## 11-002.04E GENERAL INFORMED CONSENT FOR MEDICAL DIAGNOSIS AND TREATMENT

It is the responsibility of the worker to talk to providers of mental health, substance abuse and medical services to obtain information about the risks and benefits of treatment in order to give informed consent. Informed consent is sometimes given verbally but a written signature may be required. The worker should involve the parent(s), Guardian ad litem, county attorney and the judge, as appropriate. The worker may seek consultation from physicians within the HHS System.
(See Case Management and Case Management for Juvenile Offenders and Status Offenders Guidebooks, Conflict Resolution for guidelines if there is a disagreement about treatment.)

## 11-002.04F MEDICAL DECISION MAKING

When the Department is guardian of a child resulting from court action or voluntary relinquishment, the Department is legally authorized to make all decisions regarding medical treatment while recognizing the importance of parental involvement in decision making. The worker is responsible for such decisions but will involve the parents (when parental rights are intact) to the maximum extent possible. The worker may give the foster care provider or contracted residential facilities consent to obtain emergency or routine medical treatment. Exception: permission for HIV antibody testing or other screening tests for AIDS must follow established Department policy and protocol.

## 11-002.04J PARENTAL OBJECTIONS TO MEDICAL CARE AND TREATMENT

If a parent objects to medical treatment, the worker and parent should gather information and seek medical advice or evidence of need for treatment. If the parent still objects but the worker's assessment indicates the need for medical care and treatment, the worker will consult with the supervisor. The supervisor and worker should involve the physicians or lawyers or both within the HHS System.

Describe the protocols used to monitor the appropriate use of psychotropic medications for children and youth in the foster care system. States must support their choice of protocols and provide additional information on how the child welfare workforce and providers are trained on the appropriate use of psychotropic medications. The State's protocol must address:

- Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication);

- Informed and shared decision-making (consent and assent) and methods for ongoing communication between the prescriber, the child, his/her caregivers, other healthcare providers, the child welfare worker, and other key stakeholders;

- Effective medication monitoring at both the client and agency level;

- Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible Child and Adolescent Psychiatrist (at both the agency and individual case level);

- Mechanisms for sharing accurate and up-to-date information related to psychotropics to clinicians, child welfare staff, and consumers. This should include both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials; and

- How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals is assessing the health and well-being of children in foster care, and in determining appropriate medical treatment for children, including the oversight of psychotropic medications.

Beginning in June of 2011 the Department began meeting with the Healthcare Oversight Team on a monthly basis. The Oversight Team consisted of the following members:

- Dr. Joan Daughton – Child Psychiatrist
- Dr. Tina Scott-Morhort – Pediatrician
- Megan Kelley – Community Health Educator – Oral Health
- Dr. Jeanne Garvin – Medicaid Medical Director
- Heather Leschinsky – Program Coordinator Medicaid Managed Care
- Eric Sergeant – Program Specialist Medicaid Managed Care
- Pat Taft – Medicaid Program Specialist
- Jessica Hilderbrand – Youth Consumer Representative
- Joan Kinsey – Foster Parent Representative

The oversight team's focus became about enhanced communication and collaboration regarding the healthcare needs of children in the custody of DHHS. Although the team was only to meet on a quarterly basis; the process was expedited to meet more often during the first few months. Monthly meetings were held between June 2011 and November 2011. During the November meeting the team discussed shifting priorities based on internal discussions with the Department regarding Medicaid changes including the possibility of mental health/behavioral health services being offered through an at risk provider. The external team members continue to have ongoing communication with the team leader, however, face to face meetings have not been held.

In addition to the Healthcare Oversight Team an internal team began meeting in December 2011 regarding changes in Medicaid which included reviewing expenditures for Psychiatric Residential Treatment Centers (PRTF), and Therapeutic Group homes (ThGH) being paid for by Child Welfare funding. This also led into discussions regarding the definition of Institutions for Mental Disease (IMD's) and how Nebraska was going to become compliant with the CMS rules and regulations. The Division of Medicaid and Division of CFS continued to meet to enhance data systems to work toward compliance with the rules regarding residential care.

In December of 2011 meetings also began regarding Medicaid possibly entering into an at risk contract for mental health/behavioral health services. An internal team was assembled, which included many of the same members from the Healthcare Oversight team. The internal team included representatives from the Divisions of Medicaid, CFS, Behavioral Health, and Developmental Disabilities. During these meetings the division representatives with the input of a national consultant discussed two separate requests for information (RFI's) publically released in anticipation of a request for proposal (RFP) to be released in July 2012. CFS representatives strived to ensure the needs of children in the department's custody are specifically identified and addressed through the contract. The divisions recognize children in DHHS custody have unique mental/behavioral health issues including trauma related issues. CFS specifically has requested the following areas be addressed in the RFP by the at risk organization: training regarding trauma informed care for providers specific to children in foster care, the oversight and coordination of psychotropic medications, and the sharing of information between the physical health medical home and any provider of mental/behavioral health services for the child. CFS will be part of the review team when the RFP's are submitted and will help in the scoring and awarding of the at risk contract. This collaborative effort has been a demonstration of ways to enhance medical care for children in the custody of DHHS. Ongoing meetings will continue on a weekly/bi-weekly basis with the internal team as the process toward awarding the contract continues. Once the contract is awarded, CFS will have collaborative meetings with the at risk provider, Medicaid, and other division partners regarding the specific requirements listed above for children in the Department's custody. There will a transition period to provide the at risk provider with time to get their business in place to carry out the functions of the contract.

The plan for the next fiscal year is to collaborate with other division partners regarding trauma informed care training for providers, foster parents, and case managers unique to children placed in foster care. CFS will also continue to partner with Medicaid regarding coordination between a child's physical health care medical home and providers of any mental/behavioral health treatment. These continued cooperative efforts will strengthen healthcare oversight for children in foster care.

Oversight of psychotropic medications continues to be a top priority of CFS and the Healthcare Oversight Team. Discussions are ongoing regarding the best way to oversee psychotropic medications. Nebraska participated in the Acquiring and Applying Information on Medications Study sponsored by TUFTS Medical Center earlier this year. This study examines the use of information to develop and implement an oversight plan for the use of psychotropic medications

among children in child welfare custody. This was an opportunity to discuss the state's current plans regarding the oversight of psychotropic medications, and future plans.

Nebraska also participated in the webinar series sponsored by Georgetown University called "Getting Practical: Developing Your State Plan for Psychotropic Medication Management". This series enabled Nebraska to gain better knowledge and insight into ways to oversee the use of psychotropic medications for children in the custody of DHHS. Nebraska also participated in webinars hosted by the Children's Bureau, including a presentation by Commissioner Samuels in regards to the use of psychotropic mediations for children in custody which included national research regarding the use of psychotropic medications.

Currently, Nebraska authorizes and oversees the use of psychotropic medications on a case manager level. The case manager receives a consent request from pediatricians, physicians, and psychiatrists to prescribe, change medications, or change dosages for children receiving psychotropic medications. The case manager in consultation with parents, foster parents, and family teams makes a decision regarding whether the medication is in the child's best interest. Continued planning regarding the oversight of psychotropic medications is needed in Nebraska. Representatives from the Division of Children and Family Services, Behavioral Health, and Medicaid will be traveling to Washington D.C. in August for the Psychotropics Summit as a way to continue ongoing conversations regarding this topic. Children and Family Services is also exploring the possibility of contracting with a psychiatrist with expertise on children's mental health who could provide individual case consultation when requested in regards to the use or changes in psychotropic medications.

Nebraska continues to have the Drug Utilization Review Team (DUR) through the Medicaid Division. Below is an example of the issues are discussed during these meetings. These results are dispersed amongst division representatives to gain a better understanding of decisions made by the review team.

"There were 386 youth under the age of six receiving psychotropic drugs in May, June, or July 2011. The majority, 323 kids or 84%, were also authorized for at least one behavioral health service by Magellan. We looked further into the children not authorized for behavioral health services. There were 63 children not authorized and of those, 47 were receiving appropriate management related to the psychotropic medications. For example, some of the older antidepressants are rarely used to treat depression but are commonly used to treat non-psychiatric conditions (e.g. bed-wetting, migraines, and dermatitis). Specialized behavioral health services would not be necessary or expected in the cases of uncomplicated Attention Deficit Hyperactivity Disorder (ADHD) as the point of entry into ADHD treatment for youth of this age is the family practice doctor or pediatrician.

Deeper analysis was conducted on the remaining 16 youth not receiving behavioral health services with their psychotropic medication prescription. Upon review of these 16 cases, nine were receiving Risperidone and the medical claims history included appropriate diagnoses for such use, such as Autism. Three children were receiving drugs normally used to treat ADHD, however the medical claims history was absent a diagnosis. Three were receiving antidepressants but two of the three only received a single prescription. The remaining child's medication and treatment plan were approved after review by a pediatric psychiatrist consultant under contract with Nebraska Medicaid.

The following mental health services are available for authorization to youth under the age of five, if the clinical definition and medical criteria are met: Pretreatment Assessment/Initial Diagnostic Interview, CAP (Client Assistance Program) sessions, Medication Management, Crisis Therapy

sessions, Family Psychotherapy, and Individual Psychotherapy session. Once a child is age five, authorizations are available for all outpatient services, including Family Psychotherapy, Individual Psychotherapy, Intensive Outpatient, and Day Treatment. As with children under the age of five, these clients must meet the clinical definitions and medical criteria of the service."

Although this example specifically encompasses all children served by Medicaid across Nebraska, it provides insight into one of the ways Nebraska is collaborating with professionals to oversee the use of psychotropic medications for children. CFS realizes continued efforts are needed in the oversight of these medications. Planning for the next fiscal year includes a team (including the Healthcare Oversight Members) assembling in accordance with LB 821 to discuss the current policies regarding the oversight of psychotropic medications, and enhance those policies. Medicaid and CFS have been discussing a way in which pharmacy claims data can be aggregated and reported on children in the custody of DHHS, and have an independent evaluation of the data. Discussions have occurred between DHHS and physicians at UNMC regarding the possibility of having students evaluate the data and provide further analysis to be shared with the oversight team. The internal team is also seeking through the RFP process a plan by the at risk provider to oversee and coordinate the use of psychotropic medications for children in DHHS custody, which will include collaboration between the physical health managed care organizations as many psychotropic medications are prescribed by pediatricians in Nebraska. This continued collaboration will result in a better understanding of prescriber behavior, and how to best review these practices.

# SERVICE PROVISION GUIDEBOOK

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# SERVICE PROVISION

## Definition and Purpose

The provision of family-centered services are designed to promote family preservation and self-sufficiency.

Services are provided on a time limited basis and are focused on parents maintaining or gaining responsibility in decision-making for their family and to ensure their children's basic needs and safety are met.

The Department will use the Family Treatment Team approach for decision-making by addressing the origin of the family problems. The members of the Family Treatment Team will range from case managers and bio-parents to medical providers, family support workers, home based therapists, etc. Medical services will be provided through Medicaid Managed Care in Douglas, Lancaster and Sarpy Counties as of July 1, 1995.

Medical services will be accessed through Medicaid Managed Care in Douglas, Lancaster, and Sarpy Counties as of July 1, 1995. Access will remain the same in the rest of the State. Mental Health and Substance Abuse services will be accessed through Medicaid Managed Care in all areas of the state beginning July 1, 1995.

The protective service worker will be a member of the treatment team under Medicaid Managed Care. The worker coordinates the over-all plan and communicates with and provides feedback to the provider for the treatment plan.

To promote family self-sufficiency and continuity for families, consideration will first be given to:

- Child safety;
- Assisting the family in building a support network with extended family members and friends identified by the family;
- Linking the family with community services which can be independently accessed by the family.

When community based programs are not available or appropriate, contracted or staff provided services will be considered. Service provision during the ongoing phase will also include a therapy or counseling service or a parent skill development service as part of the guaranteed services to families. A wide array of additional services are also available to children and families based on assessed needs.

## SECTION I

## COMMUNITY ASSISTANCE SERVICE

Policy: The family will be referred to and linked to community services as a first means of intervention whenever such a community service exists that can meet the family's need. If the family is already involved with a community service, but is not making appropriate use of the resource the worker will assist the family to use the resource. If the resource is not appropriate to address the needs of the family, the family will be referred to an appropriate resource.

Community assistance services can be as simple as contacting adult education resources with, or on behalf of, families or more complex such as being an active participant in service management activities for home-based agencies.

## SECTION II

## MEDICAL SERVICES

Medical services are available to children made wards of the Department and to those parents or families of wards who meet the eligibility requirements for Department programs offered outside of child protective services.

### Parental Responsibility

Parents are responsible to the extent possible, for the payment of medical services and the medical care of their families. The parental responsibility for payment may be satisfied through several different means including, but not limited to, the following:

- Private insurance coverage carried by the parent;
  If the parent's insurance requires services to be rendered by a designated provider, the worker will ensure such providers are utilized.
- Private payment by parents;
- Medicaid coverage for the child and/or family;
  If a child is a ward and living at home or has been returned home the parent must complete an application for Medicaid, if assistance with payment for medical services is needed.
- Part of a court ordered child support commitment.

Parents are also responsible for scheduling and maintaining all routine, recommended, or follow-up medical appointments for children living at home. If a child is a ward in an out-of-home placement, it is recommended that the parent be present at all medical appointments for the child, unless the parent's presence would not be in the best interest of the child. Thus, consideration will be given to the parent's ability to attend appointments, when scheduling.

### Guidelines for Medical Evaluations and Treatment for Children

The following is the recommended schedule for Health Check (EPSDT) for medical evaluations for children according to age:

- Birth;
- 3 weeks;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 1 year;
- 15 months;
- 18 months;
- 2 years old and at least every year following until age 6; and
- At least every one to two years after age 6 to ensure proper health car maintenance and required immunizations.
- Or more often, if necessary.

The Health Check is well-child care for prevention and early intervention. The attending physician should be requested to complete a total systems review including testing of the child's vision and hearing and that referrals for treatment and/or specialized treatment are made when needed. This will be handled under Medicaid Managed Care.

For children who are wards in out-of-home placements, the protective service worker will check with the Primary Care Provider to see that all recommended medical evaluations, health care maintenance, immunizations, referrals for treatment and specialized treatment are followed through on accordingly. The attending physician will use the Health Check Early and Periodic Screening Diagnosis and Treatment (EPSDT) services for the child's complete physical and mental health maintenance and treatment.

See "Worker's Guidebook on Out-of-Home Placement" regarding information that will be obtained about the child and maintenance of health records.

Nebraska Health Check Program

EPSDT

Purpose:

_To seek out eligible children and inform them of the benefits of prevention and health services available.
_Help children and their families use health resources effectively and efficiently.
_Assess the child's health needs through initial and periodic examinations and evaluations.
_Assure that health problems found are diagnosed and treated early, before becoming more complex and costly.
_Develop a "medical home" for children.

Any child or youth under age 21 who is eligible for Nebraska Medicaid is eligible for the Health Check Program. Health Check benefits and services include:

Screening Services

- Comprehensive health and developmental history (Including assessment of physical and mental health development);
- Comprehensive unclothed physical exam (Physical growth, physical inspection);
- Appropriate immunizations;
- Laboratory test; and
- Health education (Including anticipatory guidance).

Special Health Check Services

- Vision services (age appropriate vision assessment);
- Hearing service (age appropriate hearing assessment);
- Dental services;
- Nutritional counseling;
- Risk education services;
  1. Prepared childbirth session;
  2. Health education and infant/child, care/parenting session;
  3. Breast-feeding instruction; and
  4. Pediatric prenatal visit.
- Weight management.
- Any other treatment that is identified as necessary

For a child or youth to receive treatment for substance abuse the need for further assessment or treatment must be identified by a physician on the EPSDT form to access treatment.

## Federal Requirements

The EPSDT program is one of nine mandated Medicaid services which all state participating in the Federal Medicaid program must provide to children who are Medicaid recipients up to twenty-one years of age. The minimum requirements for State coverage of EPSDT including a health and developmental history, a comprehensive physical exam, vision and hearing testing, appropriate laboratory test and a dental exam by age three. Moreover, the new provision requires that states TREAT ANY PHYSICAL OR MENTAL PROBLEM identified during such screening and assessment if such "treatment" is coverable under Federal Medicaid law even if these "treatments" are not contained in the State's Medicaid plan. (For children in Nebraska this specifically relates to chemical dependency treatment.) Lastly, the provision requires the Secretary of Health and Human Services to establish annual EPSDT participation goals for states and requires states to report annually on progress toward meeting those goals. Proposed goal for each state is to achieve 80% participation of EPSDT eligible in EPSDT screening services in 1995.

## Use of Medicaid

For payment of medical services for wards through Medicaid, see Medicaid Managed Care Guidebook.

For children, who are wards, staff will use fully the services available through the Medically Handicapped Children's Program. Refer to "Services to Wards with Disabilities and Title 467.

## Payment for Medical Services by Foster Parents

Foster parents will not be reimbursed for payment of medical services for wards in their care, except in emergency situations where the foster parent is required to pay for a medical expense. The protective service worker will forward a copy of written authorization to State Ward Medical. Reimbursements will be at Medicaid rates for the specified emergency service.

## Dental

It is recommended that children be scheduled for a dental examination at age 3 (or earlier if a dental problem arises) and at least every 12 months thereafter.

For children who are wards in out-of-home placement and covered by Medicaid the following regulations apply to dental care:

- If more than one dental examination is recommended per year a request must be made for Medicaid approval.
- Medicaid does not cover a panographic x-ray until children reach the age of 13.
- Exceptions to Medicaid policy may be made for children with special needs. The dentist must request an exception from the Central Office, Dental Program representative. The request must include the following:
  1. What additional services are needed;
  2. Medical reason(s) for the need for additional services; and
  3. Information regarding the child's inability to care for his/her teeth, if applicable;

## SECTION III

## SERVICES TO WARDS WITH DISABILITIES

The three categories of individuals with disabilities include the following:

1. Developmental disabilities;
2. Mental retardation;
3. Disabilities.

An individual with a developmental disability is defined as one who:

1. Shows a physiological, anatomical, sensory, motor, mental or emotional loss or impairment or combination thereof, occurring before the age of 22 years, which is likely to continue indefinitely;
2. Has a disability which interferes with the capacity or ability to perform age appropriate activities, in three or more of the following areas as a result of loss or impairment:
   a. Self Care - eating, personal hygiene, dressing, and grooming;
   b. Expressive - Receptive Language - using spoken, written and gestural communication from others;
   c. Learning - tasks involving basic processes for acquiring behavior, including attention, perception, reasoning, retention, imitation, and applying acquired knowledge and skills in new situations;
   d. Mobility - moving form place to place, coordinating movement of body members, using body members to handle things and objects or to control the movement of tools, and sustaining movement for periods of time;
   e. Self-Direction - the regulation of behavior in a purposeful and predictable way, taking into account cultural values and expectations, environmental conditions and personal goals;
   f. Independent Living - housekeeping, meal preparation, money management, maintaining personal health and safety, recreation, and use of community resources; and
   g. Economic Self-Sufficiency - the selection of, preparation for, obtaining, and maintaining employment paying a sufficient wage to provide for personal needs; and
3. Requires individually planned and coordinated combinations of direct physical assistance, special adaptions, special technologies or special training to correct, compensate for, or circumvent activity limitations.

(Definition from Fiscal Year 1987-1989 Nebraska, State Plan for Developmental Disabilities, Department of Health.)

An individual with mental retardation is defined as one who: has been diagnosed as having significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested before the person has reached age 22. (Definition provided by Department of Public Institution, Office of Mental Retardation.)

A psychologist must complete an evaluation of mental retardation including an assessment of intellectual functioning and adaptive behavior. Individual IQ score alone should not determine if an individual is eligible for mental retardation services.

An individual with disabilities is defined as one who: has an emotional or mental illness, behavioral impairment, physical disability, developmental disability, mental retardation, or any, combination of these which requires special assistance or services to modify the effect of the disability.

## Guidelines for Services to Wards with Disabilities

1. Children with disabilities in out-of-home placement have the same right to a permanent living status as do other children in care;

2. Each person with a disability is to be maintained in the least restrictive environment capable of adequately meeting his/her respective needs;

3. The environment and program for the person with a disability should conform to the normalization principle which requires that a person with a disability lead an existence as close to the normal as possible and which makes available to her/his patterns and conditions of everyday life that are as close as possible to the norm and patterns the mainstream of society.

## Worker Responsibilities

Using the information gathered during the assessment of needs, the protective service worker will:

- Ensure that a ward with a disability is periodically assessed and received treatment services designed to address the child's needs;
- Consult with other appropriate Department staff such as, Assistance to the Aged, Blind, or Disabled; Medically Handicapped Children's Program; and Title XX workers;
- Consult with staff from appropriate community agencies;
- Provide information and referral services to the family and child regarding the resources, services, and training opportunities available;
- Link the family and child with the services needed;
- Ensure that referrals for services are done in a timely manner;
- Facilitate at least annual staffings including all appropriate service providers, parents, and child to develop and/or review the plan to address the child's special needs.

## SSI Payments

When a child residing at home or an adult member of a family appears to be eligible for SSI, the worker will refer the family to the Social Security Administration. When a worker suspects that a ward in out-of-home care is disabled or blind, the worker will ensure that an application for SSI benefits is made on behalf of the child. The worker will forward appropriate information in order to process the application (see 469 NAC 2-007.03ff.).

If the child or his/her parents are already receiving SSI payments, a change of payee form must be completed for a ward in out-of-home care. Payments from SSI are placed in the child's guardianship account.

## SSI Disabled Children's Program

SSI-Disabled Children's Program cannot serve children that are active state wards. This program provides services to the family for maintaining the child at home (467 NAC 6004.02B #2). Consult the MHCP worker when transitioning the child off state ward status. To receive services, the children must remain eligible for SSI and under the age 16.

Children age 15 or younger who are receiving SSI benefits are referred by the Social Security Administration to the Nebraska Department of Social Services program. Children age 6 or younger may be eligible for payments for services that no other agency will provide, and all children up to age 16 are eligible for referral and coordination services. The worker will ensure that the plan developed by the SSI - Disabled Children's Program worker is consistent with the child's case plan and will cooperate with the SSI - Disabled Children's worker in addressing the needs identified.

## Medically Handicapped Children's Program

The worker will consult with the worker responsible for services for Medically Handicapped Children (MHCP) if the protective service worker suspects that a child has one of the following conditions:

1. Orthopedic conditions;
2. Scoliosis;
3. Rheumatoid arthritis;
4. Cerebral palsy and neurological disorders;
5. Oral plastic handicaps including cleft lip and cleft palate;
6. Heart disease or condition that lead to heart disease;
7. Cystic fibrosis;
8. Eye conditions amenable to surgery;
9. Midline neurological defects including hydrocephalus and myelomeningocele (spina bifid);
10. Hearing loss (usually greater than 40 decibels);
11. Neoplasm, including leukemia, lymphoma and some tumors;
12. Major medical problems (major chronic or congenital conditions for which the cost of treatment is a major expense, including burns, seizures, illness as a result of premature birth, and urologic and other conditions);
13. Asthma (the most sever cases);
14. Conditions requiring home parenteral hyperalimentation (such conditions as Crohn's disease and intractable diarrhea);
15. Sleep apnea requiring a home monitoring program; or
16. Hemophilia.

Medically Handicapped Children's Program has no need to be involved unless the child needs to be followed by Cerebral Palsy or Craniofacial (facial abnormalities including cleft lip and cleft palate) Clinics/Multidisciplinary team. The worker will include the MHCP worker in staffings and case planning.

## SECTION IV

## MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

Mental health and substance abuse services available through the Department range from evaluations to inpatient hospitalization. Prior to making a referral for mental health services the protective service worker will consider the following:

1. Is there an assessed need that should be addressed by mental or health or substance intervention services?

2. Medical necessity is defined as the need for treatment services which are necessary to diagnose, treat, cure, or prevent an illness, or which may reasonably be expected to relieve pain, improve health, or be essential to life.

3. What is the specific outcome for the mental health or substance abuse service?

### Parental Responsibility

Parents are responsible, to the extent possible, for the payment of mental health and substance abuse services and the care of their families. The parental responsibility for payment may be satisfied through a variety of methods including, but not limited to the following:

1. Private insurance coverage carried by the parent;
   If the parent's insurance requires a referral from a primary care physician and/or services to be rendered by a designated mental health or substance abuse provider, the worker will utilize such provider, if appropriate.

2. Private payment by parents;
   The worker will assist the family in locating community mental health or substance abuse agencies providing services based on a sliding- fee scale if available.

3. Medicaid coverage for the child and/or family;
   If a child is a ward and living at home or has been returned home the parent must complete an application for Medicaid, if assistance with payment for mental health or substance abuse services are needed.

4. Part of a court ordered child support commitment.

   NOTE: The worker should advise parents that they will be responsible for child support.

Parents are also responsible for scheduling all necessary appointments for mental health or substance abuse services for themselves and children living at home. Parents should participate in the treatment planning, treatment and discharge planning for their child unless the parents participation would be counterproductive to the child's treatment as specifically documented by mental health or substance abuse professionals. If a child is a ward in out-of-home placement it is recommended that the parent accompany the child to all mental health or substance abuse appointments, unless the parent's presence would not be in the best interest of the child. Thus, consideration will be given to the parent's ability to attend appointments, when scheduling.

## Levels of Mental Health Services

Mental health services include four broad levels of care:

1. Assessments;
2. Outpatient services;
3. Day Treatment;
4. Out of Home Treatment services.

Resources to be Used: If resources outside the Nebraska Department of Social Services are used to obtain a psychological, psychiatric, mental health, substance abuse, assessment and/or treatment, the following resources must be used:

1. A state licensed community mental health program which is enrolled as a NMAP provider;
2. A licensed psychologist;
3. A psychiatrist;
4. A licensed hospital which provides psychiatric services;
5. A licensed mental health practitioner;
6. A certified drug and alcohol counselor for substance abuse assessments only.

## Assessments

When a protective service worker identifies a need for a professional mental health or substance abuse assessment for a child or his/her family, the worker will:

1. Share the reasons for her/his concerns and recommendations with the family;
2. Limit the recommendation for assessments to those situations in which the problem or circumstances are seen as directly related to the care of the child and the child's situation will be adversely affected by those problems or circumstances or assessments ordered by the court;
3. Refer the child to the managed care provider to obtain assessments of children who are wards when a condition or problem is identified and an assessment may be needed to identify or treat the problems or condition;
4. Attempt to obtain written parental consent for assessment of children in the Department's legal custody;
5. Ensure assessments are conducted in the least restrictive and intrusive manner;
6. The worker should:
    a. Determine if any prior assessments which are relevant to the presenting problem have been conducted provide them to the assessor;
    b. When necessary, obtain written release of information from the parents to obtain prior assessments;
    c. Review written assessments to determine if the concern was adequately addressed when the assessment is completed;
    d. Consult with his/her supervisor regarding the need to obtain a new assessment;

e. Consult with supervisor, family treatment team, and managed care provider to determine if it is appropriate to use a professional who is already knowledgeable of the family and child;

7. Select a qualified professional who has expertise or training in the presenting problem area.

Payment for Assessments

Protective service workers will determine a plan for payment of an assessment by using the following priorities:

1. Provider paid through parents' insurance, by parents (whether at full or reduced cost), or a no-cost provider; (Refer to "Parental Responsibility".)

2. Medicaid provider through Medicaid Managed Care when the child or family is Medicaid eligible and the service is reimbursable under the guidelines;

3. Department contracted provider;

4. Family support funds for assessments of parents or families of wards when the goal is reunification and priorities 1, 2, and 3 are not able to reimburse;

5. District-established special needs funds for assessments of wards, when priorities 1, 2, 5 and 3 are not able to reimburse.

Under provisions of the juvenile code, the Department does not pay for court-ordered evaluations of children to be completed at the Youth Development Center at Geneva.

Outpatient Therapy & Counseling Services

The Department distinguishes between therapy and counseling based on the type and focus of the intervention. Outpatient mental health therapy should be used when the child is experiencing a diagnosed psychiatric disorder, the intervention is prescribed or ordered by a licensed psychologist or a psychiatrist, and the intervention is medically necessary. Interventions must be provided by mental health professionals operating within the appropriate scope of practice.

Counseling services are educational in nature and should be designed to help children and families develop skills.

Counseling services for families involved with Child Protective Services will emphasize the following:

- Problem-solving skills;
- Development of supportive relationships;
- Advocacy for and by the family; and
- Specific skills development including communication skills, child management skills, etc.

Counseling services will be used only when the worker, foster parent, or other appropriate staff cannot provide the needed services. Counseling must be short term, not exceeding six months, unless exceptional circumstances warrant an exception.

## Worker Guidelines

The following guidelines will be used when the protective service worker is planning to initiate, recommend, or pay for therapy or counseling services:

1. Specific problems and/or diagnosis are targeted;

2. Specific goals and outcomes are identified for therapy or counseling which are consistent with the case plan;

3. The intervention will be clearly focused;

4. The level of intervention is the least restrictive and most appropriate intervention available to address the problem and/or diagnosis;

5. The family is willing to participate in therapy or counseling OR the court has directed or will direct it;

6. The service provider emphasizes work with the family as a system; and

7. The service is in closest proximity to the child/family.

The worker will request that the service provider submit regular progress reports that includes the therapy and/or counseling goals, objectives, progress update, and any barriers. The worker will assess the appropriateness of therapy or counseling services when:

1. There is no progress made or reported;

2. There is repeated failure to keep appointments; or

3. Services are not consistent with the case plan.

Before termination of therapy or counseling services the worker will facilitate a team meeting including the family, child, and provider, to determine why there is not progress or services are not utilized and to remedy any problems identified OR to review the progress and success of the child and family.

## Payment for Outpatient Services

Protective service workers will determine a plan for payment of therapy or counseling services by using the following priorities:

1. Provider paid through parents' insurance, by parents (whether at full or reduced cost), or a no-cost provider; (Refer to "Parental Responsibility".)

2. Medicaid provider through the Medicaid Managed Care Program when the child and/or family is Medicaid eligible and the service is reimbursable under the guidelines;

3. Department contracted provider (for counseling or services to non-Medicaid eligible);

4. Family support funds for counseling of parents or families of wards when the goal is reunification and priorities 1, 2, and 3 are not able to reimburse;

5. District-established special needs funds for assessments of wards, when priorities 1, 2, and 3 are not able to reimburse. Refer to Medicaid Managed Care Guidebook for further information about treatment services.

## SECTION V

## SERVICES TO CHILDREN AND FAMILIES THROUGH SOCIAL SERVICES BLOCK GRANT
(Formerly known as Title XX)

There are several types of services made available through Title XX funding. Those most frequently used by children and families involved in Child Protective Services (CPS) include:

1. Homemaker Service;

2. Family Support Service;

3. Child Care Service;

4. Transportation Service.

These services are available to families not involved with child protective services based on need and income guidelines. However, those families involved with CPS that have needs for such services can be eligible " without regard to income".

### Homemaker Services

Homemaker service for families is in-home assistance and instruction provided by a homemaker to maintain and strengthen families and alleviate stresses in the home.

In-home or out-of-home supervision and care of children may be provided for up to 24 hours per day due to temporary absence of the parent or usual caretaker due to hospitalization; or the parent or usual caretaker's need for assistance during recovery from illness.

Out-of-home instruction may also be provided by homemaker providers or services workers in foster care or child protective services cases to:

1. Maintain and strengthen families and alleviate stresses in the home; or

2. Prepare the natural family for the return of the child to the home.

### Homemaker Goals

The goal relating to Homemaker Service for Families are:

1. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency (Goal 1);

2. Achieving or maintaining self-sufficiency, including reduction or prevention or dependency (Goal 2); and

3. Preventing or remedying neglect, abuse, or exploitation of children unable to protect their own interests (Goal 3).

## Homemaker Tasks

The worker, homemaker, and family will work together to identify areas of inadequate family functioning and need for training or assistance in the following:

- _ Management, supervision, training and proper care of children or incapacitated family members;
- _ Organization of household activities and time management;
- _ Management, maintenance, arrangement, cleaning, and care of home appliances, equipment, eating utensils, furniture, and supplies;
- _ Obtaining, storing, planning, preparing, and serving nutritious food for self or family (including any necessary special diets);
- _ Obtaining, and properly caring for clothing, household supplies, and sundry needs of self or family (including laundry tasks of sorting, carrying, washing, drying and ironing);
- _ Maintenance of sanitation within the home;
- _ Maintenance of personal hygiene and health practices for self or family members;
- _ Obtaining any necessary medical care and treatment;
- _ Management and proper use of income and resources; and
- _ Maintaining proper relationships and communication with family members.

## Homemaker Authorization

The worker will authorize homemaker service only for parents or usual caretaker who are eligible as:

- _ Current ADC recipients;
- _ Low Income Family; or
- _ Without regard to income.

When authorizing homemaker service the worker will:

- _ List specific instruction and assistance to be performed by the homemaker; and
- _ Set time frames within which the client is to learn to perform each authorized homemaking task.

## Family Support Service

Family Support Service is not provided based solely upon the request of the family. The instruction and support provided by the Family Support provider must maintain of strengthen the family's capacity to function as independently as possible, and enable them to provide minimum parenting.

Minimum Parenting: Considering ethnic and cultural differences, an action whereby a parent/parent substitute or caregiver ensures that the child is adequately fed, clothed appropriately for the weather conditions, provided with adequate shelter, protected from severe physical, mental, and emotional harm, and provided with necessary medical care as required by law. A parent/parent substitute or caregiver may have personal and situational problems but meet minimum parenting standards.

Services provided must be for the purpose of:

1. Maintaining and strengthening the family, preventing out-of-home placement of children, and alleviating stresses in the home; or
2. Preparing the natural family, including the child(ren) in placement, for the return the child(ren) to the home.

Components of family support service include:

- In-home assistance and instruction provided by a family support provider to maintain and strengthen families and alleviate stresses in the home;
- In-home supervision, observation and modeling of the care of children; and
- Out-of-home support in conjunction with transportation to aid families in getting to and using needed services.

Family Support Service Goals

The goals relating to Family Support Service for Families are:

1. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency (Goal 1);

2. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency (Goal 2); and

3. Preventing or remedying neglect, abuse, or exploitation of children unable to protect their own interests (Goal 3).

Family Support Tasks

The worker, family support provider, and family will work together to identify the areas of family functioning that require training, support, and assistance in the following:

- Management, supervision, training, and proper care of children;
- Basic daily living and survival skills;
- Role modeling;
- Facilitating relationship building and bonding between family member;
- Providing needed emotional support and developing alternative support system;
- Seeking needed information or resources;
- Management of the home;
- Arranging for and obtaining necessary medical care and treatment;
- Management and proper use of income; and
- Maintaining communication between family members.

To accomplish assigned tasks a family support provider will:

1. Provide parents with information and techniques for working with children to assist them in meeting minimum parenting standards

2. Visit assigned families as agreed upon by the family support team (on call and/or on a regular basis);

3. Work with families to assess their own strengths and resources and guide them in problem-solving techniques;

4. Work cooperatively with case manager, parent, and involved professionals in meeting goals designed to strengthen the family and allow the child/children to remain in or return to the home;

5. Have knowledge of community and program resources and make appropriate referrals to assist families;

6. Maintain confidential records of home visits and community contact;

7. Develop and participate in group activities of interest to parents, including support groups;

8. Attend meetings, training sessions, workshops, and classes to further knowledge, leading to more effective job performance; and

9. Observe and report progress and strengths to the case manager.

Family Support Authorization

The worker will authorize family support service only for parents or usual caregiver who are eligible as:

- Current ADC recipients;
- Low Income Family; or
- Without regard to income.

When authorizing Family Support Service, the worker will:

1. List specific instruction and assistance to be performed by the family support provider;

2. Set time frames within which the client is to be independent of the need for family support service;

3. Establish a written agreement with the family which includes:

   a. Identify family information;
   b. Family-identified strengths;
   c. Family-planned goals;
   d. Services identified to assist the family in meeting its own goals;
   e. Tasks to be assumed by the family;
   f. Time limits; and

4. Provide Form DSS-1158, "Family Report," to the family;

5. Establish an initial meeting to clarify goals, direction, and time line.

The worker may authorize Family Support Service for a maximum of six months to be effective during the time the family service case is open. (Initial authorization of three months or less is encouraged.) Extension beyond six months may be obtained from the worker's supervisor.

## Child Care Service

Child care is the business of exercising care, supervision, custody, or control over children age 15 years or younger, or children 18 or younger with special needs under supervision of a court order or involved in protective services. Child care is for compensation or hire, for part of a day, in lieu of the care or supervision normally exercised by parents in their own homes. Child care services can be provided in a variety of settings including the following:

1. Child Care Center: A facility that provides child care for more than seven children between six weeks of age and under years of age.

2. Child Care Home: A registered private home where care may be provided to children from more than one family. (See 474 NAC 6-001.15B1 for the number of children for whom care may be provided.)

3. Child Care Provider: An individual or agency that has:

    a. Requested and agreed to be approved as a service provider;
    b. Become licensed, if required (see 474 NAC 6-001 and 6-002);
    c. Been evaluated by resource development staff in relation to applicable standards if no license is required; and
    d. Signed a service provider agreement jointly with a service agency;

4. In-Home Child Care: Care provided to children in their own home. Any number of siblings may be cared for in their own home.

5. Single Family Child Care: Care provided outside the client's home to children from one family other than the provider's own children.

## Child Care Goals

The goals relating to Child Care Service for Children are:

1. Achieving or maintaining economic self-support (Goal 1);

2. Achieving or maintaining self-sufficiency (Goal 2); and

3. Preventing or remedying neglect, abuse, or exploitation of children (Goal 3).

## Child Care Authorization

The worker may authorize care service only for parents or usual caregivers who are eligible as:

- Current ADC;
- Low income family;
- Low income day care only; or
- Without regard to income.

The worker will authorize care services for eligible families only if each parent or usual caretaker:

1. Is employed;

2. Is actively seeking employment. The worker may authorize a maximum of 15 days per program year July 1 through June 30 for this purpose (The maximum does not apply to families participating in Job Support.);

3. Requires care to obtain medical health services, alcoholism treatment, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and its follow-up, or to obtain family planning services. Note: The worker may submit a request for exception on Form DSS-2A for other related needs;

4. Is enrolled in and regularly attending vocational or educational training to attain a high school equivalent diploma or an under-graduate degree or certificate designed to fit him/her for paid employment. This excludes students pursuing second under-graduate degrees, second certificates, or any post-graduate schooling;

5. Is incapacitated;

6. Would benefit from care services in situations of abuse, neglect, or exploitation where a report will be made to the State Central Registrar;

7. Has a child in foster care and requires day care to receive Title XX or community services directed toward the return of the child to the home; or

8. Needs to escort a child to receive medical care or visit a child in the hospital.

If more than one parent or usual caretaker is included in the family size, a reason listed must apply to each adult.

Note: Individuals eligible as low income day care only for the reasons described in items 1, 2, and 4.

## Transportation or Escort Services For Families

### Introduction

The parent(s) and/or caregivers have the responsibility for providing transportation for themselves and their families. However, if a family has no means of transportation available to them, transportation services may be used to assist with the following:

1. Children to travel to:

    a. Child care;
    b. Programs and facilities which provide health-related treatment or care; or
    c. The Title XX agency or other community resource to receive services as a part of a child protective services plan;

2. Parents or usual caregivers to travel to:

    a. Health services; or
    b. The Title XX agency or a community resource to receive services as part of a child protective service plan; and

3. Biological parents or usual caregivers with children in foster care to receive services directed toward returning the child home.

Note: The child or caregiver must actually be in the vehicle for a trip or a mile to be considered a transportation service unit unless an exception to policy is obtained from Central Office.

## Transportation Goals

The goals which relate to transportation service are:

1. Achieving or maintaining economic self-support (Goal 1);
2. Achieving or maintaining self-sufficiency (Goal 2); and
3. Preventing or remedying neglect, abuse, or exploitation of children (Goal 3).

## Transportation Authorization

The worker may authorize transportation services to families eligible as:

- Current ADC recipients;
- Current SSI and State Supplemental recipients age 18 or younger;
- Low-income families; or
- Families eligible without regard to income.

Families must require transportation in relation to a defined area of need and must be unable to:

1. Provide needed transportation; and

2. Secure transportation by a family member, relative, friend, organization, or agency (other than the Department) at no cost.

## Child Care Transportation or Escort

The worker may authorize transportation:

1. When the care is necessary for any of the reasons listed under Child Day Care Authorization;

2. When transportation costs are not included in the total day care rate; and

3. When the child care provider is licensed, if required by law.

## Foster Care Transportation or Escort

The worker may authorize transportation to allow biological parent(s) or usual caregivers with a child in foster care to receive services directed toward the return of the child to the home.

Transportation related to placement of children in foster care and transportation necessary to carry out a court order for children in foster care is provided by foster care staff. This transportation is included in the definition of foster care service.

Routine foster care transportation required by a child following foster home placement is the responsibility of the foster home parent. For payment to a foster parent see Out of Home Placement and Payment Guidebook, pages 41 and 42.

## Medical Transportation or Escort

The worker may authorize transportation to assist any family member or caregiver, if appropriate, to:

1. Travel to facilities to receive health-related treatment or care;

2. Escort the children to health-related treatment or care;

3. Voluntarily receive family planning services from family planning clinics, private physicians, and other professional sources; or

4. Visit a child included in the family unit or in foster care who is hospitalized.

Health-related treatment or care must be a Nebraska Medicaid-coverable service; the provider does not have to be Medicaid eligible. These services may include physicians' services, mental health service, alcoholism treatment, and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and its follow-up.

Transportation or Escort for Visit

The worker may authorize transportation or escort service to enable a family member or caregiver to visit a hospitalized child who is included in the family unit or in foster care.

## MAXIMUM RATES and ALLOWABLE UNITS

The following information is used by workers when completing provider contracts , Forms DSS-4 and DSS-4A, and by providers when billing on Form DSS-5B.

| SERVICE DESCRIPTION | MAXIMUM UNIT | SERVICE RATE | UNITS/MONTH | CODE |
|---|---|---|---|---|
| Transportation | Mile | $ .20 | 250/per trip | 1805 |
| Transportation | Trip | $2.50 | 16 | 1806 |
| Transportation (Bus) | Trip (Published rate for carrier) | $2.50 | 16 | 1807 |
| Transportation (Taxi) | Trip | 95% of Published Rate | 16 | 1808 |
| Medical Transportation (Individual, bus Mini-bus, or commercial carrier - all except tax) | Trip | $2.50 or Published Rate for Carrier | 16 | 1810 |
| Medical Transportation (Individual) | Trip | $.20 | 250/per trip | 1811 |
| Medical Transportation (taxi) | Trip | 95% of Published rate | 16 | 1812 |
| Medical Escort | Hour | $3.00* | 40 | 1813** |

*The first hour rate is determined by the distance traveled; each additional hour is $3.00 an hour. To determine the first hour rate, see 474-000-502 in the NDSS Manual.

**The rate for the medical escort code (1813) includes both distance and time. The worker shall not authorize a service code for mileage/trip when the escort provider is also transporting the customer. When the escort is not transporting the client, the worker shall only authorize up to the $3.00 per hour rate.

### Transportation Exceptions

The worker will document in the client's case file when a need exists for more units. The District Administrator or his/her designee makes the determination on exception requests. The signed NCR copy of Form DSS-2A, "Social Services Exception," for medical transportation/escort will be routed to the Central Office.

The district designee may approve a per mile rate that exceeds the maximum rate at 474 NAC 5-018.06, but this exception must not exceed the state reimbursement rate per mile. The worker will document in the provider's file the need for the higher rate.

NOTE: There is no exception for exceeding rate maximums at 474 NAC 5-018.06 for a trip rate. If an individual requests an increase in the trip rate, the worker will use the per mile rate.

The worker may authorize the state reimbursement rate if the provider is transporting the client only one way and the destination is at least 50 miles from the pickup. The worker may authorize the state reimbursement for miles the client is in the car.

For example, the provider drives the client from York to Omaha and leaves the client at the hospital. The provider then return home alone. The worker would authorize the state reimbursement for the trip from York to Omaha only. The provider would not be authorized for the return trip.

Section 75-303, Section 4, Reissued Revised States of Nebraska does not allow for a rate higher than the state reimbursement rate for individual providers; Section 68-1019, Section 4, R.R.S., allows the Department to set taxi reimbursements at less then published rate(s).

## PROVIDER USE

### Authorization of Individual Providers

NDSS staff will contract with and authorize payments for individual providers only if:

1. The proposed provider is the individual who will personally drive the vehicle;

2. There is no certified carrier serving the are in which the client needs transportation; or the certified carrier is incapable of providing the specific service in question. (An individual cannot be authorized unless the carrier(s) serving the area provides a written statement that s/he is incapable. If the provider refuses to provide such a statement, the worker shall contact Central Office for possible intervention by the Public Service Commission (PSC)); and

3. The provider is registered with the PSC, certifying that all provider requirements are met. Registration is complete and the provider may be authorized as son as the PSC's self-certification checklist has been completed and a copy mailed/routed to the PSC.

### Authorization of Exempt Providers

NDSS staff may contract with and authorize services for a provider who is exempt from PSC licensure as appropriate to meet a client's needs. The availability of a licensed motor carrier does not limit the use of an exempt provider. In other words, if there is no carrier or the carrier says they cannot serve the client, a PSC carrier does not have to be used.

### Transportation Provider Requirements.

Provider standards for carriers and for individual providers are set by the Public Service Commission (See 474-000-502 of the NDSS MANUAL). Individual providers who contract with NDSS for transportation service must meet these standards in regard to driver qualifications, equipment, insurance, and filing of notice. Department staff shall also apply these standards to carriers who are statutorily exempt from PSC licensure.

NOTE: Transportation provided by child care providers, family support providers, and foster parents is exempt from PSC certification requirements since it is incidental to the service provided.

## SECTION VI

## FINANCIAL ASSISTANCE SERVICES

Any direct means of financial assistance for a family involved with Child Protective Services is available on a limited basis through

1. Family preservation funds;

2. Family support funds.

Family preservation funds are made available to each District for use in efforts to preserve families and prevent out-of-home placements.

Family support funds are made available to each District for use in efforts to reunify families. They are to be used only with families whose child(ren) is a ward and when the case plan is reunification. Family support funds are to be used for family-related expenses NOT child-related expenses.

### Guidelines for Use

Prior to any consideration of accessing family preservation or family support funds the protective services worker will have exhausted other possible resources to assist the family including, but not limited to, the following:

- Referrals to community groups, churches, organizations or other local charities;
- Referral to General Assistance provided by the county but usually applications are processed by the Department;
- Referral to Income Maintenance for such programs as Food Stamps; Aid to Families with Dependent Children; Emergency Assistance, day care, etc.

This requirement does not prohibit funding to assist a family while applications for other programs are being processed or while other checks are being processed.

Family support funds are used to purchase such things as gas, tires, transportation for visits, household items, parenting classes, telephone installation, groceries, and rent.

Evaluations and counseling can be paid from family support funds after all other resources have been exhausted; including:

1. Private resources;

2. Family's ability to pay all or part of the cost has been explored;

3. Private insurance;

4. Available community resources (including sliding fee and no cost resources);

5. Title XIX (if family therapy is done and parents are not Title XX eligible but one of the children is, billing should be done under the child's name);

6. Department Family Therapists; or

7. Intensive in-home contracted services, unless these are not appropriate or available.

Non-contracted services are paid for at no more than Title XIX rates.

## SECTION VII

## PARENT SKILL DEVELOPMENT SERVICES

Parent skill development services are available in some areas as parenting education offered through the community or by contracted providers.

Parents must be able to provide verification of their attendance at such educational programs and provide consent to release information regarding their participation and progress to their protective service worker.

Parenting skills may also be addressed on a one-on-one basis by qualified staff or contract provider such as a family support worker. If parenting issues are to be addressed one-on-one the staff person or service provider will be given clear direction by the protective service worker as to what specific parenting skills are to be worked on. The staff person or service provider will establish goals and objectives to achieve the outcome related to parenting standards that are congruent with the case plan. The staff or provider will also submit written progress reports to the protective service worker.

### Services to Wards Who Are Parents or Expectant Parents

If a child in the custody of the Department or in out-of-home care is pregnant, is an expectant father, or is a parent, the worker will offer services to prepare the young parent for childbirth and assumption of parenting responsibilities (the latter if the ward is planning to keep the baby or is undecided). Wards who are parents must be offered opportunities to participate in parenting education programs, as a member of a group and/or as individually provided. Parenting education may be provided by foster care providers, community service agencies, family support workers, or Department staff members. When a child in the custody of the Department is a young parent and has been or is likely to remain in out-of-home care for three months or longer, the worker will make all reasonable efforts to ensure that the young parent participates in a program of parenting education.

## SECTION VIII

## FORMER WARD PROGRAM

### Purpose of Program

The Department offers extended assistance to support eligible youth after their discharge from the custody of the Department to continue their education in preparing for gainful employment. This program is only available to eligible youth who were wards of the Department through a court action or relinquishment.

The services available in this extended assistance program include:

- information and referral,
- health care coverage, and
- financial assistance.

This program is managed by Income Maintenance workers who provide information and referral, determine eligibility and complete the necessary paperwork for payment. They do not perform a case management role. Former wards will not have case reviews by the Department or the Foster Care Review Board.

### Referral to Program

When a ward who age 18 or older who is out-of-home care is approaching discharge or age of majority, the worker should discuss with the ward his/her future plans for employment or school or both. If the ward has a plan to attend college or a vocational- type program to prepare for gainful employment, the worker will discuss the former ward program with the ward.

The worker will contact an Income Maintenance worker who is responsible for the program to discuss the ward's possible eligibility.

The Income Maintenance (IM) worker will not perform the case management or support services as the protective service worker does for the youth. It is important for the youth, protective service worker and IM worker to have the same understanding of the services provided through this program. An exit interview or team meeting prior to discharge is a good way to develop clear expectations of the program for all involved. The local PALS Specialist should be included in the team meeting if the youth was involved in the PALS Program or if the need for support after discharge is anticipated.

### Eligibility for Program

To be eligible for the program the youth must meet all of the following criteria:

1. Be age 18 through 20;

2. Be single;

3. Be a former court ward of the Department or ward through relinquishment who was in out-of-home care (for example, foster home, group home, independent living) at the time of her/his discharge;

4. Be a US citizen or eligible alien;

5. Be attending and successfully participating in a secondary educational program, university, vocational school or technical training school to prepare her/him for gainful employment;

6. Regularly provide verification of successful participation in an educational program as listed above;

7. Agree to and comply with a written plan outlining the responsibilities of the Department and the youth;

8. Provide current information regarding address, income, resources and health benefits.

9. Be within resource limits according to 479 NAC 6-002.06.

NOTE: If the youth's income exceeds his/her needs as calculated on the Budget form (IM-26FC), the youth may be eligible for the programs but not receive a payment. This might occur during the summer but the youth could be eligible for the next school year based on the eligibility factors.

School Enrollment

The former ward must be enrolled in a secondary or post-secondary school or vocational or technical training. The educational program may be part or full time. Enrollment will be considered as continued through regular periods of class attendance, vacation, and recess unless the student graduates, drops out, is suspended or expelled, or is not registered for the next regular school term. If the youth does not attend summer school, a monthly payment will not be made for those months. The medical coverage will be continued if he/she is eligible for Medicaid. During the school term the former ward must attend school.

Participation in the GED program does meet eligibility for this program if:

- The youth has a time frame (not to exceed three months) for anticipated completion of the GED program before enrollment; and
- The youth provides verification of regular participation in the GED program every month.

At the end of the anticipated time frame or on completion of the program, the youth will need to provide verification of completion of the GED program. The youth should be able to work and participate in the GED program. The youth's budget will be adjusted accordingly.

School Performance

A former ward shall regularly attend classes and maintain a passing average. The Income Maintenance (IM) worker will verify the ward's grades at the end of each school term. The school's definition of passing is used.

Exceptions

If a youth does not attend a post-high school or secondary educational program at discharge of Department custody, he/she is not eligible for this program. If a youth is discharged between school terms, he/she must be enrolled for the school next term unless the plan was for the youth to "sit out" that semester. Program benefits will be terminated if the youth does not attend a school program the next term. The youth may continue to receive benefits and not attend school under the following exceptions:

EXCEPTIONS:

1. When the youth's attendance is postponed due to a mental or physical capacity which prevents participation in a school program for a temporary period of time. Documentation must be provided by the youth's health care provider before the discharge; or

2. When the youth is attending an educational program, is on this program and there is an interruption in attendance due to a mental or physical capacity which prevents participation in a school program for a temporary period of time. Documentation must be provided from the youth's health care provider at the time of the interruption.

3. The youth may "sit out" one school term from the time of discharge from wardship through age 20 or until discharge for this program. The youth may "sit out" the semester immediately following discharge if that was the plan before discharge.

If the youth's physician determines that the youth is unable to work or attend school for a period of time, the youth may receive a monthly payment if she/he provides the doctor's statement of her/his incapacity and the expected time frame for recovery. Six months is the maximum time this can be provided. The youth should apply for other programs such as SSI or AABD and Medicaid.

Under the first two exceptions, the youth may receive one month's payment to avoid losing his/her apartment if the youth is in the hospital. A doctor's statement of incapacity is required. If the youth is still hospitalized after one month, only the personal needs allowance will be paid for a maximum of six months. The youth may be eligible for medical assistance under the Nebraska

Medical Assistance Program (NMAP). After the youth's hospitalization he/she is expected to work until the next school term. The monthly payment will be adjusted to reflect the income.

Under the third exception, the youth will not receive a monthly payment and is expected to support herself/himself. The youth will not lose eligibility for this program by not attending one school term over the time she/he is eligible for the former ward program. The youth may apply for health benefits through NMAP if benefits are not offered through her/his employment.

The former ward is required to enroll in an available health plan if the Department determines it is cost effective and the youth can enroll on his/her own behalf. If the youth is Medicaid eligible, the Department will pay for premiums, deductibles, co-insurance and other cost saving obligations.

Team Meeting

Prior to the ward's discharge, a team meeting will be held to discuss the expectations and services of the Former Ward Program. The meeting should include the protective service worker, youth, IM worker, care provider - if appropriate, PALS Specialist - if appropriate, and parent - if appropriate.

The following issues should be discussed:

- current case plan and services;
- plan for school, housing and employment after discharge including the budget;
- description of program;
- responsibilities and expectations of youth, IM worker, PALS Specialist - if appropriate and care provider or parent - if appropriate;
- requirements of program, including reasons for closure;
- components of an educational plan & written agreement.

The PALS Specialist may assist the youth in any of the following ways:

- identifying a support system for the youth at school;
- providing a support person or mentor for the youth; or
- acting as a liaison between the youth and IM worker.

Written Agreement

The youth, protective service worker and IM worker will develop an educational plan and written agreement. The written agreement will be tailor-made for the youth based on his/her situation. It will be signed by the youth, protective service worker and IM worker. This agreement will be reviewed annually or as the situation changes by the IM worker and former ward.

The written agreement will include but not be limited to:

1. The youth's educational plan, including:

   a. the educational program, including area of study and location of program; and
   b. number of credit hours per semester or quarter.

2. The youth's living arrangements;

3. The number of hours of employment per week or month, if applicable; and

4. The youth's responsibilities for maintaining eligibility in the program to include:

   - compliance with the education plan, including providing verification of successful participation;
   - maintaining employment as determined;
   - providing current information to the IM worker regarding address, income, resources and health benefits;
   - advising the IM worker of major changes such as marriage, quitting school, joining the armed services;
   - maintaining a passing grade point average.

## Services Provided

This program may provide the following services:

Information and Referral
Health Care Coverage
Financial Assistance

A. Information and Referral

The former ward may be eligible for other programs in the community or the Department. The IM worker should inform the youth of programs she/he may be eligible for. Other Department programs may include Health Check (EPSDT), Nebraska Medical Assistance Program, AABD, or Food Stamps, other public assistance programs.

B. Health Care Coverage

To be eligible for Medicaid, former wards in this program must meet income and resource criteria. If the youth is covered by her/his parent's insurance, it will be the primary health care coverage and Medicaid will be secondary. The youth must show her/his medical card to all providers and must inform the worker of any health insurance plan and any individual or group that may be liable for the former ward's medical expenses.

C. Financial Assistance

An eligible former ward will receive a monthly payment to assist in meeting living expenses. The youth will apply for grants and scholarships to pay for his/her educational program. The youth may apply for student loans. The youth should be encouraged to be employed while in school as long as it does not affect his/her academic status.

The youth and IM worker will complete the Payment Computation Budget, Form IM-26FC to determine the amount of monthly assistance and prepare the youth for budgeting his/her own finances. The budget is completed by subtracting any earned and unearned income from the total living expenses to arrive at the amount of payment up to $351.00 The youth will provide current documentation of income and resources to the IM worker.

Payment for Former Ward Completing High School:

Payment may be made up to the amount that would be paid in foster care as determined by FCPAY if:

1. The youth had his/her 19th birthday during high school;

2. The youth will complete high school and has a plan to continue his/her education;

3. The youth will remain in the foster home while finishing high school;

4. There has been a needs assessment indicating that the higher level of need continues; and

5. The higher payment level is necessary for the youth to complete high school.

The higher payment is allowed only until the youth completes high school.

The placement worker may continue oversight and case management based on the youth's needs to see that needed services are being provided.

## Former Ward Responsibilities

The former ward or his/her representative is required to:

1. Provide complete and accurate information;

2. Report any change in circumstances no later than ten days following the change;

3. Present his/her medical card to providers;

4. Inform the medical provider and worker of any health insurance plan, any individual or any group that may be liable for the former ward's medical expenses;

5. Cooperate in obtaining any third party medical payments;

6. Reimburse to the Nebraska Department of Social Services or pay to the provider any third party medical payments received directly for services which are payable by the Nebraska Medical Assistance Program; and

7. Complete a written agreement with the placement worker outlining the responsibilities of the Department and the youth, and meet the requirements of the agreement.

## Responsibilities of Income Maintenance Worker

The general responsibilities of the IM worker include:

- explaining the program to youth;
- determining eligibility and completing necessary paperwork;
- verifying information, as necessary;
- providing information and referral for the youth;
- inform the youth of his/her rights and responsibilities and right to appeal.
- review the written agreement and educational plan with the former ward annually or when the situation changes. (See 479 NAC 6-001.05 for specific duties.)

## Reasons to Close Case

Assistance under the Former Ward Program will terminate when the youth:

- Turns 21;
- Fails to cooperate and provide information necessary to determine continued eligibility;
- Joins the Job Corp or the armed services;
- Gets married;
- Quits school; or
- Is suspended academically and is not attending any school program.

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