☐	☐
Natural or Manmade Disaster	☐	☐	Disrupt in Caregiving/Attachment Losses	☐	☐

Please write a rationale for any item rated 'YES'.

EARLY CHILDHOOD DOMAIN (Age birth thru age 5)

Items	NA	0	1	2	3
Challenges					
Impulsivity/Hyperactivity		☐	☐	☐	☐
Depression		☐	☐	☐	☐
Anxiety		☐	☐	☐	☐
Oppositional Behav (36 mos+)	☐	☐	☐	☐	☐
Aggressive Behav (24 mos+)	☐	☐	☐	☐	☐
Attachment Difficulties		☐	☐	☐	☐
Adjustment to Trauma		☐	☐	☐	☐
Regulatory		☐	☐	☐	☐
Atypical Behaviors		☐	☐	☐	☐
Sleep (12 mos +)	☐	☐	☐	☐	☐
Functioning					
Family Functioning		☐	☐	☐	☐
Early Education		☐	☐	☐	☐

Items	NA	0	1	2	3
Functioning continued					
Social and Emotional Functioning		☐	☐	☐	☐
Developmental/Intellectual		☐	☐	☐	☐
Medical/Physical		☐	☐	☐	☐
Risk Behaviors & Factors					
Self-Harm (12 months+)	☐	☐	☐	☐	☐
Exploited		☐	☐	☐	☐
Sexually Probl Behav (24 mos+)	☐	☐	☐	☐	☐
Prenatal Care		☐	☐	☐	☐
Exposure		☐	☐	☐	☐
Labor and Delivery		☐	☐	☐	☐
Birth Weight		☐	☐	☐	☐
Failure to Thrive		☐	☐	☐	☐

For the **Early Childhood Strengths**, use the following categories and action levels:

0 – Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan

1 – Identified and useful strength. Strength will be used, maintained or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength

2 – Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.

3 – An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

Strengths				
Family Strengths	☐	☐	☐	☐
Interpersonal	☐	☐	☐	☐
Natural Supports	☐	☐	☐	☐

Resiliency (Persistence & Adaptab.)	☐	☐	☐	☐
Relationship Permanence	☐	☐	☐	☐
Playfulness	☐	☐	☐	☐

Please write a rationale for any item in the Early Childhood Domain rated actionable ('2' or '3').

TRANSITION AGE YOUTH DOMAIN (Ages 14+)

For the **Transition Age Youth Needs Domains**, use the following categories and action levels:

0 – No evidence of any needs; no need for action.

1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

2 – Action is required to ensure that the identified need is addressed; need is interfering with functioning.

3 – Need is dangerous or disabling; requires immediate and/or intensive action.

Items	N/A	0	1	2	3
Behavioral/Emotional Needs					
Interpersonal Problems		☐	☐	☐	☐
Functioning					
Independent Living Skills (K)		☐	☐	☐	☒
Parental/Caregiving Roles (L)	☐	☐	☐	☐	☐
Job Functioning (M)	☐	☐	☐	☐	☐

Items	0	1	2	3
Functioning continued				
Medication Adherence	☐	☐	☐	☐
Intimate Relationships	☐	☐	☐	☐
Transportation	☐	☐	☐	☐
Educational Attainment	☐	☐	☐	☐

K. INDEPENDENT ACTIVITIES OF DAILY LIVING MODULE *(To complete when the Independent Living Skills item is rated '1', '2' or '3'.)*

Items	0	1	2	3
Meal Preparation	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Housework	☐	☐	☐	☐

	0	1	2	3
Money Management	☐	☐	☐	☐
Communication Device Use	☐	☐	☐	☐
Housing Safety	☐	☐	☐	☐

L. PARENTING/CAREGIVING MODULE *(To complete when the Parental/Caregiving Role item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
Knowledge of Needs	☐	☐	☐	☐	*Organization*	☐	☐	☐	☐
Supervision	☐	☐	☐	☐	*Marital/Partner Viol. In the Home*	☐	☐	☐	☐
Involvement with Care	☐	☐	☐	☐					

M. VOCATIONAL/CAREER MODULE *(To complete when the Job Functioning item is rated '1', '2' or '3'.)*

Items	0	1	2	3		0	1	2	3
Career Aspirations	☐	☐	☐	☐	*Job Performance*	☐	☐	☐	☐
Job Attendance	☐	☐	☐	☐	*Job Relations*	☐	☐	☐	☐

Please write a rationale for any item in the Transition Age Youth Domain and related modules rated actionable ('2' or '3').

CAREGIVER RESOURCES & NEEDS DOMAIN (All Ages) ☐ Not applicable; no caregiver identified.

0 – No current need; no need for action. This may be a resource for the child/youth.

1 – Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement. This may be an opportunity for resource building.

2 – Need is interfering with the provision of care; action is required to ensure that the identified need is addressed.

3 – Need prevents the provision of care; requires immediate and/or intensive action.

Caregiver Information

First Name: | **Last Name:** | **Relationship:**

	0	1	2	3		0	1	2	3
Supervision	☐	☐	☐	☐	Substance Use	☐	☐	☐	☐
Involvement with Care	☐	☐	☐	☐	Developmental	☐	☐	☐	☐
Knowledge	☐	☐	☐	☐	Safety	☐	☐	☐	☐
Organization	☐	☐	☐	☐	Family Stress	☐	☐	☐	☐
Social Resources	☐	☐	☐	☐	Caregiver Post-traumatic Reactions	☐	☐	☐	☐
Residential Stability	☐	☐	☐	☐	Marital/Partner Viol. In the Home	☐	☐	☐	☐
Medical/Physical	☐	☐	☐	☐	Family Relationship to the System	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	Legal Involvement	☐	☐	☐	☐

Please write a rationale for any item in the Caregiver Resources and Needs Domain rated actionable ('2' or '3').

Caregiver Information

First Name: **Last Name:** **Relationship:**

	0	1	2	3		0	1	2	3
Supervision	☐	☐	☐	☐	Substance Use	☐	☐	☐	☐
Involvement with Care	☐	☐	☐	☐	Developmental	☐	☐	☐	☐
Knowledge	☐	☐	☐	☐	Safety	☐	☐	☐	☐
Organization	☐	☐	☐	☐	Family Stress	☐	☐	☐	☐
Social Resources	☐	☐	☐	☐	Caregiver Post-traumatic Reactions	☐	☐	☐	☐
Residential Stability	☐	☐	☐	☐	Marital/Partner Viol. In the Home	☐	☐	☐	☐
Medical/Physical	☐	☐	☐	☐	Family Relationship to the System	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	Legal Involvement	☐	☐	☐	☐

Please write a rationale for any item in the Caregiver Resources and Needs Domain rated actionable ('2' or '3').

Caregiver Information

First Name: **Last Name:** **Relationship:**

	0	1	2	3		0	1	2	3
Supervision	☐	☐	☐	☐	Substance Use	☐	☐	☐	☐
Involvement with Care	☐	☐	☐	☐	Developmental	☐	☐	☐	☐
Knowledge	☐	☐	☐	☐	Safety	☐	☐	☐	☐
Organization	☐	☐	☐	☐	Family Stress	☐	☐	☐	☐
Social Resources	☐	☐	☐	☐	Caregiver Post-traumatic Reactions	☐	☐	☐	☐
Residential Stability	☐	☐	☐	☐	Marital/Partner Viol. In the Home	☐	☐	☐	☐
Medical/Physical	☐	☐	☐	☐	Family Relationship to the System	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	Legal Involvement	☐	☐	☐	☐

Please write a rationale for any item in Caregiver Resources and Needs Domain rated actionable ('2' or '3').

Caregiver Information

First Name: **Last Name:** **Relationship:**

	0	1	2	3		0	1	2	3
Supervision	☐	☐	☐	☐	Substance Use	☐	☐	☐	☐
Involvement with Care	☐	☐	☐	☐	Developmental	☐	☐	☐	☐
Knowledge	☐	☐	☐	☐	Safety	☐	☐	☐	☐
Organization	☐	☐	☐	☐	Family Stress	☐	☐	☐	☐
Social Resources	☐	☐	☐	☐	Caregiver Post-traumatic Reactions	☐	☐	☐	☐
Residential Stability	☐	☐	☐	☐	Marital/Partner Viol. In the Home	☐	☐	☐	☐
Medical/Physical	☐	☐	☐	☐	Family Relationship to the System	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐	Legal Involvement	☐	☐	☐	☐

Please write a rationale for any item in the Caregiver Resources and Needs Domain rated actionable ('2' or '3').

Clermont County Wraparound Program

Decision Support Model: Ohio Brief CANS

Treatment/Population Eligibility Need			Complexity	
Information and Referral **Criterion 1.1 AND (Criterion 1.2 or 1.3)**	**1.1**	**At least one** rating of '2' or '3' on any Behavioral/Emotional Need: - Psychosis - Impulsivity/Hyperactiv. - Depression - Anxiety - Oppositional Behavior - Conduct - Adjustment to Trauma – Anger Control - Substance Use - Eating Disturbance - Attachment Difficulties - Interpersonal Prob (+14)	**1.2**	**At least one** rating of '2' or '3' on any Risk Behavior: - Suicide Risk - NSSI Behavior - Other Self-Harm - Danger to Others - Delinquent Behav. - Runaway - Intentional Misbehavior - Fire Setting - Victimization/Exploit. – Sexually Prob. Behav.
			1.3	**At least one** rating of '2' or '3' on any Functioning Needs: - Family Functioning - Living Situation - Social Functioning - Sleep - School
Service Coordination **Criterion 2.1 AND (Criterion 2.2 or 2.3)**	**2.1**	**At least one** rating of '3' or **two or more** ratings of '2' or '3' on any Behavioral/Emotional Needs: - Psychosis - Impulsivity/Hyperactiv. - Depression - Anxiety - Oppositional Behavior - Interpersonal Prob (+14) - Adjustment to Trauma – Anger Control - Substance Use - Eating Disturbance - Conduct	**2.2**	**At least one** rating of '3' or **two or more** ratings of '2' or '3' on any Risk Behavior: - Suicide Risk - NSSI Behavior - Other Self-Harm - Danger to Others - Delinquent Behav. - Runaway - Intentional Misbehavior - Fire Setting - Victimization/Exploit. – Sexually Prob. Behav.
			2.3	**At least two** ratings of '3' or **three or more** ratings of '2' or '3' on the following Functioning Needs: - Family Functioning - Living Situation - Social Functioning - Develop./Intellect. - Legal - Sleep - Medical/Physical - Decision Making – School
High-Fidelity Wraparound **Criterion 3.1 AND Criterion 3.2**	**3.1**	Child/Youth meets criteria for Service Coordination	**3.2**	**At least one** rating of '3' or **two or more** ratings of '2' or '3' on any of the following Caregiver Needs: - Supervision - Residential Stability - Mental Health - Family Stress - Knowledge - Medical/Physical - Substance Use

ATTACHMENT FOUR

POLICY AND PROCEDURE

Policy Name:	**Pooled Funds Policy**
Policy Number:	**2.04**
Effective Date:	**7/9/04**
Revised:	**7/19/06, 8/8/08, 12/10/10, 10/14/11, 12/14/12, 12/1/16, 5/4/23**

Matt Earley
Co-Chairperson _____ 6/1/23
Date

Dan Ottke
Co-Chairperson _____ 6/1/23
Date

Cross Reference

N/A

Policy Statement

The Clermont County Family and Children First (FCF) Council (Council) shall have Pooled Funds as allowed by local contributions and the approved budget.

Purpose

To financially support needed services/supports for multi-need, multi-system children/youth when other funding sources are unable to do so.

Key Terms

Pooled Funds – Funds that are available per an approval process for financial support for multi-need, multi-system children/youth. Pooled Funds are provided via local contributions to FCF.

Procedure

I. All children/youth for whom Pooled Funds are requested must be engaged in Wraparound or Service Coordination with the Clermont County Wraparound Program. The youth's team shall determine a youth's current strengths and needs, develop a Plan of Care, and outline how accessing Pooled Funds will assist in meeting an identified need. All children/youth must be multi-need, multi-system eligible children per Wraparound Program eligibility criteria.

II. To be eligible to apply for Pooled Funds, the child's/youth's Wraparound Facilitator shall complete the Pooled Funds Application Form

III. The Application shall be submitted to the Wraparound Supervisor along with a Plan of Care highlighting the identified need and the team's request to meet that need through the use of Pooled Funds. The Wraparound Supervisor will review and approve/deny the use of Pooled Funds prior to funds being expended. Determination of the approval of Pooled Funds will be based upon:

- Identification of a need through Wraparound or Service Coordination
- Documentation of how accessing Pooled Funds will build a strength or meet a need
- Availability of Pooled Funds

IV. The Wraparound Supervisor will be in consultation with the FCF Program Administrator, as needed, to ensure the appropriate use of Pooled Funds.

V. Pooled Funds can be requested for a variety of services or supports. Examples include: a special club or group for a child/youth to assist in mental health development, short-term respite, or team celebrations for youth successes (maximum of $25.00 for celebrations). Alternative resources must be investigated prior to applying for Pooled Funds.

VI. Pooled Funds will not be approved for

- basic needs (i.e. groceries, clothing, gas, car payments, rent/mortgage, utilities, phones, child care)
- Long-term needs unless the request is short term until longer term funding can be approved
- Out of home placement, excluding respite

VII. The use of Pooled Funds shall be time limited.

Associated Forms & Attachments

N/A

# # #

ATTACHMENT FIVE

POLICY AND PROCEDURE

Policy Name:	**FCSS Funds Policy**
Policy Number:	**4.01**
Effective Date:	**1/14/05**
Revised:	**1/13/06, 8/8/08, 10/14/11, 10/14/14, 12/1/16, 5/4/23**

Matt Earley
Co-Chairperson _____ 6/1/23
Date

Dan Ottke
Co-Chairperson _____ 6/1/23
Date

Cross Reference

N/A

Policy Statement

The Clermont County Family and Children First (FCF) Council (Council) shall have a process by which children are determined eligible to receive services funded by Family Centered Services and Supports (FCSS) dollars and a process by which these children are tracked by FCF.

Purpose

To ensure the appropriateness of children funded by FCSS funds and to ensure appropriate reporting of information to Ohio Family & Children First (OFCF).

Key Terms

FCSS – Family-Centered Services and Supports Funds are a combination of federal child welfare dollars (Social Security Act Title IV-B funds) from the Ohio Department of Job & Family Services (75%) and state general revenue funds from the Ohio Department of Mental Health & Addiction Services, Ohio Department of Youth Services, and Ohio Department of Developmental Disabilities (25%), administered through Ohio Family & Children First. The purpose is to maintain children and youth in their own homes through the provision of non-clinical, community-based services. Families who have children with multiple systemic needs identified through the county Family and Children First Council (FCFC) service coordination process may be eligible for FCSS funded services and supports.

Procedure

In order to access FCSS funds, Clermont County FCF must assure the required service coordination components are in place as outlined in the FCSS Guidance Document.

I. In order to be determined eligible for the use of FCSS, the child must be accessing local FCFC Service Coordination (or Wraparound), and be 0-21 years of age with multi-systemic needs (i.e., child is not necessarily involved in two or more systems, but child's needs involve more than one system).

II. A child may be ineligible for the use of FCSS for a variety of reasons, including:

- The use of FCF Pooled Funds is most appropriate
- The child is placed in an out of home care setting (residential treatment, group home, therapeutic foster care, traditional foster care)

- The FCSS supports would not assist in maintaining the child in the home or support a child being reunified with a parent/relative upon discharge from an out of home care placement

III. The FCF Project Administrator shall maintain a list of FCSS eligible children. The effective date of eligibility shall be the date that the FCF Project Administrator determines a child eligible for FCSS services.

IV. The child's termination date shall be when the child is discharged from the FCSS service or when FCSS funds are exhausted, whichever comes first.

V. FCSS supports in Clermont County shall be focused on families with youth stepping down from a residential placement, a psychiatric hospitalization, or detention into the family home or to maintain a youth in the family home that is presenting high risk behaviors, such as suicidal gestures/ideation, psychosis, or highly aggressive behaviors.

VI. FCSS supports will be approved for a maximum of ninety (90) days, with the exception of Parent Peer Support. No extensions will be approved.

VII. Youth/families must be actively participating in the Wraparound process in order to be eligible for FCSS funds. While FCSS funds are being accessed, the youth/families must participate in at least bi-weekly meetings with the Wraparound Facilitator.

VIII. Wraparound Teams will ensure that a solid safety plan and/or crisis plan are in place for the youth/family.

IX. Wraparound Team meetings will focus on brainstorming longer term, sustainable supports for the youth/family if support beyond the approved 90 days for FCSS funds in necessary or desired.

X. The family (custodian) must sign a letter stating that they are aware of the length of FCSS funded supports. The letter shall also state the requirement of participating in bi-weekly meetings with the Wraparound Facilitator and the need for the Wraparound Team to develop a safety and/or crisis plan and brainstorm longer term, sustainable supports for the youth/family.

XI. Family may be required to pay for a portion of the cost of the support.

The FCSS Guidelines for each individual FCSS service must be adhered to by the referral source. The following are examples of **allowable** family support expenditures when identified on the individual family service coordination plan (IFSCP):

☐ Non-clinical in-home visits;
☐ Non-clinical parent support groups;

☐ Parent education;
☐ Mentoring;
☐ Respite care (including summer camp);
☐ Transportation (i.e. cab/taxi fares, gas vouchers);
☐ Social/recreational activities;
☐ Safety and adaptive equipment;
☐ Structured activities to improve family functioning;
☐ Parent advocacy; and
☐ Service coordination (to utilize the FCSS funding for FCFC service coordination, a unit rate must be established).

Non-allowable expenditures include:

☐ Out of home placements and services/supports to those children and in out of home placements and their families;
☐ Court related expenses;
☐ Administrative or operating expenses;
☐ Federal match;
☐ Clinical interventions (i.e., services, assessments, and clinical case management);
☐ Medical services and equipment;
☐ General programs costs (i.e., non-individualized services);
☐ Food, clothing, shelter, utilities, and/or household expenses; and
☐ Family and work related childcare.

Associated Forms & Attachments

N/A

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ATTACHMENT SIX

POLICY AND PROCEDURE

Policy Name:	**MSY policy**
Policy Number:	**4.06**
Effective Date:	**3/9/2020**
Revised:	**10/1/2020, 8/2/2021**

Karen Scherra
Co-Chairperson

Karen J. Scherra

9/8/21
Date

Dan Ottke
Co-Chairperson

D Ottke

8/5/21
Date

Cross Reference

N/A

Policy Statement

The Clermont County Family and Children First (FCF) Council (Council) shall have a process by which requests for technical assistance and/or MSY funds are reviewed and a determination is provided.

Purpose

To ensure MSY youth are appropriately served and have the ability to request MSY funds if the youth is at risk of custody relinquishment or custody has already been relinquished and support is needed to transition the youth back to the community.

Key Terms

MSY – Multi-System Youth - a youth, age 0-17 years, who is involved with more than one child serving system (i.e. mental health/addiction, developmental disabilities, juvenile probation, Children's Protective Services, specialized health care), is open and active with Clermont County FCF Wraparound, and is at risk of custody relinquishment or custody may have already been relinquished.

MSY Review Team – a team of representatives from Clermont County systems and agencies tasked with reviewing all requests for MSY technical assistance and funding.

Procedure

I. MSY Technical Assistance: Any system or agency can make a referral to the MSY Review Team for Technical Assistance. See attached MSY Technical Assistance Request flow chart for process.

II. MSY Funding:
   A. Eligibility
      1. Youth must be open and active with the Clermont County FCF Wraparound program. Active is defined as having at least one (1) full team meeting with the youth/family. If funding is approved, team meetings must occur at least once a month.
      2. Youth must be at risk of custody relinquishment or custody may have already been relinquished and funding is requested to support a smooth transition back to the community.
      3. Youth must have multi-system needs.
      4. Youth must be 0-17 years old.
      5. Financial resources must be reasonably exhausted, i.e. Medicaid, private insurance, PASSS and/or county funds.

B. Referrals for funding may be made only by Clermont County FCF. The MSY Application is attached.
C. Funding sources:
   1. MSY Pooled Funds: Ohio Department of Job & Family Services provided funds to local public children's service agencies (Clermont County Children's Protective Services (CPS) to assist with costs for children who require support from multiple systems and have been relinquished or are at risk of relinquishment. CPS is to allocate 5% of their local allocation to Clermont County FCF in SFY 2020 and 10% in SFY 2021-2023 to support MSY youth. Funds will be maintained in a separate line item in the Clermont County FCF budget – MSY Pooled Funds.
   2. State MSY funds: Ohio Department of Medicaid and Ohio Job & Family Services jointly developed a state-level program to provide financial support to youth and families with complex needs who may be at risk of custody relinquishment or have already been relinquished to CPS. Local FCFs can apply for direct financial aid to cover the costs associated with a youth's care.
D. Clermont County FCF will focus on maintaining the youth in the home/community whenever possible. When out of home placement is necessary, the youth will be placed in the least restrictive environment possible.
E. Process. The attached flowcharts 1) MSY Funding Request – MSY Pooled Funds and 2) MSY State Funding Request – State MSY Funds detail the application process.
F. Release of Information.
   1. The Clermont County FCF Release of Information must be signed by the parent/guardian.
   2. The Release of Information must be signed less than 30 days prior to the date of application.
   3. The Release of Information must include all the systems/agencies of the MSY Review Team members.
G. MSY Review Team.
   1. The MSY Review Team is comprised of youth-serving systems and agencies in Clermont County as determined appropriate by Clermont County FCF Council.
   2. The MSY Review Team will set aside two (2) dates each month to review applications. Reviews will occur via Zoom, conference call or in person.
   3. In order to review an application, a minimum of five (5) members of the MSY Review Team must be present at the meeting. If five (5) members are not present, the application will be reviewed at the next scheduled MSY Review Team meeting.
   4. All decisions made by the MSY Review Team are final.

H. Allowable expenses may include in-home and/or community supports to prevent custody relinquishment or in-home and/or community support for a relinquished youth transitioning back into a community setting.
   1. Allowable expenses may include, but are not limited to:
      - Clinical services not covered by another payer/insurance
      - In-home parent/youth coaching
      - Parent support groups
      - Parent Education
      - Parent Advocacy
      - Mentoring
      - Respite Care
      - Transportation (i.e. cab fares, Lyft, gas cards)
      - Respite Care
      - Medical services and equipment
      - Safety and adaptive equipment
      - Home modifications
      - Structured interventions to improve family functioning
      - Food, clothing, shelter, utilities, and/or household expenses
   2. Non-allowable expenses include
      - Services billable to other payer sources, including health insurance
      - General program costs (i.e. non-individualized services)
      - Classroom instruction or any require public education cost or responsibility, including tutoring, school-based credit recovery, and/or summer school programming
      - The room and board costs of a Developmental Center

I. The application must thoroughly document the services and funding sources that have been accessed by the youth/family.

J. The family must agree to participate in services approved by the MSY Review Team.

K. When MSY funding is approved by the MSY Review Team, Clermont County FCF will work with the approved provider to ensure payment can be made through the Clermont County Auditor (provider must be willing to become a provider through the county's MUNIS system in order to receive payment). The approved time period and maximum amount of funds for the youth/family will be communicated to the provider in writing. Services provided outside the time period or above the maximum amount of funds will not be reimbursed.

L. Requests for continued funding will be requested by the Clermont County FCF Wraparound program three (3) weeks prior to the current funding request expiring.

M. Funding is limited and is not guaranteed beyond the approval provided.

Associated Forms & Attachments
Governor DeWine's press release dated October 8, 2019
MSY Technical Assistance Request

MSY Funding Request – MSY Pooled Funds
MSY Funding Request – State MSY Funds
MSY Application
Ohio Family & Children First Guidance for Multi-System Youth Technical Assistance and Funding Application

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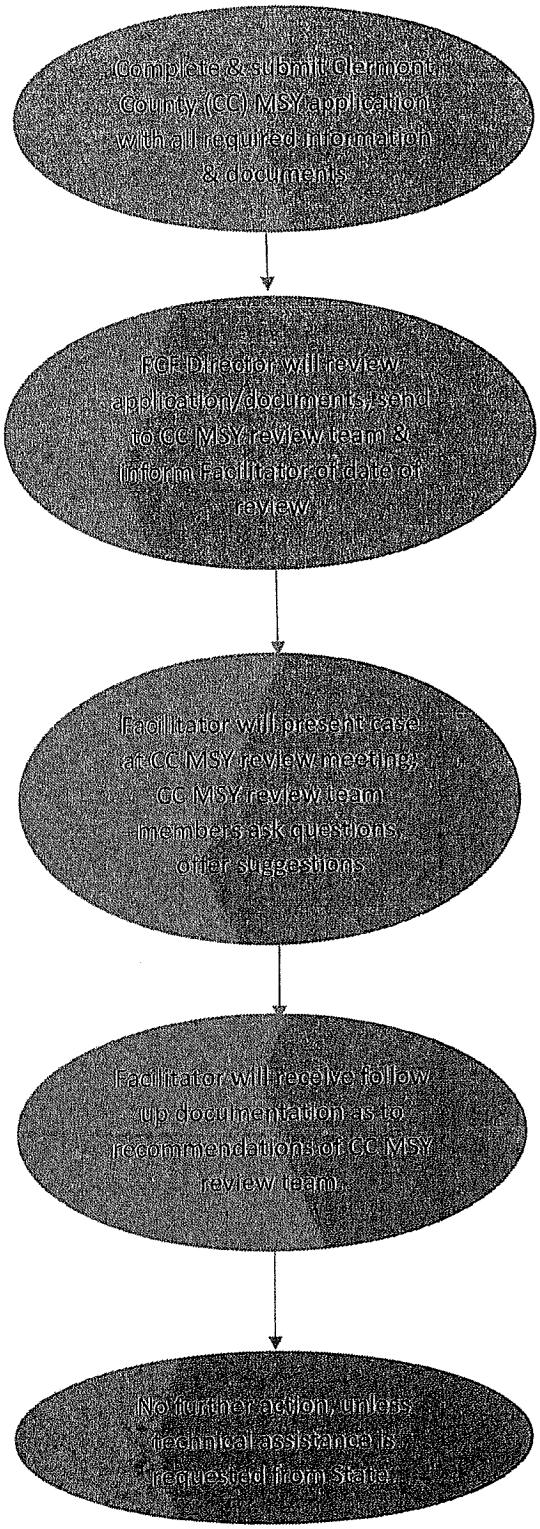
MSY TECHNICAL ASSISTANCE REQUEST



MSY FUNDING REQUEST – MSY POOLED FUNDS

Youth must be open and active with Wraparound

Youth must be at risk of custody relinquished or custody may have already been relinquished and funding is requested to support a smooth transition back to the community

MSY Pooled Funds will be used to support the provision of Wraparound to non-TANF eligible youth with multi-system needs at risk of custody relinquishment or youth transitioning back to the community. Youth may or may not be receiving other services funded by MSY funds. The MSY Review Team will not review these cases unless additional MSY funds are requested.

OR

Youth must have multi-system needs

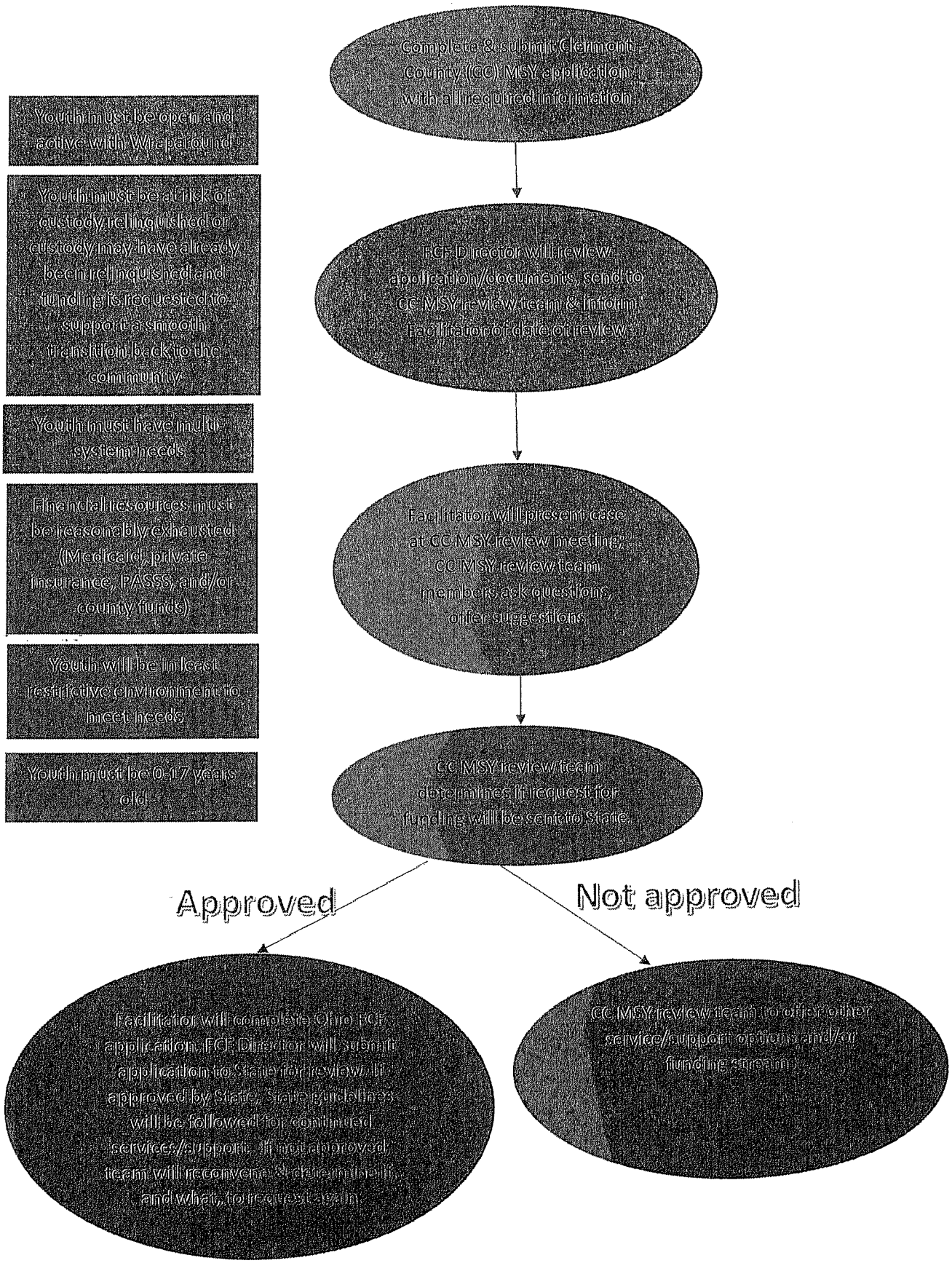
Financial resources must be reasonably exhausted (Medicaid, private insurance, PASSS, and/or county funds)

Youth will be in least restrictive environment to meet needs

Youth must 0-17 years old

MSY Pooled Funds will be used to support the temporary provision (less than 30 days) of supports/services that are determined to be urgent and have been requested to be supported by MSY ODM funding, as approved by the MSY Review Team, excluding any out of home placement, with the exception of respite. All MSY criteria must be met, in order for MSY Pooled Funds to be used.

MSY FUNDING REQUEST – STATE MSY FUNDS



Clermont County MSY Funding Application

☐TA or ☐Funding

☐State MSY or ☐MSY Pooled Funds

Child's Name _____ **IV-E eligible** Yes ☐ No ☐
Last First Middle Initial

DOB _____ **Ethnicity** _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**_____

Guardian Name/s: _____

Relationship to Child: _____

Address: _____ **City:** _____ **State:** Ohio **Zip:** _____

Phone Number: _____ **Cell Phone:** ( ) _____

Current Placement: _____ **Adoption: Yes** ☐ **No** ☐

Guardian e-mail: _____

Medicaid ☐ **MCP** _____ **Private Insurance** ☐ **Provider** _____

School/School District: _____ **Grade:** _____ **IEP Yes** ☐ **No** ☐

Wraparound Facilitator: _____

Current Local System Involvement:
❑ **FCF** ❑ **Child Welfare/CPS** ❑ **Juvenile Probation** ❑ **Juvenile Court - Diversion** ❑ **Developmental Disabilities**
❑ **Public Health/BMH** ❑ **Mental Health-provider**_____ ❑ **Substance Use-provider**_____
❑ **Parent Peer Support** ❑ **Other** _____

Release of Information: Yes ☐ **No** ☐ **(Application will not be reviewed without the proper Release of Information attached. All MSY Review Team agencies/systems must be included on Release of Information)**

At risk of custody relinquishment? Yes ☐ **No** ☐ **or Custody already relinquished? Yes** ☐ **No** ☐

The child/youth has multi-system needs? Yes ☐ **No** ☐

Reason for Referral (check all that apply)
☐ **Assistance with facilitation of outreach to and engagement of local partners**
☐ **Request for clinical review**
☐ **Child/youth at risk of custody relinquishment**
☐ **Child/youth at risk of out of state placement**
☐ **Custody already relinquished – support for transition to community/home**

Services/Resources Utilized for Child/ Youth & Family	Current	Past 6 months	Past 12 months	Describe Specific Services/Resources. Include Providers & Relevant Outcomes, Actual or Estimated Funds Utilized
Wraparound	☐	☐	☐	
Case Management/CPST/ TBS/PSR	☐	☐	☐	
In-home services/ supports	☐	☐	☐	
Community-based behavioral health services: Individual Therapy	☐	☐	☐	
Community-based behavioral health services: Family Therapy	☐	☐	☐	
Community-based behavioral health services: Group Therapy	☐	☐	☐	
Residential Treatment	☐	☐	☐	
Group Home	☐	☐	☐	
Therapeutic Foster Care	☐	☐	☐	
Foster Care	☐	☐	☐	
Inpatient Psychiatric Treatment	☐	☐	☐	
Respite – overnight or hourly	☐	☐	☐	
Parenting classes/services	☐	☐	☐	
Crisis Services/MRSS	☐	☐	☐	
Mentors	☐	☐	☐	
Skills Building Services/Supports	☐	☐	☐	
Specialized Health Care	☐	☐	☐	
Children with Medical Handicaps (CMH)	☐	☐	☐	
Prevention Services	☐	☐	☐	
Parent Peer Support	☐	☐	☐	
Psychiatric Services	☐	☐	☐	
School-based Mental Health Services	☐	☐	☐	

Behavioral Health Diagnosis/Diagnoses, if any:

Describe the strengths of the child/youth and the family:

Describe current challenges and additional details on request:

Any additional information that would be helpful (include any risk for out of home placement):

Please attach additional supporting documentation: ❑ Wraparound Plan (required) ❑ CANS
❑ Psychological ❑ Treatment Plan ❑ IEP ❑ Crisis or Safety Plan ❑ Other Supporting Documentation

Detail the purpose of this request by providing the following information:

Service	Estimated Time	Amount Requested
☐ In-home and/or community supports to prevent custody relinquishment	☐ 30 days ☐ 60 days ☐ 90 days	$
Detail:		
☐ In-home and/or community supports for a relinquished child/youth transitioning into a community setting	☐ 30 days ☐ 60 days ☐ 90 days	$
Detail:		
☐ Residential treatment and/or room and board for treatment to prevent custody relinquishment	☐ 30 days ☐ 60 days ☐ 90 days	$
Detail:		

If an agency is deemed necessary to be present when the application is reviewed, please state that agency and the reason why: _____

By signing below, the applicant certifies that the information submitted with this application, including any attachments, is true and accurate to the best of their knowledge and belief. The parent/legal guardian commits to maintaining involvement in the child's plan of care and to allowing the child, if placed out of the home, to return to their home when deemed clinically appropriate. Funding is limited. The applicants acknowledges that the receipt of funding is not guaranteed and waives any right to beyond 30 days of initial authorization and can be rescinded at any time. Funding determinations are final and not subject to appeal.

_____ _____

FCFC Director (signature) Date

_____ _____

Parent/Legal Guardian (signature) Date

Ohio Family & Children First

Guidance for Multi-System Youth Technical Assistance and Funding Application

General Instructions:

This Application must be used for the following types of requests:

Technical assistance for children and youth with needs from multiple systems. Technical assistance can be requested to facilitate coordination of clinically appropriate services, supports, and resources for children / youth and their families.

An application for technical assistance for a child or youth with multi-system needs can be made by a family or any local agency (County Family and Children First Council, Public Children's Services Agency, Board of Developmental Disabilities, Board of Mental Health and Addiction Services, and others.)

Multi-system youth custody relinquishment funding. Funding must only be requested to support children and youth who are at risk for custody relinquishment or have already been relinquished and need services and/or supports to transition to community and/or non-custody settings.

An application for multi-system youth custody relinquishment funding should only be made by County Family and Children First Councils (FCFCs). Local FCFCs are expected to submit complete applications that meet all of the requirements outlined in this guidance document. To be eligible to receive funding for a child/youth, a County FCFC must execute a grant agreement with the Ohio Department of Medicaid (ODM.) All applications will be vetted by a multi-system team composed of child/youth serving state agencies, and funding will be authorized (or not authorized) by ODM. Authorized funding will be subject to the terms of ODM's executed grant agreement with each County FCFC.

Application Components:

All application components must be completed by a single applicant / agency for each case. For example, if requesting funding, the full application should be completed by the County Family and Children First Council.

PART A of the application must be completed by ALL applicants requesting case-specific technical assistance and/or funding.
PART B of this application must only be completed by applicants requesting funding.
ATTACHMENT A must be completed for ALL new applications.
ATTACHMENT B must be completed to provide updates on authorized funding.
ATTACHMENT C must be completed for all continued funding requests.

PART A: This section must be completed by ALL applicants requesting technical assistance and/or funding.

I. Requesting Applicant Information

All fields are required. Signatures for the applicant are required on the bottom of page 5, where at a minimum, the application must be signed by the County FCFC Director/Coordinator and the parent/legal guardian.

II. Child/youth Information

Please complete all applicable fields to indicate the child's / youth's demographics, system involvement and other contributing factors, current and past utilization of services and supports, strengths, and other information that may be helpful in assessing the request. **If the applicant is a County FCFC, the child's / youth's FCF service coordination plan must be included.** Complete and detailed information in this section will assist with reviewing applications and reduce the need for follow-up.

III. Reason for Referral

Please check all that apply.

IV. Release of Information

All initial applications for technical assistance and funding must complete Attachment A, which is a release of information. Please check the box in this section of the application to indicate that a release is being included with the application submission. Applications that do not include a completed release of information will be returned to the applicant.

PART B: This section must be completed by applicants requesting funding. Applicants requesting funding must complete ALL of the following sections.

Part B does *not* need to be completed if funding is not being requested.

V. Eligibility Criteria

Funding will be authorized / not authorized on a case-by-case basis. Funding requests will be authorized only if **all five** of the following eligibility criteria have been met.

1. The child/youth has multi-system needs and is at risk for custody relinquishment or has already been relinquished;
2. The applicant has identified availability of local resources (including funding) and/or clinically indicated services to support the child/youth and family;
3. Multi-system local and/or regional agencies are working to coordinate care for the child/youth and family;
4. Financial resources have been reasonably exhausted *(at a minimum: Medicaid, private insurance, Post Adoption Special Services Subsidy (PASSS), and/or county funds)*; and
5. The child/youth will be placed in the least restrictive setting, and the setting will be documented as clinically appropriate to meet the treatment needs of the child/youth and family.

VI. Funding Request

Please check the specific services(s) for which funding is being requested, check the box for the amount of time funding will be used (30, 60, 90 days), and indicate how much funding is being requesting for that time period.

Please note, funding requests can be made for up to 90 days of service / support. Should funding be authorized, county FCFCs will need to provide updates on the use of funds and case progress to ODM at least every 90 days using Attachment 2. If funding is authorized for residential treatment services and/or room and board, updates must be provided to ODM on a monthly basis (every 30 days). Continued funding beyond the authorized time period can be requested using Attachment 3. Continued funding requests must be made at least seven calendar days before current authorized funding expires; if continued funding requests are not received at least seven

calendar days before current authorized funding expires, a new application will need to be completed to request additional funding.

The following categories of services may be funded:

1. **Care Coordination/Wraparound to prevent custody relinquishment or for a relinquished child/youth**
Requests for care coordination / wraparound may be made to prevent custody relinquishment or for a child/youth who is currently in an out-of-home placement and/or has already been relinquished.

To utilize the funding for FCFC Service Coordination/Wraparound, a unit rate must be established. See Appendix H on how to calculate a unit rate, or download Appendix H at: https://www.fcf.ohio.gov/Portals/0/Home/Initiatives/System%20of%20Care%20(FCSS)/FCSS%20Service%20Coordination%20Unit%20Rate%20Example%2011.12.09.pdf

Allowable Expenses may include:

FCFC Service Coordination – a collaborative, coordinated, cross-system team planning process implemented to address the needs of families with multiple and complex problems. The process is family-focused and strengths-based and is responsive to the culture, race and ethnicity of the family. It results in a unique set of community services and natural supports individualized for the child and family and based on the child and family's perceptions of their strengths and needs to achieve a positive set of outcomes. The purpose of service coordination is to provide a venue for families to meet the need for services and supports across multiple systems which may not have been adequately addressed within traditional agency systems. The FCFC Service Coordination Process FCFC Service Coordination must meet all the statutory requirements found in ORC 121.37; must follow the OFCF Service Coordination Guidance; and must be locally described in each county Family and Children First Council's Service Coordination Mechanism.

High-Fidelity Wraparound –a comprehensive team process to develop a uniquely designed helping plan based on the child/youth and family's unmet needs and is inclusive of unique resources linked to child/youth and family strengths. It is applicable and most effective for those with complex needs and histories of extensive and costly service utilization. Ohio's Wraparound model is based on the National Wraparound Initiative. For more information, refer to the National Wraparound Initiative website.

2. **In-home and/or community supports to prevent custody relinquishment**
AND
3. **In-home and/or community supports for a relinquished child/youth transitioning back into a community setting**

Funding requests for must only be made for expenses not otherwise covered by another payer source. At a minimum, expenses that are or could be covered by Medicaid, private insurance, PASSS, and/or county programs must be exhausted before funding through this program may be authorized. All expenses should directly relate to services or supports for children at risk for custody relinquishment or those who have already been relinquished.

Allowable Expenses May Include, but are not Limited to:

- Clinical services not covered by another payer / insurer
- In-home parent/child coaching
- Parent support groups
- Parent education

- Parent advocacy
- Mentoring
- Respite care
- Transportation (e.g., Cab/taxi fares, gas vouchers)
- Medical services and equipment
- Safety and adaptive equipment
- Home modifications
- Structured interventions to improve family functioning
- Food, clothing, shelter, utilities, and/or household expenses

Non-Allowable Expenses Include:

- Services billable to other payer sources, including health insurance
- General program costs (i.e., non-individualized services)
- Classroom instruction or any required public education cost or responsibility (to include tutoring, school-based credit recovery, and/or summer school programming)

4. Residential treatment and/or room and board for treatment to prevent custody relinquishment

Residential treatment may include settings that consist of 24-hour supervision for children in settings such as group homes, detention facilities, or residential treatment facilities.

Monthly submission of Attachment B and additional follow-up communications will be required when residential treatment and/or room and board for treatment are authorized.

PART B: Reporting and Evaluation

Authorization of these funds is intended to promote results-based interventions while limiting administrative burden to the FCFCs and local community partners. Attachment A (release of information) is required at submission. Attachment B (funding update) is required up to 3 months from application at the end of the requested funding period. For all residential treatment and/or room and board for treatment requests, Attachment B and additional follow up information will be required on a monthly basis. Attachment C should be completed by applicants requesting authorization for continued funding.

All required applications and updates should be submitted via email to MSY@medicaid.ohio.gov.

PART B: Disclosures

All MSY authorized funding expenditures must reflect the actual costs of services delivered and must be spent between October 9, 2019 and June 30, 2020 for services delivered between those dates. Funds cannot be used for expenses incurred before the date of application. Agencies cannot apply for funding more than 30 days in advance of potential placement.

The applicant certifies that the information submitted with this application, including any attachments, is true and accurate to the best of their knowledge and belief. The parent/legal guardian commits to maintaining involvement in the child's plan of care and to allowing the child, if placed out of the home, to return to their home when deemed clinically appropriate. The Multi System Youth Custody Relinquishment Prevention program is a pilot program for State Fiscal Year 2020 and grant funding is limited. The applicant acknowledges that the receipt of funding is not guaranteed. Applications will be processed in the order in which they are received, and determinations are made using objective criteria. Applicant also acknowledges the information

above will be shared for purposes of determining grant eligibility consistent with the terms of the attached information release. Funding authorizations and non-authorizations are final and not subject to appeal.

ATTACHMENT A: This attachment must be completed by all applicants requesting technical assistance and/or funding.

All applicants for technical assistance and funding must complete this release of information. Please email this attachment with all new applications to MSY@medicaid.ohio.gov.

ATTACHMENT B: This attachment must be completed this at least every 90 days to provide updates on expenditures and case progress. This update must be completed on a *monthly basis* (every 30 days) when funding is being used for residential purposes.

Please email this completed attachment and associated invoices/payments for the time period to MSY@medicaid.ohio.gov

ATTACHMENT C: This attachment must be completed for continued funding requests.

This attachment must be sent to request continued funding. Continued funding requests must be made at least seven calendar days before current authorized funding expires; if continued funding requests are not received at least seven calendar days before current authorized funding expires, a new application will need to be completed to request additional funding. Please email this completed attachment to MSY@medicaid.ohio.gov

(Family Name) Plan of Care

Family Name:	Date:
Team Members	
Name:	Role:
Family and Youth's Strengths	
Team Mission:	

Need 1:			
Strategy:			
Tasks:			
Start Date:	Who:	What:	Report Back:

Strategy:			
Tasks:			
Start Date:	Who:	What:	Due/Report Back:

Outcome Measure for Need:			
Progress Towards Outcome Measure:			
Progress Toward Met Need (Circle One): 0 – No progress has yet been made 1 – A little progress, but need is less than halfway met 2 – Some progress, with the need about halfway met 3 – Good progress, with the need more than halfway met 4 – This need has been met to our satisfaction			
Progress Towards Need Comments:			

Need 2:				
Strategy:				
Tasks:				
Start Date:	Who:	What:	How Often:	Due/Report Back:

Strategy:				
Tasks:				
Start Date:	Who:	What:	How Often:	Due/Report Back:

Outcome Measure for Need:

Progress Towards Outcome Measure:

Progress Toward Met Need (Circle One):

0 – No progress has yet been made

1 – A little progress, but need is less than halfway met

2 – Some progress, with the need about halfway met

3 – Good progress, with the need more than halfway met

4 – This need has been met to our satisfaction

Progress Towards Need Comments:

ATTACHMENT EIGHT

PRESSLEY RIDGE
Strong Families. Strong Communities.

Individual Safety Plan

Client Name: Click or tap here to enter text.

Date: Click or tap to enter a date.

Safety Plan for: Choose an item.

Step 1: Warning Signs - thoughts, images, mood, situation, behavior) that a crisis may be developing:		
1. Click or tap here to enter text.	2. Click or tap here to enter text.	3. Click or tap here to enter text.

Step 2: Internal Coping Strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):		
1. Click or tap here to enter text.	2. Click or tap here to enter text.	3. Click or tap here to enter text.

Step 3: People and Social Settings that Provide Distraction:			
Name: Click or tap here to enter text. Phone: Click or tap here to enter text.	Name: Click or tap here to enter text. Phone: Click or tap here to enter text.	Place: Click or tap here to enter text.	Place: Click or tap here to enter text.

Step 4: People Whom I Can Ask for Help:		
Name: Click or tap here to enter text. Phone: Click or tap here to enter text.	Name: Click or tap here to enter text. Phone: Click or tap here to enter text.	Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Step 5: Professionals or Agencies I can Contact During a Crisis:	
Clinician Name: Click or tap here to enter text. Phone: Click or tap here to enter text. Clinician Emergency Contact/On-Call #: Click or tap here to enter text.	Clinician Name: Click or tap here to enter text. Phone: Click or tap here to enter text. Clinician Emergency Contact/On-Call#: Click or tap here to enter text.

Pressley Ridge On Call:	Mobile Crisis:	Suicide Prevention Hotline:
513-559-1402	513-528-SAVE (7282)	1-800-273-TALK (8255) or Text 741-741

Step 6: Making the Environment Safe – Remove specific triggers or means of self-harm, not be alone, ect:	
1. Click or tap here to enter text.	2. Click or tap here to enter text.
The one that that is most important to me and worth living for is: Click or tap here to enter text.	
Signatures:	
Client Signature:	Date:
Parent Signature:	Date:
Staff Signature:	Date:

ATTACHMENT NINE

Clermont County Wraparound Satisfaction Survey

Name: _____ **Date:** _____

Please Check the Box that Best Describes How You Feel about Your Experience with Clermont County Wraparound:	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
1. Team meetings were a positive experience.					
2. My team had a balance of professional and non-professional team members.					
3. My child was encouraged to participate in team meetings.					
4. My customs, beliefs and preferences were considered throughout meetings.					
5. I felt that my input and contribution to the team was respected and valued.					
6. The facilitator ensured that everyone's input was obtained during team meetings.					
7. The facilitator kept the meetings on track and respected people's time.					
8. The team developed goals for my child that are based on our strengths and preferences.					
9. The plans that were developed used the strengths (skills, talents, assets) of my family, child and other team members.					
10. The safety of my child, family and community were discussed and plans were developed to address any needed safety concerns.					
11. I believe a good plan was created to help support myself, my child and my family.					

Please tell us in what areas the team, facilitator and/or program could improve:

_____

_____

_____

_____

OFFICE USE ONLY

Level of Service Provided: _____ Information and Referral _____ Service Coordination

_____ High Fidelity Wraparound

ATTACHMENT TEN

PRESSLEY RIDGE

PRESSLEY RIDGE
AUTHORIZATION TO OBTAIN, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby request and authorize _____ to release information from the medical,
(name of facility, organization, school, and person)

psychiatric, or drug and alcohol treatment records of _____ _____.
(client name) (date of birth)

This information is to be released to: Pressley Ridge
(name of person and facility or organization, if applicable)
754 Old State Rt 74 Suite C; Cincinnati, OH 45245
(street address, city, state, zip code)

Phone: (513)559-1402 Fax: (513)752-4642

Records are requested for the purpose of (PROVIDE A DETAILED DESCRIPTION) Treatment Planning, Coordination of Services.

Dates of written information requested from (past or present date) _____ to _____(present or future date)

Dates of verbal communication from (present date) _____ to _____(future date)

INFORMATION TO BE RELEASED		
❑ Psychiatric Evaluation	❑ Progress Notes	❑ Academic School Records
❑ Medical History/Physical Exam	❑ Medications	❑ Most Recent Evaluation Report
❑ Social/Family History	❑ Neurological	❑ Current IEP and NOREP
❑ Discharge Summary	❑ Psychological Evaluations	❑ Attendance Records
❑ Course of Treatment	Dates: _____	❑ Teacher's Observations
❑ Treatment Recommendations	❑ Psychological Testing	❑ Complete Behavior Checklist
❑ Drug and Alcohol records	Dates: _____	❑ Two-way written Communications
❑ Lab Reports	❑ Birth Records	❑ Two-way verbal Communication
❑ Summary of Hospitalization	❑ Developmental History	❑ Other: _____
Dates: _____	❑ Mother's Prenatal Records	❑ Other: _____

HIV, Behavioral Health, and Drug & Alcohol information contained in the parts of the record(s) indicated above will be released through this consent unless otherwise indicated. DO NOT RELEASE: ___HIV ___Behavioral Health (Psychiatric) ___Drug & Alcohol

I understand the following:

- that I will receive a signed copy of this completed authorization,
- that I may revoke (withdraw) this authorization at any time by completing a written form that I can get from Pressley Ridge,
- that my decision to withdraw this authorization does not apply to any release of my health records that may have taken place before the date of my request to take back the authorization,
- that my decision to withdraw this authorization may result in Pressley Ridge refusing to provide further treatment if the information was to have been used for treatment, insurance coverage (payment), or agency operations (auditing, performance improvement, compliance, etc.);
- that I have the right to read or get a copy at my expense of the information that is shared, however, there may be some times when I will not be allowed to do this,
- that information released by the agency/person named above may be re-disclosed by the agency/person that receives the information. The information would no longer be protected by the Privacy Rule.
- that Pressley Ridge may not require that I sign this form in order to receive treatment, enrollment or eligibility for services, unless that has been explained to me, and
- that I do not need to allow the information that was requested to be released, unless we are mandated to release it due to one or more reasons stipulated under section B of the Notice of Privacy Practices. I do not need to sign this form. I choose to do so for the purpose written above. I understand that this information will be held strictly confidential.

I have read this form, it has been explained to me, and I understand its contents. This authorization remains in effect until _____ (no longer than 12 months). If no date is indicated, this authorization shall expire 90 days from the date this form is signed.

Client Signature (14 years of age or older): _____ Date: _____

Signature of Parent/designated legal representative: _____ Printed Name: _____

Relationship to Client (parent, guardian, power of attorney, etc.): _____ Date: _____

Staff Signature: _____ Date: _____

ATTACHMENT ELEVEN

RELEASE OF INFORMATION

I, _____, hereby authorize the agencies and entities, which comprise the Clermont County Family and Children First Wraparound Team, service coordination team, clinical review team, OhioRISE team and/or Multi-System Youth Review Team and are initialed below, to exchange information (from whatever source derived) related to both my own participation and that of my minor child in the services they provide.

I understand that the identified agencies may be contacted (please initial).

	Child Focus, Inc.#		Clermont County Juvenile Court#		Greater Cincinnati Behavioral Health Services
	Cincinnati Children's Hospital		Clermont County Educational Service Center#		NewPath Child & Family Solutions
	Clermont County Department of Job & Family Services#		Clermont Recovery Center/GCBHS**		Pressley Ridge#
	Clermont County Board of Developmental Disabilities#		Clermont County Children's Protective Services#		Other:
	Clermont County Public Health#		Clermont County Mental Health & Recovery Board#		Other:
	Other:		Other:		Other:

**A SEPARATE RELEASE OF INFORMATION MUST BE SIGNED BY THE PARENT/GUARDIAN WHEN COMMUNICATION/INFORMATION IS DESIRED FROM OR WITH CLERMONT RECOVERY CENTER.
#MSY REVIEW TEAM MEMBER

_____ **If initialed here, I agree to the use of telehealth platforms for videoconferencing between myself, my family, my child, Clermont County Family & Children First and the agencies identified above. Please note that third-party applications, such as Zoom, Microsoft Teams, etc., potentially introduce privacy risks.**

_____ **If initialed here, I acknowledge that my child is enrolled in OhioRISE and information may be exchanged with the Ohio Department of Medicaid, Aetna Better Health of Ohio, and Cincinnati Children's Hospital/HealthVine.**

The purpose of the sharing of this information is to coordinate, plan, review and evaluate the services and supports provided by Clermont County Family & Children First.

I understand the following:
1. The purpose of this information sharing is to facilitate the referral for and coordination of treatment services and to evaluate the effectiveness of these services for my child, family and/or myself.
2. The above listed and initialed agencies and entities have agreed:
    a. To share this information only with others in accordance with this authorization.
    b. Not to share this information with non-affiliated agencies and entities without my written authorization unless otherwise required or authorized by law.
3. Any and all rights to confidentiality that I may have under state of federal law will continue, except for information covered by this form.
4. An electronic health record data system through Ohio Family & Children First will be used to collect and analyze data on children/families served through Wraparound and/or Service Coordination.^^
5. An electronic health record data system through Cincinnati Children's Hospital/HealthVine will be used to collect and analyze data on children/families served through OhioRISE.^^
6. The Child and Adolescent Needs & Strengths (CANS) tool is an assessment used by Clermont County Family & Children First. The CANS assessment will be entered into the statewide CANS IT database.^^
7. Any information related to the status of HIV or AIDS confirmation will not be released without a written authorization to share the information specifying to whom and for what intended purpose.
8. I may revoke this Authorization at any time except related to information that has been previously exchanged.

9. This Release of Information shall not restrict the sharing of information otherwise authorized by law.
10. All reports and publications of findings related to the evaluation of services received will not reveal my name or that of my family members, and all information and results will be presented in group format.
11. This information is subject to re-disclosure.

^^Information on my child, family, and/or myself may be accessed and used for the purpose of providing and evaluating services or coordinating care for my child, family, and/or myself by state agencies and agencies from other counties who utilize the same statewide electronic health record/database on a need to know basis. Information may be reported in aggregate form on state and local reports.

_____

Name of the Child Date of Birth

_____

Name of Parent/Guardian Parent/Guardian DOB Name of Parent / Guardian Parent/Guardian DOB

Check one:
☐ This Release of Information covers the length of my involvement and the involvement of my child with Family and Children First, without expiration.
☐ I request that this Release of Information be reviewed and re-signed on _____ (date) or in _____ months from the original date.

Subject to applicable state and federal law, I authorize the sharing of the following information regarding my child and me:
1. Records of services provided by any of the above-mentioned agencies or entities.
2. Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional functioning or mental status, and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, or other test results.
3. Medical records including, but not limited to, results of physical and mental examinations, diagnoses of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment or services received, summary of treatment plans and treatment needs, social history and financial information.
4. Drug and alcohol abuse diagnoses and treatment including, but not limited to, results of evaluations, diagnoses, treatment and services received, treatment plans and treatment needs. (This information will be disclosed ONLY IF INITIALED here to permit such release _____). *
5. Any information regarding HIV and AIDS diagnoses and treatment. (This information will be disclosed ONLY IF INITIALED here to permit such release _____). **
6. Treatment summaries and recommendations from above-mentioned agencies or entities.

*Information disclosed pursuant to this authorization has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit further disclosure of alcohol or drug related diagnosis or treatment information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**Information disclosed pursuant to 45 CFR 103 privacy rule. No information will be released regarding HIV/AIDS diagnosis and/or treatment without specific written consent to the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

AGREEMENT:

This Release of Information has been explained to me. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to the sharing of information as described above.

_____ _____
Signature of Child Effective Date

_____ _____
Signature of Parent/Guardian Effective Date

_____ _____
Witness Effective Date

☐ I revoke this release of information effective _____ for ☐ all listed entities ☐ for entities listed below.

_____

REFUSAL:

Initial and sign below:

_____ I refuse to allow my case information to be exchanged. I understand that my signing or refusing to sign this authorization will not affect public benefits or services to which I am otherwise entitled.

_____ _____
Signature of Child Effective Date

_____ _____
Signature of Parent/ Guardian Effective Date

_____ _____
Witness Effective Date

WRAPAROUND TEAM SIGN IN

Listed below are the names/signatures of team members who participated in the development of the plan reflected above. Our signatures reflect our individual acknowledgement that we participated in the development of the plan. In addition, our signatures below reflect our commitment to follow through with the tasks and activities outlined in the plan.

NAME:_____ **DATE:** _____ **LOCATION:** _____ **START TIME:**_____ **END:**_____.

Name	Signature	Relationship/Agency	Phone #	Email Address	Mileage

** We the undersigned, agree to keep confidential all personal and identifying information and records regarding the child and family, whom the Wraparound Team Meeting is for, except otherwise provided for via separate and properly executed Releases of Inormation and in pending Juvenile Court or other Court action. A written summary of this meeting will be distributed to all participants.

ATTACHMENT TWELVE

Plea mplete and return to program staff:

PRESSLEY RIDGE YOUTH/FAMILY GRIEVANCE & RESOLUTION FORM

Youth Name: _____

Grievance Filed by: *(Check one)*
Youth [ ] Family Member [ ] Designated Legal Representative [ ] if representative, please note relationship to client:

_____

Program: _____
Date of Grievance: _____
Subject of Grievance: *(Check one)*
Staff [ ] Program Procedure [ ] Other [ ] if other, please be specific:_____
If Staff, please provide name:_____

(Name & Title)
Description of Grievance: _____

_____
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Staff Receiving Written Grievance:_____
(Name & Title)
Other Staff Notified:
_____Date:_____
(Name & Title)
_____Date:_____
(Name & Title)
_____Date:_____
(Name & Title)

PRESSLEY RIDGE
All Children. Always

Pressley Ridge Gr. ance Process

This policy provides a clear structure for clients or their designated legal representatives to voice, document, and resolve concerns and complaints appropriately and consistently in all programs and support areas of the organization. Pressley Ridge is committed to preventing mistreatment, abuse, neglect, and exploitation of clients and families, and to promoting improvements in provision of services and program practices.

Pressley Ridge Ohio/KY Programs

◊Southwest Ohio Treatment Foster Care, Community Based and Supported Transitional Living Services

Hamilton County Office
2368 Victory Parkway Suite 600
Cincinnati, OH 45206
Phone: 513-559-1402
Fax: 513-559-5475

Butler County Office
734 Dayton St.
Hamilton, OH 45011
Phone: 513-737-0400
Fax: 513-785-3892

Clermont County Office
4424 Aicholtz Rd Suite F
Cincinnati, OH 45245
Phone: 513-753-0395
Fax:513-753-4716

◊Northern Ohio Treatment Foster Care

Cuyahoga County Office
4853 Galaxy Parkway
Warrenville Heights, OH 44128
Phone: 216-292-1525
Fax: 216-292-1530

Lorain County Office
347 Midway Blvd
Elyria, OH 44035
Phone: 440-324-2644
Fax: 440-324-2304

◊Kentucky Treatment Foster Care
7711 Ewing Blvd Suite A-12
Florence, KY 41042
Phone: 859-371-0463
Fax: 859-371-0360

www.pressleyridge.org

COA

ALLIANCE FOR CHILDREN & FAMILIES

PRESSLEY RIDGE
All Children. Always.

Client Grievance Procedure

ATTACHMENT THIRTEEN

Pressley Ridge Client Grievance Procedure

Clients or their designated legal representatives have the right to voice a complaint or file a written grievance to seek resolution for any issue or concern. Pressley Ridge staff addresses and resolves these complaints and grievances in a timely and professional manner.

General

Complaint: A complaint is a concern expressed verbally by a client or their designated legal representative about any issue regarding their treatment within a Pressley Ridge program. It is typically resolved verbally within 72 hours of its communication. It can be reported to staff at any level, but is usually relayed to direct care or supervisory staff, and is resolved at one of those levels.

Grievance: A grievance is a concern expressed in a formal/written manner by a client or their designated legal representative about any issue regarding their treatment within a Pressley Ridge program, which has not been resolved at a verbal level. A written grievance, like a complaint, can be communicated to staff at any level. The procedures in this policy are to be implemented when a written grievance is received.

Grievance & Resolution Form: This form is completed by the client or their designated legal representative making a grievance, and by staff as the resolution process is implemented. (See Grievance & Resolution Form.)

Grievance Log: This is a compilation of all Grievance & Resolution Forms within a given Program, whether still in the process of resolution or completed, and is maintained by the Program Director.

Notification of Final Resolution: This is a notification letter provided to a client or their designated legal representative that documents the final resolution of a grievance. The letter of notification is brief in nature. It indicates the date of the grievance, date of resolution, staff, client and/or their designated legal representative involved in the final resolution meeting. (In an effort to protect confidentiality, the details regarding the description of the grievance and how it was resolved are documented on the Grievance & Resolution Form, not in the letter of notification.)

Procedures

1. All program staff receives training and is provided with a copy of this policy and procedure, as well as related forms, during orientation.

2. At intake, the client or their designated legal representative receives a copy of this policy. Staff will review it with them and they have the opportunity to ask questions. If the client or their designated legal representative is not present at intake, they will receive a copy of the policy at their first meeting with Pressley Ridge staff or by mail within 30 days of admission, whichever is sooner.

3. The client or their designated legal representative is required to sign and date a statement indicating receipt and understanding of the policy, including confirmation that they have had the opportunity to ask questions about the policy. The signed receipt is then placed in the client record.

4. If the client or their designated legal representative is unwilling or unable to acknowledge receipt in this way, the staff member shall document his/her effort to obtain this acknowledgement and the refusal, or the reason the client or designated legal representative did not sign the acknowledgement. This shall be documented on the acknowledgement form with the date and the staff member's signature.

5. Staff will provide the Grievance and Resolution Form to the client or their designated legal representative who expresses the desire to file a grievance, or when a staff member is aware that a complaint or concern has been voiced more than once yet remains unsolved.

6. Staff will provide any assistance or resources necessary to facilitate the documentation of the grievance. (Examples: pens, paper, telephone access, reading or writing assistance, etc., as requested)

6. When a grievance is received by direct care staff it will be reported to a program supervisor within 24 hours of receipt.

7. Action will be taken to address and resolve the grievance within 72 hours.

8. The program supervisor will complete the Review & Action portion of the Grievance & Resolution Form, indicating if the grievance is resolved as a result of their action, and will then sign and date this form. Please see procedure step #14.

9. If the grievance is not resolved at the level of Program Supervisor, the Program Director (or the next level of staff authority in the program) will be notified of the unresolved grievance within 24 hours.

10 If possible, action will be taken to address and resolve the grievance within 72 hours.

11. The Program Director will complete the Review & Action portion of the Grievance & Resolution Form, indicating if the grievance is resolved as a result of their action, and will sign and date this form. See procedure step #14.

12. If this process fails to produce a satisfactory resolution, the client or their designated legal representative has the right to continue the grievance process by requesting a meeting with any of the following organization representatives: Senior Director, State Executive Director, Service Line Vice-President, Compliance Officer, or Executive Vice-President and Chief Operating Officer.

13. At any time upon resolution of a grievance, the following steps occur:

    A. The completed Grievance & Resolution Form is given to the Program Director and filed in the program's Grievance Log;

    b. Notification of Final Resolution letter is prepared and provided to the aggrieved, informing them of the final resolution of the grievance. A copy of the letter is filed in the client record;

    c. A copy of all completed Grievance and Resolution Forms are provided quarterly to the State's Performance Improvement Coordinator for review at the Performance Improvement State Committee Meeting;

    d. State Performance Improvement grievance summaries are provided quarterly to the Organization Rights and Ethics Performance Improvement Committee for review and action as needed;

    e. A summary of the Performance Improvement Rights and Ethics Committee's review of organization-wide grievances is provided regularly to the Pressley Ridge Performance Improvement Committee.

14. If a client or their designated legal representative wishes to lodge a complaint pertaining to their Privacy Rights under HIPAA, staff will provide them the appropriate HIPAA complaint form, and will assist them in completing this form as needed or requested. Staff will then verbally notify their Program Supervisor and the Privacy Officer of the complaint and forward the completed HIPAA complaint form within 24 hours of receipt. The privacy officer will take the necessary actions outlined above in procedure #14 to resolve the complaint and communicate the resolution to the client.

15. Clients or their designated legal representatives may also report alleged HIPAA privacy complaints to the Office of Civil Rights (OCR). Should a client express their wish to do so, staff will provide them with the appropriate OCR complaint form and offer any assistance necessary to complete this form. It should be noted that the client is not required to complete this form in order to lodge a complaint with the OCR. They may also write a letter, send an email, or contact the OCR by telephone. The OCR email address and telephone numbers are both included on the complaint form.

16. Staff will verbally notify their Program Supervisor and the Privacy Officer as outlined above if a client expresses their intent to file a complaint with the OCR Committee.

ATTACHMENT FOURTEEN

POLICY AND PROCEDURE

Policy Name:	**Dispute Resolution Process**
Policy Number:	**1.03.01**
Effective Date:	**6/11/04**
Revised:	**8/8/08, 9/11/09, 10/14/11, 2/13/15, 4/6/17, 11/1/18, 5/4/23**

Matt Earley
Co-Chairperson _____ 6/1/23
Date

Dan Ottke
Co-Chairperson _____ 6/1/23
Date

Cross Reference

N/A

Policy Statement

It is the policy of the Clermont County Family and Children First Council (Council) to resolve any dispute within and regarding the Council, a Family and Children First (FCF) representative or a FCF funded program in a timely manner.

Purpose

To define the process of dispute resolution to be followed by the Council when agreement cannot be reached or concerns arise.

Key Terms

Complainant – the person(s) who is in disagreement with a decision or has a concern regarding the Council, an FCF representative or an FCF funded program and follows the dispute resolution process.

Dispute Resolution Committee (DRC): The DRC reviews all complaints received by FCF and works to develop a plan consistent with the child's needs and meeting the concerns of each system responsible for providing services and/or funding. DRC members are the FCF Program Administrator, a Chair or Co-Chairs of FCF Council, and at least three other FCF Council members as voted on by FCF Council. DRC membership continues until a member requests to be removed from the DRC.

Procedure

I. The complainant will state his/her disagreement or concern either verbally or in writing to the FCF Program Administrator.

   A. Parents and children (when age appropriate) must have access to the dispute resolution process.

   B. All agencies involved with FCF or the family must have access to the dispute resolution process.

   C. All Council members and FCF staff must have access to the dispute resolution process.

   D. Families involved with Clermont County Early Intervention Service Coordination may utilize Policy 1.03.02 – Dispute Resolution Process (Early Intervention Service Coordination)

II. For routine (non-emergent) situations:

A. The FCF Program Administrator will gather all relevant information from the complainant and other involved individuals/agencies. This includes recommendations proposed and alternatives developed or considered by the Wraparound team and/or providers and agencies.

B. The FCF Program Administrator will schedule a meeting or conference call with the Council's Dispute Resolution Committee (DRC) within ten (10) business days of receipt of the information regarding the disagreement or concern.

C. The DRC shall make a good faith effort to develop a plan consistent with the child's needs and meeting the concerns of each system responsible for providing services and/or funding.

D. The DRC shall attempt to develop a consensus, but shall proceed by majority vote as may be necessary to formulate a recommended resolution.

E. The FCF Program Administrator will communicate the recommended resolution of the DRC to the complainant in writing within five (5) business days of the decision.

III. For emergent situations:

A. The FCF Program Administrator will gather all relevant information from the complainant and other involved individuals/agencies. This includes recommendations proposed and alternatives developed or considered by the Wraparound team and/or providers and agencies.

B. The FCF Program Administrator will schedule a meeting or conference call with the Council's DRC within one (1) business day of receipt of the information regarding the disagreement or concern.

C. The DRC shall make a good faith effort to develop a plan consistent with the child's needs and meeting the concerns of each system responsible for providing services and/or funding.

D. The DRC shall attempt to develop a consensus, but shall proceed by majority vote as may be necessary to formulate a recommended resolution.

E. The FCF Program Administrator will communicate the recommended resolution of the DRC to the complainant verbally within two (2) hours of the decision. The recommended resolution will also be sent to the

Complainant in writing within two (2) business days of the decision of the DRC.

IV. The child and/or family will receive necessary services while the dispute is being resolved.

V. All parties shall make a good faith effort to work with the recommended resolution to the extent that it is not contradictory to legal responsibilities and fiscal capabilities.

VI. All DRC decisions are final with the exception being those disputes specified in ORC 121.38 – Resolving agency disputes concerning services or funding. In this situation, the steps outlines in ORC 121.38 shall be followed.

VII. The FCF Program Administrator shall record all disputes/concerns on a Dispute Resolution Form (see attached).

VIII. The completed Dispute Resolution Form and the written recommended resolution of the dispute/concern will be maintained in the FCF Program Administrator's office.

IX. The FCF Council's DRC will review all disputes/concerns, if any, at least annually to determine trends and/or service areas for improvement.

X. If a complaint or concern is regarding the FCF Program Administrator or an agency sitting on the committee, a substitute member will be asked to sit on the committee in that person's place.

XI. All FCF agencies shall have their own complaint/concern policy or procedure. The FCF Dispute Resolution Committee will be used secondary to that agency's policy or procedure and concerning FCF functions and decisions.

Associated Forms & Attachments

Clermont County FCF Dispute Resolution Form

# # #

DISPUTE RESOLUTION FORM

Name of Complainant:_____ Date:_____ Time:_____

Complainant is a:

- ❑ Parent
- ❑ Child
- ❑ Guardian
- ❑ Agency representative
- ❑ FCF Council member
- ❑ FCF staff

Dispute/Concern is:

- ❑ Routine
- ❑ Emergent

Nature of dispute/concern:

Received by _____ Date_____ Time _____
FCF Program Administrator

Meeting/conference call with Dispute Resolution Committee:

_____ _____
Date Time

Dispute Resolution Committee members participating:

_____	_____
_____	_____
_____	_____

Decision of Dispute Resolution Committee

Communicated to Complainant:

- ❑ Verbally (if emergent only) _____ Date _____ Time
- ❑ In writing _____ Date _____ Time

Attach written response to dispute/concern to this form. Form to be maintained in dispute/concern file in FCF Program Administrator's office.