Nebraska Children's Commission

Foster Care Reimbursement Rate Committee

Recommendations to the Nebraska Children's Commission and the Health and Human Services Committee of the Legislature

June 22, 2020

Submitted Pursuant to Neb. Rev. Stat. §43-4216

Executive Summary

The Foster Care Reimbursement Rate Committee (FCRRC) of the Nebraska Children's Commission (Commission) was created pursuant to Neb. Rev. Stat. §43 4216 for the purpose of making recommendations in the following areas: foster care reimbursement rates, the standardized level of care assessment, and adoption assistance payments. The FCRRC must review and make recommendations to the Health and Human Services Committee of the Legislature every four years.

The FCRRC monitors and makes recommendations regarding the service array for foster care across both child welfare and juvenile justice, including the appropriate reimbursement rates for agencies supporting foster homes (licensed child placing agencies) and foster parent caregivers. Statewide, there are 2,731 children and youth in foster care in Nebraska.

The rates were increased in 2014, were not recommended to change in 2016, and are being recommended to increase in 2020. In 2019, DHHS implemented a 2% increase in agency and foster parent caregiver reimbursement rates. The 2019 rate increase was taken into consideration in developing recommendations for this report.

In preparation for this report, the FCRRC has developed recommendations derived from the FCRRC statutory charge, as well as work that has been assigned the FCRRC through the Commission since 2016. Since 2016, the FCRRC and Children's Commission has identified the need for the development of a higher level of caregiving reimbursement for children with exceptional medical, developmental and/or behavioral health needs, and the need for an in home wraparound treatment family care model to maintain family like settings and prevent residential treatment placement.

Recommendations

1. **The FCRRC recommends the Foster Parent reimbursement rates be adjusted for a 2% inflation over the next six years.** An inflation increase to the foster parent reimbursement rates and the agency supported foster care rates to span until the 2025 legislative session immediately following the report due in 2024. Recommended rates are detailed on page 4.
2. **The FCRRC recommends the development and implementation of a fourth tier of reimbursement for specialized caregiving** for children who have exceptional medical, behavioral or developmental needs which necessitate extenuating caregiving responsibilities. Recommended rates are detailed on page 4.

3. **The FCRRC recommends DHHS, Saint Francis and Tribal Courts adopt and implement the use of the revised Nebraska Caregiver Responsibility Tool.** The Nebraska Caregiver Responsibility assessment tool modifications contained herein reflect the uniqueness of the specialized level of responsibility and the needs of children and their caregivers achieving permanency through adoption or legal guardianship.
    a. Implement the use of the NCR at DHHS, Saint Francis and in Tribal Courts.
    b. Develop revised training curriculum for the most recent version of the NCR for case managers and supervisors.

c. Assimilate components of the NCR Specialized Level of Care with service definitions and vouchers for Juvenile Probation.
d. Utilize the NCR Specialized Level of Care to minimize letters of agreement and reduce permanency barriers.

4. **The FCRRC recommends DHHS Divisions of Medicaid and Long Term Care and Children and Family Services adopt the recommended Treatment Family Care service definition and rate structure.** The development of a service definition and rate structure for Treatment Family Care can be found in *Appendix J*.

5. **The FCRRC recommends updates to the Nebraska Administrative Code 479, Chapters 7 & 8 specific to the Guardianship and Adoption Assistance programs increase request and appeal process to ensure equitable access to services and support to all children subject to assistance agreements.** The Administrative Code should be updated to clarify that all assistance agreements (adoption and guardianship), regardless of funding source (federal or state), must have a means to provide each caregiver the ability to request a maintenance rate increase and the ability to appeal the determination by DHHS, in accordance with the Administrative Appeals Act.

Nebraska Reimbursement Rate Recommendation Fact Sheet

Nebraska Foster Parent Proposed Essential Rates compared with current daily and annual rates effective July 1, 2019. The increases are proposed to span 2021 until 2025.

AGE	DAILY	PROPOSED DAILY	ANNUAL	PROPOSED ANNUAL
0-5	$20.40	$22.26	$ 7,446.00	$8,124.72
6-11	$23.46	$27.06	$ 8,562.90	$9,876.57
12-18	$25.50	$28.73	$ 9,307.50	$10,485.87

Nebraska Foster Parent reimbursement rates for tiered caregiving responsibilities according to age and need of children. The table below compares the current daily rates (effective July 1, 2019) with the proposed daily rates. Each column increases by $7.50/day consistent with current tiered rate distribution.

AGE	ESSENTIAL	PROPOSED ESSENTIAL	ENHANCED	PROPOSED ENHANCED	INTENSIVE	PROPOSED INTENSIVE
0-5	$20.40	$22.26	$28.05	$29.76	$35.70	$37.26
6-11	$23.46	$27.06	$31.11	$34.56	$38.76	$42.06
12-18	$25.50	$28.73	$33.15	$36.23	$40.80	$44.73

AGE	PROFESSIONAL FOSTER CARE*	PROPOSED SPECIALIZED**
0-5	$75 to $80/day	$77.75
6-11		$82.55
12 18		$84.22

*Professional Foster Care is a fourth level of caregiving reimbursement used by PromiseShip until December 31, 2019 and is currently being used by Juvenile Probation under a pilot program.

**The FCRRC recommends the development of a statewide standardized Specialized Level of Care to be added. For more information see page 11.

Agency Support Proposed Rate

Daily rate paid to the licensed child placing agency to support the foster family.

LEVEL OF RESPONSIBILITY	DHHS EFF. 7/1/19	JUVENILE PROBATION	PROPOSED DAILY RATE
ESSENTIAL	$22.20		$26.92
ENHANCED	$28.73	$38.76	$32.16
INTENSIVE	$39.54		$41.73
SPECIALIZED**		$80.00	$78.95

Foster Care Reimbursement Rate Committee

The Foster Care Reimbursement Rate Committee (FCRRC) of the Nebraska Children's Commission (Commission) was created pursuant to Neb. Rev. Stat. §43 4214 for the purposes of making recommendations related to the statewide standardized level of care assessment and foster care reimbursement rates. A listing of FCRRC members and workgroup members can be found at *Appendix A*. The FCRRC provided its recommendations to the Commission and Health and Human Services Committee of the Legislature in May of 2014, and July 1, 2016 and has continued to work to monitor and review the implementation of its recommendations. In addition to the 2014 recommendations report, the FCRRC has been tasked with submitting a report on July 1, 2016, and every four years thereafter. This report is submitted pursuant to Neb. Rev. Stat. §43 4217 to satisfy the July 1, 2020 reporting requirement.

History & Background

The FCRRC first began working on foster care reimbursement rates following its creation in 2012. The FCRRC and the work charged to it are products of LR37 (2011), a legislative study created to review, investigate, and assess the effects of child welfare reform. LR37 found that foster parent compensation in Nebraska was inconsistent and lacking in a statewide standard. These findings indicated a need to create a basic statewide rate for compensation.

As a result of the LR37 study, the FCRRC was established by LB820 in 2012. At the time, Nebraska foster care rates were among the lowest in the nation. LB820 (2012) required the creation of base rates for foster parents and for the parents to be paid directly, instead of through child placing service agencies. The FCRRC did significant work to ensure that the new base rates and direct payment to foster parents were adequate to recruit and retain quality foster homes and would not have an adverse impact on the agencies that provide foster parent support.

The FCRRC was continued in 2013 by LB530, which required the FCRRC to create a standard statewide assessment tool and foster parent reimbursement rates. The FCRRC released its legislative report containing the rate recommendations, Nebraska Caregiver Responsibilities Assessment Tool, and other recommendations to monitor the implementation process in May of 2014. This report and recommendations were the result of countless hours of work from the Department of Health and Human Services (DHHS), PromiseShip, child placing agencies, foster parents and many other organizations and individuals. Since that time, the FCRRC has continued to monitor implementation of the rates and tool, accept additional assignments from DHHS and the Commission, and work to create its legislatively required report.

Rate Change Timeline

2012 FCRRC submitted their first legislative report. FCRRC recommended the rate structure and methodology in use today. Until 2012, no formal foster care rate study had been completed and the rates, then frozen since the 1990s, were amongst the lowest in the nation.

2013 Legislation was passed and signed into law enforcing the use of the recommended rates proposed by the FCRRC in 2012.

2014 Tiered caregiving responsibility levels "Essential, Enhanced and Intensive" rates were implemented statewide for all foster parents caregiving for children in state custody and those who were under the care of PromiseShip (then known as Nebraska Families Collaborative).

2016 FCRRC submitted their second legislative report indicating **no recommended rate changes.**

2019 DHHS implemented an 'across the board' 2% rate increase for all services including the Essential, Enhanced and Intensive rates for foster care shown on the rate fact sheet on page 4.

2020 FCRRC will make recommendations for rates in their third legislative report since 2012. The recommendations are to cover the period of time until the legislative session following the next legislative report is due (2020 2025).

2021 In order for changed rates to be implemented, legislation must be introduced in the 107th Legislature, 1st session

2022 If passed, rates would go into effect, likely at the beginning of 2022

2024 FCRRC will submit their fourth legislative report.

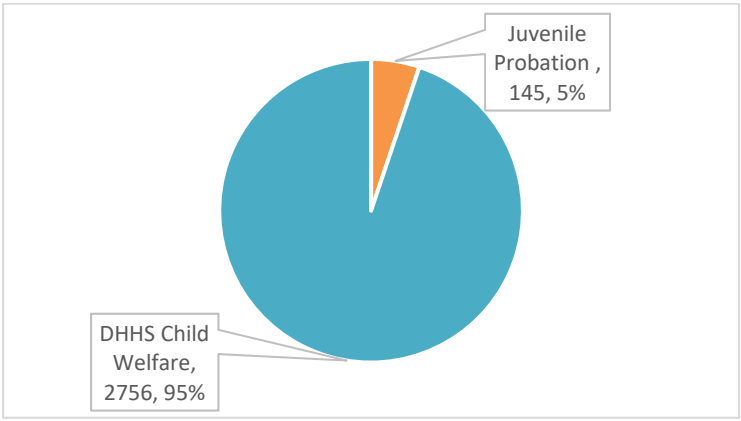
2025 In order for changed rates to be implemented, legislation must be introduced in the 109th Legislature, 1st session.

2026 If passed, rates would likely go into effect at the beginning of fiscal year 2026.

Nebraska Foster Care Data

The Nebraska Department of Health and Human Services reported[1] there were 2,731 children placed in foster care (licensed, relative and kinship homes).

According to the Administrative Office of the Courts & Probation[2], the Juvenile Services Division serves 145 youth through out of home placement in foster care.



[1] DHHS Division of Children and Family Services CFS Point in Time Dashboard Summary Report June 2, 2020 http://dhhs.ne.gov/Reports/CFS%20Point%20in%20Time%20Dashboard%20Report%20 %202020.pdf

[2] State of Nebraska Judicial Branch Administrative Office of the Courts & Probation *Juvenile Services Division Fiscal Year 2017-2018 Detailed Analysis* *https://supremecourt.nebraska.gov/sites/default/files/files/14/12.2018_Juvenile_Detailed_Analysis.pdf*

Foster Parent Reimbursement Rates

Intended Scope of Reimbursement

The reimbursement rates described in this section include the reimbursement rates to foster parents for the care of children and youth in foster care ages 0 18. This would include expenses such as housing, food, transportation, clothing, educational and extracurricular expenses. The majority of children in foster care are eligible for Medicaid and/or the Child Care Subsidy Program, therefore health care and child care costs are not typically provided by foster parents.

The rates are recommended for all children and youth in foster care in both the child welfare and juvenile justice systems.

Methods and Research

The FCRRC divided the work into four workgroups comprised of state and child placing agency representatives, foster care and foster parent advocates and stakeholders. The recommendations contained herein are based on federal reports, Nebraska foster care data, use of past formulas and historical information, national and border state research, Nonprofit of the Midlands Salary indices, surveys with foster parents and foster care agencies and market rate of current Professional Foster Care services by PromiseShip and Juvenile Probation.

Assessment Tool

The FCRRC has developed two assessment tools to be used in the determination of reimbursement rates for foster care and for those children who are exiting foster care to permanency through adoption or legal guardianship.

The Nebraska Caregiver Responsibility (NCR) tool is an assessment tool used by a case manager and foster parent to determine the caregiving responsibilities and corresponding maintenance rates. The assessment uses the child's age and caregiving needs to determine the level of accommodations, interventions, additional planning and consideration in a variety of settings required for the child's safety and well being. Payment increases as the caregiver responsibility increases. Payment level decreases as caregiving intensity decreases in accordance with the child's growth, development and decreased need.

The NCR has been in use since 2014 and has been revised three times since its original form. During 2019, the Level of Responsibility Workgroup has developed a fourth tier of the NCR to outline the specialized caregiving responsibilities necessary for children and youth with exceptional medical and/or behavioral needs.

- The workgroup used the comments from the foster parent survey administered in 2019 (see *Appendix F*) and feedback from DHHS and agencies represented on the workgroup to inform the changes made to the NCR.
- The Foster Family Treatment Association (FFTA) of Nebraska assisted by submitting recommended language.

- PromiseShip and Juvenile Probation were consulted and participated in the development of the NCR. Their unique contributions assisted the implementation of the fourth tier because these entities contract or issue vouchers for professional foster care.
- The changes resulted in the development of a fourth tier of specialized caregiving responsibility for three distinct categories of the NCR. These categories were selected as they best fit the target audience for this elevated care for those children with exceptional medical/physical needs, developmental and/or behavioral health needs.
    - LOR1: Medical, Physical Health & Wellness
    - LOR3: Supervision, Structure, & Behavioral
    - LOR7: Specialized Skills [of the Caregiver]

The revised NCR can be found in *Appendix D*.

Assessment Tool Recommendations:

1. Implement the use of the NCR at DHHS, Saint Francis and in Tribal Courts
2. Develop revised training curriculum for the most recent version of the NCR for case managers and supervisors.
3. Assimilate components of the NCR Specialized Level of Care with service definitions and vouchers for Juvenile Probation.
4. Utilize the NCR Specialized Level of Care to minimize letters of agreement and reduce permanency barriers.

Nebraska Permanency Resource Responsibility Tool (NPRRT). During 2018, the FCRRC workgroups focused on enhancements and changes to better meet the needs of adoptive families by creating an adoptive parent and guardian responsibility tool to be used in preparation for and after permanency. With the expertise of the Level of Responsibility Workgroup, which developed the Nebraska Caregiver Responsibility Tool, adoption professionals, foster parent organizations, and DHHS came together to create the Nebraska Permanency Resource Responsibility Tool (NPRRT). The FCRRC finalized the newly created tool and approved it in May 2019.

The Nebraska Department of Health and Human Services Division of Children and Family Services begun using the NPRRT as part of a subsidy pilot and for subsidy increase requests in 2019. The NPRRT can be found in *Appendix E*.

Reimbursement Rate Changes

Essential Rate

The essential rate is the minimum rate of reimbursement for which all tiered levels of caregiving responsibility are based. The Essential Rate Workgroup developed the rate recommendations using census data found within the *USDA Expenditures on Children by Families* (2017), as well as the Bureau of Labor Statistics inflation calculator to update reimbursement rates for 2019. The calculations took into

consideration variables unique to the Midwest, low moderate income levels, weighting based upon Nebraska's urban/rural geographic composition and divided into three age groups (0 5 years, 6 11 years, and 12 17 years old). For more details on the rate methodology please see *Appendix G*.

The inflation adjustment was applied to adjust the rates for the duration of the legislative reporting schedule. Increase of 6% assuming 2% inflation annually over a 6 year period (2019 2025). This 6 year time period estimates the time between the Rate Committee's legislative report, introduced legislation, and when it is anticipated to go into effect if passed. The rates below indicate the annual and daily rate which are reimbursed directly to the foster parent.

Proposed Essential Foster Care Reimbursement Rate

Age of Child	***Essential Annual Rate (effective July 1, 2019)***	***Proposed Annual Reimbursement Rate***
0 - 5	$ 7,446.00	$ 8,124.72
6 - 11	$ 8,562.90	$ 9,876.57
12 - 18	$ 9,307.50	$ 10,485.87
Age of Child	Essential Daily Rate (effective July 1, 2019)	Proposed Daily Reimbursement Rate
0 - 5	$ 20.40	$ 22.26
6 - 11	$ 23.46	$ 27.06
12 - 18	$ 25.50	$ 28.73

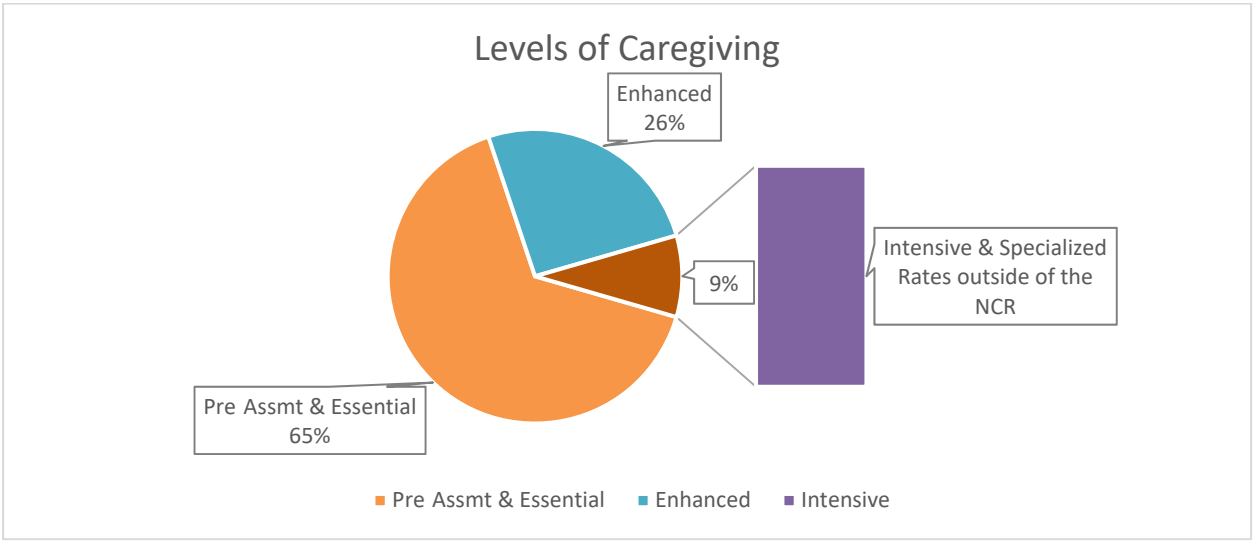
Tiered Rate Structure

The NCR rates were developed for three age groups (0 5, 6 11, and 12 18 years old) and four tiered levels of responsibility (Essential, Enhanced, Intensive, and Specialized). For the first three tiers, the rates increase by $7.50 with each advanced level of caregiving responsibility, which is consistent with the historical rate distribution. This original range was distributed consistent with the previous rate ranges found within the original FC Pay rates used by DHHS until 2014. The rates below indicate the current and proposed rates.

AGE	**ESSENTIAL**	**PROPOSED ESSENTIAL**	**ENHANCED**	**PROPOSED ENHANCED**	**INTENSIVE**	**PROPOSED INTENSIVE**
0-5	$20.40	$22.26	$28.05	$29.76	$35.70	$37.26
6-11	$23.46	$27.06	$31.11	$34.56	$38.76	$42.06
12-18	$25.50	$28.73	$33.15	$36.23	$40.80	$43.73

Tiered Level of Care Data

According to DHHS Division of Children and Family Services point in time data on December 2, 2019, there were a total of 2705 children in foster care placed through DHHS (Child Protection & Safety). The majority of the children (65%) are at the Essential or Pre Assessment Rate[3], while 26% are at the Enhanced level, and 9% of children are at the Intensive level. According to DHHS, the 9% of children being served at the intensive level may also have separate service agreements called, "letters of agreement" to pay for higher reimbursement rates to meet the placement needs of these children. Specialized rate agreements are already in place for some children with exceptional needs.



Specialized Rate

The fourth tier of caregiving and reimbursement exists in the continuum of foster care services available in Nebraska already, however there is a lot of variation in the rates, implementation, and outcomes. Until December 2019, PromiseShip used what was referred to as "Professional Foster Care" to support caregivers caring for children with very high medical needs, developmental, and/or high behavioral health needs. Currently the Administrative Office of the Courts & Probation use a form of "Professional Foster Care" under a pilot program for youth involved in the juvenile justice system who have very high risk and

[3] The Pre Assessment Rate is the rate paid to foster parents when an NCR has not yet been completed. The default amount for DHHS is the Essential rate for the child's age.

behavioral health needs at risk of or stepping down from congregate care settings. Both of these organizations have reported using a rate of $160/day to the supporting foster care agency and foster parent. Approximately $80/day to the child placing/supporting agency and $80/day to the foster care giver.

DHHS has some reimbursement agreements, called "Letters of Agreement" to reimburse caregivers and agencies to support the exceptional, or *specialized,* caregiving needs of children outside of the NCR with a limited number of providers and foster caregivers. Some are accessing a caregiver and network through the Enhanced Family Home model used by the DHHS Division of Developmental Disabilities. The reimbursement range varies extensively.

The use of a specialized rate outside the established Nebraska Caregiver Responsibility Tool and rate structure can create a barrier to permanency for children entering adoption and guardianship. According to the Nebraska Administrative Code[4] DHHS is unable to provide maintenance payments higher than the established foster care reimbursement rates. Therefore, a family receiving a specialized or professional foster rate outside the established NCR may not be able to provide the same level of support without the consistency in rates for a child with exceptional needs.

NEW Specialized Level of Responsibility Rate for Foster Parent Caregiver

AGE	***PROFESSIONAL FOSTER CARE****	**PROPOSED SPECIALIZED**
0-5	$75 to $80/day	$77.75
6-11		$82.55
12-18		$84.22

*Professional Foster Care is a higher level of caregiving reimbursement used by PromiseShip until December 31, 2019 and is currently being used by Juvenile Probation under a pilot program.

Reimbursement Rate Recommendations

1. Implement the proposed reimbursement rate structure for Essential, Enhanced, Intensive and Specialized Levels of Care.
2. Create and implement the specialized level of reimbursement and caregiving across both child welfare and juvenile justice systems.

[4] Nebraska Administrative Code 479 Chapters 7 & 8 Subsidized Guardianship and Adoption Programs

Agency Support Rates

When the FCRRC was initially charged with the rate study, the foster care reimbursements were sent through agencies to be paid to foster parents. The original work of the FCRRC included separating out the agency rate and the foster parent rates. Through the historical research and methods used, the FCRRC continues to monitor and make recommendations for both the appropriate agency supported foster care rate and the foster parent reimbursement rates.

The agency support rates reimburse direct and indirect costs to Child Placing Agencies contracted by DHHS to recruit, train and provide support and retain foster parent caregivers for children in need of agency supported foster care. These costs include things such as on call availability to the foster caregivers, number of visits to the foster home, caseload size, and foster care staffing ratios, licensing, and training and recruitment costs.

Agency Rate Research and Methods

The Agency Support Rate Workgroup conducted surveys of nine participating child placing agencies across Nebraska. The survey responses were compared and adjusted based on the 2019 Nonprofit Association of the Midlands for reasonableness. The results of the survey to providers indicated an increase in staffing costs and indirect costs. Using the methodology used in 2014, the survey results and research for updated calculations, the inflation adjustment was made at 2% for 6 years.

For the Specialized rate, additional weighting and consideration was given for a lower staffing ratio, higher standards of recruitment, support and retention for caregivers of children with exceptional medical, developmental, and/or behavioral health needs. In addition to the additional staffing considerations, certification and clinical components, respite will be a necessary component which must be provided by the supporting agency to the caregivers at 4 days (or 8 half days)[5] per month.

Respite costs should be included in the Administrative and Support Rate so respite caregivers can be trained and supported according to child specific needs.

For more details on Agency Support Rates and corresponding expectations see *Appendix H and I*.

[5] 12 hours or more= full day; 11:59 or less = partial, or half, day. Overnights would not automatically equate to a full day.

Recommended Agency Support Proposed Rate

LEVEL OF RESPONSIBILITY	AGENCY SUPPORT RATES EFF. 7/1/19	JUVENILE PROBATION*	PROPOSED AGENCY SUPPORT RATE
ESSENTIAL	$22.20		$26.92
ENHANCED	$28.73		$32.16
INTENSIVE	$39.54	$38.76	$41.73
SPECIALIZED		$80.00	$78.95

*The Administrative Office of the Courts & Probation (ACOP) currently uses one rate for Essential, Enhanced and Intensive Levels of Caregiving. AOCP provides a similar program to "Specialized" called "Professional Foster Care" at $80.00/day to the Supporting Agency.

Treatment Family Care

Background

Children and youth in the child welfare and juvenile justice systems with complex needs are often served in congregate settings which are costly and delay permanency and community reintegration. Treatment foster care programs serve children in family homes at a lower cost to taxpayers and typically with better outcomes. The Nebraska Children's Commission has strongly supported Treatment Foster Care for child welfare and juvenile justice systems. The Children's Commission tasked the FCRRC with developing the service description and rate structure to develop the framework to implement this in Nebraska.

The FCRRC convened the Treatment Family Care Workgroup to research and make recommendations related to a rate structure that includes expectations regarding treatment components to serve youth in out of home care for whom placement is problematic, disruptive and requires treatment interventions to address their behavioral needs. The Workgroup has met since 2016, to create a service description and rate structure for Treatment Family Care (TFC).

Overview of Service

Treatment Family Care is a service in a home like environment intended to divert children/youth with high treatment needs in an effort to decrease congregate and out of state placements. Treatment Family Care occurs in a home by caregiver(s) or specially trained foster parents to provide consistent behavior management programs, therapeutic interventions, and clinical services as part of a multi disciplinary team and under the direction of a supervising practitioner.

Treatment Family Care Statement of Values

1. Children and youth grow best in families and should access treatment in their own homes when possible. Treatment Family Care must be available to biological families, guardianship families, adoptive families, and kinship placements.
2. Treatment Family Care services must be juvenile justice and child welfare informed, community based, family focused, culturally competent, and developmentally appropriate.

3. Treatment is provided within a family environment with services that focus on improving the child/youth/family's adjustment emotionally, behaviorally, socially, and educationally.

4. Treatment Family Care should be available to children and youth who have co occurring developmental or intellectual disabilities, or who are medically fragile.

5. Treatment Family Care is focused on outcomes. There is no one size fits all model to serve the children and families of Nebraska. Outcomes are more important than compliance to the requirements of one model.

Treatment Family Care Outcomes

1. Families experience seamless systems of care with braided funding. Multiple agencies are involved in Treatment Family Care, and must develop a system for billing which does not disrupt families' experiences of a seamless system of care.

2. Children and youth do not experience automatic placement disruption after completing a course of treatment. Many funding sources are created in such a way that children and youth move once treatment is finished, leading to harmful placement changes. Reducing placement disruptions and changes will also reduce the amount of court time spent on placement changes, and reduce docket congestion.

3. Placements in congregate care and institutional settings are reduced. Placement in these settings can make integrating into a family unit difficult for youth. This reduction will help youth who are child welfare involved reach permanency or reunification in less time, and youth who are juvenile justice involved return to their homes sooner and in a way that preserves community safety. When youth are in an out of home setting, it often is difficult to achieve timely permanency.

Treatment Family Care Service Description

The Workgroup submits the attached service description with recommendations to support the values of the Treatment Family Care workgroup. The document includes modifications to the current draft service definition for Therapeutic Foster Care. Collaborative meetings to discuss recommendations included the Department of Health and Human Services Division of Medicaid and Long Term Care, Division of Children and Family Services, Division of Behavioral Health, and Division of Developmental Disabilities along with providers, foster parents, advocacy groups and other stakeholders. The TFC is designed to be an add on service to the recommended Specialized Level of Care outlined in the NCR.

The full service description approved and recommended by the Nebraska Children's Commission can be found in *Appendix J*.

Treatment Family Care Rate Recommendations

As designed and recommended above, the Treatment Family Care model acts as a wraparound in home treatment service in a foster or family home providing specialized caregiving to a child with behavioral health needs who is at risk of, or stepping down from, out of home congregate treatment placement. It uses blended funding to support the caregivers and prevent placement disruption. The rate structure

includes Medicaid wraparound in home services, Agency Supported foster care providing specialized support to foster parent caregivers.

Rate components taken into consideration:

- Medicaid wraparound services previously known as "Community Based Alternative to Residential" treatment which are now unbundled were used to develop the service components using the current Medicaid rates. This includes weekly in home Certified Treatment Aide (CTA) hours, individual therapy sessions, family therapy, an Initial Diagnostic Interview (IDI) and clinical consultations.
- Therapist and clinical supervisor salary considerations for licensed child placing agencies providing the service.
- Respite to be arranged, trained, and coordinated by the licensed child placing agencies providing the service up to 4 days per month.

RECOMMENDED SERVICE COMPONENT	(SERVICE DURATION= 4 MONTHS)	MEDICAID RATE	OCCURRENCE	FREQUENCY	TOTAL	
INITIAL DIAGNOSTIC INTERVIEW (CHILD)		$ 125.52	1	per year	$ 31.35	(divided by 4 months of service duration)
CERTIFIED TREATMENT AIDE	6 hours at 15 minute increments	$ 11.98	24	per week	$ 287.52	
INDIVIDUAL THERAPY SESSION (CHILD)	twice weekly	$ 112.08	2	per week	$ 224.16	
FAMILY THERAPY SESSIONS	twice weekly	$ 90.42	2	per week	$ 180.84	
CLINICAL CONSULTATION*	2 hours/ month	$ 87.25	2	month	$ 38.77	(divided by 4.5 weeks)

**CLINICAL CONSULTATION $42.31 - $87.25/HR MEDICAID RATE*

RECOMMENDED WEEKLY RATE: $762.64
RECOMMENDED DAILY RATE: $108.95

Adoption Assistance Pilot

Background

The Nebraska Children's Commission charged the Foster Care Reimbursement Rate Committee with reviewing the pilot and making recommendations about the DHHS pilot and revised rate methodology used for all new adoption and guardianship assistance agreements in the Southeast Service Area.

DHHS implemented the pilot in 2018 and there is currently no timeline for statewide implementation. In order to be consistent and equitable across permanency objectives, the pilot was administered to both adoption and guardianship families so as to not incentivize guardianship over adoption or vice versa.

The Essential Rate and Foster Parent Survey (ERFP) Workgroup was assigned to conduct research and make findings related to the adoption and guardianship assistance pilot.

The Workgroup researched other state adoption assistance programs by contacting border state adoption specialists, reviewed publications and consulted with the North American Council on Adoptable Children (NACAC). Data gathered by DHHS during the pilot was also reviewed.

Surrounding state post-adoption assistance programs: Each state reports the maximum for maintenance, rather than a minimum (no more than a child would be eligible for reimbursement as a foster child, which is consistent with federal regulation).

- State to state comparisons fall short as there is considerable variation in the way the programs are administered. For example, Nebraska groups the ages into three age categories (0 5, 6 11, 12 18), whereas Iowa uses four age categories and South Dakota uses two age categories.
- Assistance programs can include additional services beyond maintenance to support the needs of the child including but not limited to medical assistance, post adoption support services, and treatment placements.

Rate development and methodology: Limited documentation exists in border states contacted about how the rates are set, and what methodology was used to establish statewide rates.

National Rate Comparison: According to the NACAC website[6], Nebraska's foster care reimbursement rates are consistent with other states in the nation and are not considered outliers (high or low).

65% of the minimum foster care rate: Iowa established the 65% of the USDA "Cost of Raising Children" as a minimum assistance rate and reported this 65% was established by the Iowa Legislature.

Nebraska is proposing a 65% minimum assistance rates[7] for both adoption and guardianship subsidies. The DHHS established the 65% of the minimum foster care reimbursement rate for Essential Level of Care based on border state research. The workgroup also found the only existing border state with a stated minimum methodology was Iowa's program. No other states have a stated rationale for minimum amounts.

The 65% is based on the rate formula and methodology found within the original reimbursement recommendations developed by the FCRRC in 2012[8] and the *USDA Expenditures on Children by Families* (2011).

Special considerations: Health insurance stipends are available for the limited number of state funded adoption and guardianship assistance agreements which are not eligible for Medicaid to offset the premium costs to adoptive parents and guardians following finalization.

Adoption and Guardianship & the NCR: The pilot includes the use of the Nebraska Permanency Resource Responsibility Tool for children entering adoption and guardianship assistance agreements.

The revised assistance rates are offered only for children whose responsibility scores at the "essential" level. The reduced assistance rate is not offered for those whose caregiving responsibility level scores at the Enhanced, Intensive and Specialized levels.

[6] https://www.nacac.org/help/adoption assistance/adoption assistance us/all states at a glance/

[8] Nebraska Children's Commission *Final Report, Foster Care Reimbursement Rate Committee- December 15, 2012.*

Increase requests: Nebraska Administrative Code[9] outlines a process for adoptive parents to request and receive an increase in their adoption assistance amount when necessary. These increase requests are subject to an appeal process in accordance with the Administrative Appeals Act. According to DHHS, most requests for increase in adoption assistance maintenance rates are approved[10].

- Nebraska Administrative Code[11] does not outline a process for Guardians to request and receive an increase of their state funded guardianship assistance amount. The majority of guardianship assistance agreements are state funded and therefore requests for increases are not functionally available, nor are administrative appeal processes. This is concerning for children achieving permanency through Guardianships through Tribal Courts as adoption is not culturally appropriate.

Nebraska Administrative Code outlines a process for Guardians to request and receive an increase of their federal KinGAP, or guardianship assistance amount when necessary.

Rationale: The workgroup discussed the rationale behind offering the new rate. The workgroup agreed that making the transition from foster care to permanency alleviates some financial requirements of foster care such as visits, specialists, frequent agency meetings, and other court expectations. The workgroup also agreed with the Department's philosophical perspective that the transition to permanency demonstrates the enhanced commitment, claiming and integration of the child into the family unit, which increases the share of responsibility in meeting the child's day to day needs, with assistance from the Department to offset the costs of the child's special needs.

Barriers to Permanency: At this time, DHHS reports no delays or barriers to permanency as a result of the pilot. Unique situations which result in barriers to permanency because of the subsidy are reported to be because the maximum foster care reimbursement rate is insufficient to meet the needs of children with exceptional medical/behavioral needs.

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[9] "Subsidized Adoption Program," *Nebraska Administrative Code,* Title 479 (2004): Chapter 8 http://www.sos.ne.gov/rules and regs/regsearch/Rules/Health and Human Services System/Title 479/Chapter 8.pdf

[10] *Adoption Assistance Pilot Presentation to FCRRC* 11/05/2018; January to October 2018, 150 adoption increase requests were submitted. 75% were approved; 25% were denied due to no change in circumstances, no supporting documentation or were approved but were at the maximum rate.

[11] "Subsidized Guardianship Program," *Nebraska Administrative Code,* Title 479 (2015): Chapter 7 http://www.sos.ne.gov/rules and regs/regsearch/Rules/Health and Human Services System/Title 479/Chapter 7.pdf

Assistance Agreement Recommendations

1. The workgroup agrees with the Department's initiative to implement a standardized process which is equitable and fair across jurisdictions as this did not exist before the pilot.
2. 65% of the maximum foster care reimbursement rate for those children whose responsibility level is essential is an acceptable minimum offer for children who do not present with a guarded prognosis and whose caregiving responsibility level is "essential."
3. **The workgroup recommends updates to the Nebraska Administrative Code 479, Chapters 7 & 8 specific to the Guardianship and Adoption Assistance programs increase request and appeal process. The Administrative Code should be updated to clarify that all assistance agreements (adoption and guardianship), regardless of funding source (federal or state), must have a means to provide each caregiver the ability to request a maintenance rate increase and the ability to appeal the determination by DHHS, in accordance with the Administrative Appeals Act.**

Appendix

Foster Care Reimbursement Rate Committee Membership

Member Name	Member Type	Title and Organization	Representation
Phillip Burrell	Voting	**Director of Youth Services**, Project Everlast	representative from a child advocacy organization that supports young adults who were in foster care as children
Peg Harriott (Co-Chair)	Voting	**President & CEO**, Child Saving Institute	representative of a child welfare agency that contracts directly with foster parents from the Eastern service area
Jessica Kroeker	Voting	**Foster Parent with Nebraska Children's Home Society**, Foster Parent / Project Harmony	foster parent who contracts with a child welfare agency
Bobby Loud	Voting	**Foster Parent with Boys Town**, Foster Parent / Our House Youth Services	foster parent who contracts with a child welfare agency
Liz Lovejoy-Brown	Voting	**Secretary**, Nebraska Indian Child Welfare Coalition	representative from an advocacy organization, the singular focus of which is issues impacting children
Jackie Meyer	Voting	**Executive Director**, Building Blocks for Community Enrichment	representative of a child welfare agency that contracts directly with foster parents from the Northern service area
Felicia Nelsen	Voting	**Executive Director**, Nebraska Foster and Adoptive Parent Association	representative from a foster and adoptive parent association
Jennifer Potterf	Voting	**Director of Kinship / CPA Services**, Saint Francis Ministries	representative of a Lead Agency
Cindy Rudolph	Voting	**CFO/Treasurer**, CEDARS Youth Services	representative of a child welfare agency that contracts directly with foster parents from the Southeastern service area
Lisa Story	Voting	**Foster Parent**,	foster parent who contracts directly with the Department of Health and Human Services
Lana Temple-Plotz	Voting	**Chapter Chairperson / Chief Program Officer**, FFTA / Nebraska Children's Home Society	representative from an advocacy organization which deals with legal and policy issues that include child welfare
Bill Williams (Co-Chair)	Voting	**Chief Operating Officer**, COMPASS	Co-Chair Representative from the Nebraska Children's Commission
Olivia Biggs	Ex-Officio	**Program Specialist**, DHHS, Division of Children and Family Services	representative from the Division of Children and Family Services from the Eastern service area
Brenda Brooks	Ex-Officio	**Western Service Area Administrator**, DHHS, Division of Children and Family Services	representative from the Division of Children and Family Services from the Western service area
Doug Kreifels	Ex-Officio	**Southeastern Service Area Administrator** DHHS, Division of Children and Family Services	representative from the Division of Children and Family Services from the Southeastern service area
Mike Puls	Ex-Officio	**Northern Service Area Administrator**, DHHS, Division of Children and Family Services	representative from the Division of Children and Family Services from the Northern service area
Kari Rumbaugh	Ex-Officio	**Assistant Deputy Administrator**, Administrative Office of Probation, Juvenile Services Division	representative of the Administrative Office of Probation, Division of Juvenile Services
Kathleen Stolz	Ex-Officio	**Central Cervice Area Administrator**, DHHS, Divsion of Children and Family Services	representative from the Division of Children and Family Services from the Central service area

Foster Care Reimbursement Rate Committee Statute

43 4217

Foster Care Reimbursement Rate Committee; duties; reports.

(1) The Foster Care Reimbursement Rate Committee created in section 43 4216 shall review and make recommendations in the following areas: Foster care reimbursement rates, the statewide standardized level of care assessment, and adoption assistance payments as required by section 43 117. In making recommendations to the Legislature, the committee shall use the then current foster care reimbursement rates as the beginning standard for setting reimbursement rates. The committee shall adjust the standard to reflect the reasonable cost of achieving measurable outcomes for all children in foster care in Nebraska. The committee shall (a) analyze then current consumer expenditure data reflecting the costs of caring for a child in Nebraska, (b) identify and account for additional costs specific to children in foster care, and (c) apply a geographic cost of living adjustment for Nebraska. The reimbursement rate structure shall comply with funding requirements related to Title IV E of the federal Social Security Act, as amended, and other federal programs as appropriate to maximize the utilization of federal funds to support foster care.

(2) The committee shall review the role and effectiveness of and make recommendations on the statewide standardized level of care assessment containing standardized criteria to determine a foster child's placement needs and to identify the appropriate foster care reimbursement rate. The committee shall review other states' assessment models and foster care reimbursement rate structures in completing the statewide standardized level of care assessment review and the standard statewide foster care reimbursement rate structure. The committee shall ensure the statewide standardized level of care assessment and the standard statewide foster care reimbursement rate structure provide incentives to tie performance in achieving the goals of safety, maintaining family connection, permanency, stability, and well being to reimbursements received. The committee shall review and make recommendations on assistance payments to adoptive parents as required by section 43 117. The committee shall make recommendations to ensure that changes in foster care reimbursement rates do not become a disincentive to permanency.

(3) The Foster Care Reimbursement Rate Committee shall provide electronic reports with its recommendation to the Health and Human Services Committee of the Legislature on July 1, 2016, and every four years thereafter.

Historical Timeline

LR37 (2011) The FCRRC and the work charged to it are products of LR37 (2011), a legislative study created to review, investigate, and assess the effects of child welfare reform. LR37 found that foster parent compensation in Nebraska was inconsistent and lacking in a statewide standard. These findings indicated a need to create a basic statewide rate for compensation.

LB820 (2012) As a result of LR37, LB820 was introduced in January and signed April 2012. The Foster Care Reimbursement Rate Committee (FCRRC) was created under the Department of Health and Human Services.

- Make recommendations for a statewide standardized level of care assessment and foster care reimbursement rates.
- Base Rates recommended using USDA cost to raise a child in the Midwest
- Nebraska Caregiver Responsibility (NCR)Tool established
- Focus moves from child's needs to the responsibilities of the Caregiver

Recommendations:

- Create base rates for foster parents and for the parents to be paid directly, instead of through child placing service agencies.
- New base rates and direct payment to foster parents must be adequate to recruit and retain quality foster homes and would not have an adverse impact on the agencies that provide foster parent support.

LB530 (2013) Signed by Governor in July 2013. The FCRRC was continued, followed the administrative moved under the Nebraska Children's Commission to the Foster Care Review Office and additional formal requirements of the FCRRC.

- NCR pilot was authorized as a "statewide standardized assessment tool"
- FCRRC was established under the Nebraska Children's Commission; Membership was also established including voting and non voting ex officio membership
- Three focus areas emerged:
    1. Foster Care Rates
    2. Level of Care tool
    3. Impact on Adoption Subsidies
- Rate recommendations due July 2016 and every 4 years thereafter
- DHHS to implement FCRRC Rate Recommendations by 7/2014

Oct 2013 Rate Committee approves membership and holds its first meeting.

- NCR pilot results analyzed
- Sub workgroups established

May 2014 The FCRRC released its legislative report, following minor changes and approval by the Nebraska Children's Commission.
Recommendations included:

1. Base Rate

2. Level of Care Rate
3. Pre Assessment Rate
4. Agency Support Rate
5. Makes upgrades to NCR tool
6. Makes recommendations for implementation and training
7. Makes recommendations for ongoing monitoring and reporting
8. Makes recommendations for transportation costs in rural areas

2015 The FCRRC continued work to refine the NCR, assess the appropriateness of the rates through the use of surveys and took on a special project.

- The Group Home Rate Sub Committee was formed to develop a methodology for unbundling group home rates at the request of DHHS.

The Group Home recommendations:

- A legislative review of group home quality of care, cost of care, and performance outcomes.
- The legislative review must also identify the acuity of children and youth served when considering outcome based performance measures.

March 2016 The FCRRC released a legislative report highlighting

- Results of a foster parent survey
- Recommendation of a pre assessment rate to be used during the first 30 days of placement
- Recommendations included modifications to the NCR including the RPPS, foster parent liability insurance among other recommendations
- Training needs were identified and recommendations were made to further the ongoing implementation of the NCR.

April 2017 Treatment Foster Care Service Definition advanced and approved.

2018 Further work to monitor the implementation of the FCRRC including the following activities:

- Treatment Foster Care Service Definition modifications
- NCR tool enhancements
- The development of an Adoptive Parent NCR
- Separate workgroup reported out on Kinship licensing and training work completed for DHHS
- Requested and received information on a DHHS adoption subsidy pilot

Nebraska Caregiver Responsibility Tool

The Nebraska Caregiver Responsibility Tool determines the foster care maintenance rate for caregivers of children and youth in foster care.

The tiered caregiving responsibilities take into consideration the level of accommodations, interventions, additional planning and consideration in a variety of settings required for the child's safety and well-being. Each level includes the responsibilities of the previous level. Payment increases as the caregiver responsibility increases. Payment level decreases as caregiving intensity decreases in accordance with the child's growth, development and decreased need.

LEVEL OF RESPONSIBILITY	TIERED CAREGIVING RESPONSIBILITIES
ESSENTIAL (L1)	• Routine caregiving and nurturance for a child that is developmentally on track and consistent with chronological age.
ENHANCED (L2)	• Caregiving requires a low level of modifications or minor adaptations; these could be temporary or ongoing. • Additional consideration and planning is needed in some settings but not all. • Caregiver(s) seeks support, advocates and self-educates about the child's special circumstances.
INTENSIVE (L3)	• Caregiving requires a moderate level of special planning and accommodations in multiple settings. • Condition-specific training or certification, intensive involvement with service providers is expected at this level of responsibility.
SPECIALIZED (L4)	• Caregiving requires a high level of safety dependent and/or medically required interventions. • Caregiver(s) must have additional training and/or certification to provide therapeutic or medical interventions for child's exceptional needs.

How the NCR Should be Completed?

For each of the responsibilities, indicate the level of responsibility (LOR) currently required to meet the needs of the child (based on results of the current assessment model). The focus is on the caregiver's responsibilities, not on the child's behaviors. Outline caregiver responsibilities in the box provided for any category rated (level) L2 or higher.

Forms should be filled out during a face-to-face meeting with the caregiver, the assigned worker, and the child placing agency worker (if applicable). Caregivers and the child placing agency worker (if applicable) should receive copies of the completed tool. If the caregiver disagrees with the results of the NCR document, he/she should notify the case worker and/or child placing agency worker as applicable.

When the NCR Should be Completed?

When the child is removed from their home and placed in a foster home, the NCR should be completed **no more than 30 days from the initial removal**.

When a placement change is made, the NCR should be completed **within seven days of the placement change.** The caregiver is expected to assume the level of responsibility from the most recent NCR in the time before the NCR can be completed in the placement.

The NCR should be completed **no more than 30 days from the following**:

- Caregiver Request
- Agency Supporting the Caregiver Request
- Division of Children and Family Services Request
- When the Permanency Plan changes for the child
- When the child's circumstances change (such as needing more or less care from the caregiver)
- Every six months from the date of the placement (unless an additional NCR has been completed in the last six months)

Notice of Change in Payment Rate

If the rate of payment decreases due to a reassessment and change in level of caregiver responsibility, notice will be provided to caregiver thirty days in advance of the rate change. If the rate of payment increases due to a reassessment and change in level of caregiver responsibility, the rate change will be effective immediately when all necessary approval and signatures have been obtained.

Liability Coverage

Federal and state law mandate liability coverage for caregivers. For more information, speak with your child's case worker and/or agency representative.

Reasonable and Prudent Parenting Standard

In accordance with the Strengthening Families Act (SFA) caregiver should exercise reasonable and prudent parenting standards. REASONABLE PRUDENT PARENT STANDARD (RPPS) means a standard characterized by careful and sensible parental decisions which maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the State to participate in extracurricular, enrichment, cultural, and social activities.

Transportation and Mileage

Department of Health and Human Services Policy

One hundred miles of transportation is included in the monthly maintenance rate. The cost of transportation of 100 miles or less is considered to be a "usual" expense related to care of a child. The caregiver(s) may receive monthly reimbursement at the Department established rate. Transportation arrangements should be detailed in the LOR Tool.

Nebraska Caregiver Responsibility Tool

Child's Name:_____ Child's Master Case # _____

Child's Age: _____ Child's Date of Birth: _____

Today's Date: _____ Last Assessment Date: _____ Previous Score: _____

Service Area: _____ Child Placing Agency:_____

Assessment Type:

☐ Initial

☐ Request of caregiver

☐ Change of placement

☐ Reassessment (6 months from date of previous tool)

☐ Request of agency/department

☐ Change in child's circumstances

☐ Change in law or regulation indicates a need for revision

LOR1 Medical, Physical Health & Wellness	
The Medical, Physical Health and Wellness category of the NCR describes the physical health, wellness and medical caregiving responsibilities.	
L1	Definition: • Caregiver ensures the child attends routine medical, optical and dental appointments; schedules, arranges and participates as appropriate; • Caregiver maintains record of appointments and follow up care, shares developmentally appropriate health information with child. • Caregiver follows established policies to ensure child's physical health needs are met by providing basic healthcare and response to illness or injury. • Caregiver administers medications as prescribed, keeps a medication log of all prescribed and over-the-counter medications, understands the medications, and submits the medication log monthly.
L2	Definition: • Caregiver arranges and participates with additional visits with medical specialists, assists with treatment and monitoring of specific health concerns, and provides periodic management of personal care needs. Examples may include treating and monitoring severe cases of asthma, orthodontics, physical disabilities, and pregnant/parenting teen. • Caregiver provides instruction and assistance to a parenting youth to ensure safety and wellness as well as increased abilities to be self-sufficient. • Additional health concerns and Caregiver's role in meeting these additional needs must be documented. • Caregiver transports* and participates in additional medical appointments, including monthly medication management, and monitors health concerns as determined by case professionals. • Caregiver transports* and participates in physical, occupational and/or speech therapy.

L3	Definition: • Caregiver provides hands-on specialized interventions to manage the child's chronic health and/or personal care needs. Examples include support of hearing and visually impaired, using feeding tubes, physical therapy, or managing HIV/AIDS. • Any specialized interventions provided by the Caregiver should be reflected in the child's case plan and/or treatment plan. • Caregiver works with family of origin to co-parent the child, coaching techniques and attending appointments. Examples include attending meetings with doctors, specialists, educators, and therapists together. • Documentation should illustrate Caregiver's training and/or certification; specialized interventions utilized to manage chronic health and/or personal care needs; efforts to engage parent(s).
L4	Definition: • Caregiver has advanced specialized knowledge and training by medical/treatment professional to provide and/or collaborate to provide all medical care to a child with complex medical needs so that the child can be safely cared for in a home setting. Examples include (but are not limited to) Caregiver providing and coordinating medical care for a child with a tracheostomy and/or ventilator, a child undergoing or who has undergone a transplant, a child with severe burns, a child participating in hospice or palliative care, a child undergoing chemotherapy, radiation, or other therapies. • Caregiver provides all appropriate activities of daily living due to child's medical condition; • Caregiver attends all medical procedures, surgeries, and hospitalizations; • Caregiver provides a home environment that supports the child's medical equipment and/or is willing to make home and/or vehicle modifications.
Comments	

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

LOR2 Family Relationships/Cultural Identity	
The Family Relationships and Cultural Identity category of the NCR describes caregiving responsibilities necessary to support the child's relationship with their family of origin, and to support the child's healthy development of an integrated identity relevant to their culture and developing identity as an individual.	
L1	Definition: • Caregiver supports efforts to maintain connections to family of origin, including siblings and extended family, and/or other significant people as outlined in the case plan; • Prepares and helps child with parenting time and other contacts; shares information and pictures as appropriate; supports the parents and helps the child to form a healthy view of his/her family; treats/speaks about family of origin respectfully. • Caregiver follows established parenting time plan and supports ongoing child- parent and sibling contact. • Caregiver provides opportunities for the child to participate in culturally relevant experiences and activities including transportation.* • Caregiver assists with the integration and development of the child's identity. Activities could include working together on the child's lifebook, advocating for the child in school, medical and other settings when appropriate, collecting and sharing photo/videos of family members. • Caregiver fosters connections to members of the child's racial, ethnic, religious, cultural, and tribal heritage.
L2	Definition: • Caregiver arranges and supervises ongoing contact between child and family of origin and/or other significant people or teaches parenting strategies to other Caregivers as outlined in the case plan. • Caregiver provides regular instruction to the parent(s) outlining parenting strategies. This feedback must be reflected in Caregiver's required ongoing documentation. • Caregiver seeks information to learn about identity, intercultural and interracial families, and the importance of cultural connections for children in out of home placement. • Caregiver helps the child work through dynamics of family of origin. This could include seizing teachable moments, coaching the child/family, and seeking services to assist the child in understanding healthy coping skills for managing challenging and meaningful relationships.

L3	Definition: • Caregiver works with family of origin to co-parent child, sharing parenting responsibilities, OR supports parent who is caring for child. • Caregiver partners and collaborates with parents to ensure both Caregiver and parent attends child's appointments and activities. • Caregiver allows parental interaction in the foster home and provides support to the parent while the child is in the parent's home. • Caregiver allows the parent to participate in daily routine of the child in the foster home (i.e. dinner, bedtime routine, morning routine). • Caregiver helps child make sense of challenging and meaningful relationships by seeking services, training, interventions, and/or other supports. • Caregiver regularly attends cultural events with the youth/child to enhance cultural connections, such as attending places of worship, salons, community events and other cultural lifestyle activities in order to support the youth's identity formation and self-expression. • Caregiver recognizes cultural differences and allows for time to celebrate all cultures; • Seeks out additional supports and family to create a pro-social network long-term.
Comments	

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

LOR 3 Supervision, Structure, & Behavioral	
The Supervision, Structure, and Behavioral category of the NCR describes the level of supervision and structure necessary to meet the child's needs.	
L1	Definition: • Caregiver provides routine direct care and supervision of the child, assists child in learning appropriate self-control and problem solving strategies; utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change, adapts schedule or home environment to accommodate or redirect occasional outbursts. • Caregiver provides age and developmentally appropriate supervision, structure, and behavioral and/or emotional support. • Caregiver provides examples of strategies and interventions implemented. • Caregiver provides supervision that is appropriate and expected for the chronological age of the child. For instance, 24 hour supervision of an infant or two year old would be considered appropriate for the age of the child.
L2	Definition: • Caregiver follows current established treatment plan or safety plan to ensure child's safety and well-being are addressed. • Structure and supervision requires minor adaptations or modifications in some but not all settings on a temporary, or on an ongoing basis. • Additional consideration and planning is needed in some settings such as afterschool, playing outside, running errands, or during family outings, but not all settings. • Caregiver seeks out and self-educates about the child's specific condition and advocates on behalf of the child's needs. • Caregiver has regular contact with medical, mental health, or other treating professionals and participates, and/or supports the family of origin, in participating in mental health services for the child as appropriate.
L3	Definition: • Requires individualized and ongoing special planning and modifications in order to be successful in all settings such as home, school, extracurricular, errands, family outings. • Caregiver provides direct care and supervision that involves the provision of highly structured interventions such as using specialized equipment and/or techniques and treatment regiments on a constant basis. • Caregiver seeks assistance from external sources to create specialized structure in the home that meets the child's behavioral and emotional needs. • Interventions are developed in consultation with case management staff and must be followed to ensure the child's safety, behavioral, and emotional needs are met. • Treatment plan requires immediate, ongoing, and continuous monitoring outside of what is expected for the age of the child. If the plan is not followed, the child is at risk of imminent danger. • Caregiver maintains frequent, contact (at least two or more times per month) with mental health professionals and actively participates in mental health services for the child and monitors the child's behavioral health needs.

	• Caregiver provides instruction and assistance to a parenting youth to ensure safety and well-being, as well as increased abilities to be self-sufficient. • Caregiver works closely with all professionals to understand court supervision expectations including risk, need, and responsivity (such as gender, learning style, motivation, culture and mental health) for justice involved youth.
L4	Definition: • Caregiver provides direct care and supervision on a continual basis during all awake time with the possibility of additional checks during not-awake periods. This level of supervision would be expected for a child with high medical needs. • Supervision includes the provision of highly structured interventions such as using specialized equipment and/or techniques and treatment regimens to ensure the safety of child and others. Examples of specialized equipment include apnea monitors, alarms, single bedrooms modified for treatment purposes, or adaptive communication systems, etc.; • Continuous direct care and supervision could also be the result of caring for a parenting youth in the home who has the additional responsibility of rearing their own biological child. • Caregiver will accept assistance from external sources to create specialized structure in the home that meets the child's behavioral and emotional needs. This includes working with multiple professionals to develop, implement and monitor strategies to intervene with behaviors that put the child or others in imminent danger or at immediate risk of serious harm or legal risk. • This level requires at least one Caregiver to have a flexible schedule when a child repeatedly cannot be maintained in other settings, including daily programming disruptions, unpredictable behaviors or cautionary measures linked to a parenting youth or frequent illnesses necessitating a Caregiver's immediate response. • Caregiver maintains at minimum, weekly contact with mental health professionals and is an integral participant in the child's mental health services and behavioral interventions. • Respite needs must be determined in advance with specialized pre-determined Caregivers included in an established plan. • Child and condition specific training could include criminogenic risk, trauma, crisis response, verbal de-escalation, caring for youth after institutional placements, special populations, etc. • Caregiver works with the child's team to keep a current support plan understanding high risk domains and building skill around those, incentives and sanctions for youth involved in court.
Comments	

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

LOR 4 Education and Cognitive Development	
The Education and Cognitive Development category of the NCR describes the level of educational and developmental interventions and techniques necessary to meet the child's needs.	
L1	Definition: • Caregiver provides developmentally appropriate learning experiences for the child, noting progress and special needs; assures school or early intervention participation as appropriate; supports the child's educational activities; addresses cognitive and other educational concerns as they arise. • Routine educational support includes providing transportation* to and from school, providing a structured homework routine and help with homework; maintaining regular, ongoing contact with school to ensure age-appropriate performance and progress. This includes participation in regularly scheduled parent-teacher conferences with the parents (as appropriate). For non-school age children, the Caregiver will ensure the child is working on developmental goals (i.e. colors, ABCs, counting, etc.) • Educational goals may include both school-based as well as job training goals (for older youth).
L2	Definition: • Caregiver maintains increased involvement with school staff to address specific educational needs that require close home/school communication for the child to make progress AND responds to educational personnel to provide at-home supervision when necessary; or works with others to implement program to assist youth in alternative education or job training. • Caregiver implements monitoring in the home to reflect established learning plan objectives or collaborates with professionals regarding truancy matters, suspensions, advocating and bringing attention to educational concerns and engagement with school professionals to ensure child's educational goals are met. • Caregiver provides examples of efforts to support education. • Caregiver provides support and structure for child if suspended or expelled from school. • Caregiver implements interventions per an established alternative education plan, IEP or 504 plan which involves specialized activities and/or strategies outside of the educational setting. Implementation of this plan requires regular communication with school and is not considered routine educational support.
L3	Definition: • Caregiver works with school staff to administer a specialized educational program AND carries out a comprehensive home/school program (more than helping with homework) during or after school hours. • Caregiver may require specialized training or certification in order to meet the child's educational and cognitive needs. • Caregiver is an active participant in transition planning for a child moving from one educational setting to another. Examples include re-entry, truancy, transition from inpatient or congregate care, alternative education programming, etc.

Comments:

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

LOR 5 Socialization	
The Socialization category of the NCR describes the extent of caregiving responsibilities for a child to participate in developmentally appropriate activities. This could include school-based activities, sports, community-based activities, etc. Caregiver exercises Reasonable and Prudent Parenting standards.	
L1	Definition: • Caregiver works with others to ensure child's successful participation in community activities; ensures opportunities for child to form healthy, developmentally appropriate relationships with peers and other community members, and uses everyday experiences to help child learn and develop appropriate social skills. • Caregiver encourages and provides opportunities for child to participate in age-appropriate peer activities at least once per week. • Caregiver can give examples of the child's participation in the activity. Caregiver transports* to activity if needed. • Caregiver monitors negative peer interactions.
L2	Definition: • Caregiver provides additional guidance to the child which enables the child's successful participation in community and enrichment activities AND provides assistance with planning and adapting activities AND participates with child when needed. Examples include shadowing, coaching social skills, sharing specific intervention strategies with other responsible adults, etc. Examples may include educating coaches, camp counselors, etc. on higher needs of child, characteristics of an under-socialized child, be available (i.e. on call) to assist the child in participation. • Caregiver's intervention and participation is beyond what would be expected for the chronological age of the child in order to ensure the child's participation in the activity. • The child may not be able to participate without adult support requiring the Caregiver to attend and potentially shadow or intervene when necessary. Caregiver can give examples of the child's normalized participation in the activity.
L3	Definition: • Caregiver provides ongoing, one-to-one supervision and instruction (beyond what would be age appropriate) to ensure the child's participation in community and enrichment activities AND Caregiver is required to participate in or attend most community activities with other responsible adults, etc. • Caregiver seeks out specialized and individualized activities appropriate for the child's needs and aligned with the child's interest. • Caregiver must participate and fully supervise child during all community and enrichment activities beyond what is expected for the chronological age of the child. Child requires special accommodations to participate in some normative activities and may not meet minimal performance requirements for some of those activities. • Understands specific needs of the child, educating themselves to finding highly specialized activities for the child, and ensuring the child has the ability to socialize and be engaged in the community with their peers in way that is safe and appropriate, and meets their needs. • Caregiver can provide examples of child's normalized involvement in the activity.

Comments

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

LOR 6 Support/Nurturance/Well-Being	
The Support, Nurturance and Well-Being category of the NCR describes caregiving to support the child, provide nurturance to promote healing and well-being. Examples include reassurance, affection, and involvement in family and community activities as necessary in order to promote the child's well-being.	
L1	Definition: • Caregiver provides nurturing and caring to build the child's self-esteem; engages the child in constructive, positive family living experiences; maintains a safe home environment with developmentally appropriate toys and activities; provides for the child's basic needs advocates for services as needed. • Caregiver meets child's established basic needs to assure well-being. • Caregiver understands and responds to the child's needs specific to removal from their home. • Caregiver transports* and participates in services as needed.
L2	Definition: • Caregiver seeks out and self-educates about the child's condition, • Works with professionals to develop, implement, and monitor specialized behavior management, support, and/or intervention strategies to address ongoing behaviors that interfere with support/nurturance and well-being needs. • Caregiver provides structure, behavioral and/or emotional support beyond what is considered to be age and developmentally appropriate. • Caregiver is able to provide examples of strategies and interventions implemented and professional who is guiding the plan. • Caregiver engages the family of origin to promote transfer of learning and continuity across settings.
L3	Definition: • In accordance with a formal behavioral management or support plan as directed by child's needs and outlined by a professional, Caregiver works with services and programs to implement intensive child-specific in-home strategies of interacting in a therapeutic manner to promote emotional well- being, healing, and understanding, and sense of safety on a constant basis. • Caregiver provides immediate and ongoing interventions which are developed in accordance with Service/Support Plans and are developed in consultation with case management staff, service providers, and/or treatment professionals (if applicable) and must be followed to ensure the child's well-being. • If interventions are not followed child is at risk of emotional harm or dysregulation. Caregiver maintains frequent contact (at least two or more times per month) with involved professionals and actively participated in activities designed to support, nurture, and enhance the child's well-being. • Caregiver can provide examples of strategies implemented and their relevance to the child's specific support, nurturance, and well-being needs.

Comments

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

LOR 7 Specialized Skills	
The Specialized Skills category of the NCR describes the level of interventions, technique, training, and skill of the Caregiver to meet the child's needs. Caregiver can provide documentation of training and certifications acquired to meet the child's needs.	
L1	Definition: • Caregiver maintains open communication with the child's team about the child's progress and adjustment to placement. • Caregiver communicates openly and regularly with case manager, provides required monthly documentation and participates in family team meetings. • Caregiver must actively participate in developing a support plan to eliminate placement disruption. • Caregiver has a documented respite plan.
L2	Definition: • The child's needs require Caregiver expertise that is developed through fostering experience, participation in support group and/or mentor support, and consistent relevant in-service training, such as adolescent brain development or the effects of trauma on development. • Caregiver must utilize specialized knowledge, skills, and abilities to maintain child's placement. • Demonstrates flexibility to respond to child's needs in the moment and makes minor accommodations as needed to support the child. • Caregiver should provide examples of their specialized knowledge, skill, and abilities to ensure placement stability and participation in in-service training.
L3	Definition: • The child's needs require daily or weekly involvement/participation by the Caregiver with intensive services and external supports provided by service providers as defined in case plan and/or treatment team. • Caregiver must collaborate with external supports in order to maintain placement. These external supports provide intensive interventions within the Caregiver's home, without which child could not safely be maintained. Interventions must be selected and implemented in collaboration with the case manager. • Caregiver collaborates with intensive service interventions and demonstrates specialized knowledge, skills, and abilities to maintain child's placement. • Additional condition specific training is required to maintain placement and prevent disruption. • Utilizes trained Caregivers to provide planned respite and Caregiver has their own support systems available to help. • Caregiver is open to additional trainings to stabilize the placement.
L4	Definition: • Interventions at this level are safety dependent or medically required. • Caregiver must be trained or certified to provide the therapeutic or medical interventions. • External supports provide intensive interventions within the Caregiver's home, without which child could not safely be maintained.

	• The child's needs require daily involvement/participation by the Caregiver with intensive in- home services and/or other treatment team members as defined in the case plan and or treatment team. The child's needs require structured interventions specific to his/her needs as identified by the treatment team. • Planned respite with skilled Caregivers that are also trained in how to administer the high medical needs, or backup support that knows the child's needs and is able to provide specialized interventions. • Demonstrates a high degree of skill and the resiliency to maintain stability for the youth. Examples include the ability to de-escalate intimidating behavior, property destruction, and frequent episodes of missing from care. • Caregiver is equipped to provide medical interventions, and uses a support network available to provide backup medical interventions.
Comments	

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

LOR 8 Transition To Permanency and/or Another Planned Permanent Living Arrangement	
The Transition to Permanency and/or Another Planned Permanent Living Arrangement category of the NCR describes the level of preparation and involvement by the Caregiver necessary to prepare the child or youth for their permanency objective. This includes reunification with the family of origin, adoption, guardianship and Another Planned Permanent Living Arrangement. In this category, L1 and L2 are for permanency and L3 is for preparing a youth for transition planning for another planned permanent living arrangement.	
L1	Definition: • Caregiver provides efforts to work with family and/or other significant adults to facilitate successful transition home or into another permanent placement. • Caregiver maintains communication with child's team about progress towards permanency and availability as a permanency option for the child; • Caregiver completes the "Caregiver Information Form" for Juvenile Court review hearings; • Caregiver is an active participant in the child's team and transition planning and advocates for the child's need for permanency. • Caregiver regularly collaborates with team members to ensure child's permanency goals are met.
L2	Definition: • Provides mentoring and coaching with the family of origin on the child's schedule, techniques, interventions, in preparation for "discharge planning" and continuity of care. • Caregiver collaborates with case manager and other community resources to ensure child's permanency goal is met. • Caregiver assists the youth in completing a life skills assessment and uses the results to inform daily activities that promote development of life skills to include assistance with budgeting, education, self-care, housing, transportation, employment, accessing community resources and lifelong connections. • If the Caregiver will be providing permanency for the child, the Caregiver actively participates in adoption preparation activities. Examples include training, support groups, mentor support, respite care). • The Caregiver (with direction from their agency and in accordance with the case plan), cooperates and works with team members, potential adoptive parents, therapists and specialists to ensure the child achieves permanency.
L3	Definition: • Caregiver actively teaches and builds competence in the development of life skills, including attending classes with the youth when relevant and plays an active, hands-on approach in teaching life skills, to ensure youth is prepared for transition to adulthood. • Caregiver supports active participation of youth age 14 or above (who is able to transition to independent living) in services to facilitate the development of life skills and the transition to living independently as an adult. • Caregiver takes an active role in planning and coordinating day services, special education planning, self-sufficiency and other highly specialized services to be provided after age 19 due to the youth's needs.

	• The Caregiver ensures the young adult has obtained all necessary documentation and all necessary ongoing connections have been established, such as ongoing doctor appointments, a list of stable adults the young adult can call for help, etc. • For a youth with high medical needs, the Caregiver works with the child's treatment and medical team to arrange for continuity of services following discharge from state custody.
Comments	

*Please detail transportation arrangements in responsibilities section. If the Caregiver is unable to provide transportation, alternate arrangements must be discussed in detail at this time and documented in the responsibilities section.

Required Signatures

Caregiver 1: _____
(Print) (Sign) (Date)

Caregiver 2: _____
(Print) (Sign) (Date)

CFS/Case Manager: _____
(Print) (Sign) (Date)

CPA Worker: _____
(Print) (Sign) (Date)

Nebraska Caregiver Responsibility Tool
Summary and Level of Parenting

Child's Name: _____ Child's Master Case #: _____

Today's Date: _____ Last Assessment Date: _____ Previous Score: _____

Assessment Type:

☐ Initial ☐ Request of Caregiver ☐ Change of Placement

☐ Reassessment (6 months from date of previous tool) ☐ Request of Agency/Department ☐ Permanency Plan Change

☐ Change of Child Circumstance

Worker Completing Tool: _____ Service Area: _____

Caregiver(s): _____

Child Placing Agency: _____ CPA Worker: _____

Select the Age Range of the Child: ☐ 0-5 ☐ 6-11 ☐ 12-18

Take the scores for each of the LOR categories on the Nebraska Caregiver Responsibilities tool and record them below:

LEVEL OF Responsibility (LOR)	**SCORE**
LOR 1: Medical/Physical Health & Wellness	
LOR 2: Family Relationships/Cultural Identity	
LOR 3: Supervision, Structure, & Behavioral	
LOR 4: Education/Cognitive Development	
LOR 5: Socialization and Age-Appropriate Expectations	
LOR 6: Support/Nurturance/Well-Being	
LOR 7: Specialized Skills	
LOR 8 Transition To Permanency and/or Living Independently as an Adult	
TOTAL LOR SCORE	

Circle the scores for LOR 1, 3 and 7. Add these three scores together to determine the weighted score.

Weighted Score: _____

Record the Total LOR Score from page 1: _____

Using the Total LOR Score above, determine what column to reference below. Once a column has been chosen, use the weighted score to determine Level of Parenting required.

Circle the scores for LOR 1, 3 and 7. Add these three scores together to determine the weighted score.

Weighted Score: _____

Record the Total LOR Score from page 1: _____

Using the Total LOR Score above, determine what column to reference below. Once a column has been chosen, use the weighted score to determine Level of Parenting required.

	Total Score 1-8	**Total Score 9-17**	**Total Score 18-23**	**Total Score 24-27**
Essential	Weighted score =3	Weighted score =3		
Enhanced		Weighted score =4-5	Weighted score =4-5	
Intensive		Weighted score =6-9	Weighted score =6-9	
Specialized				Weighted score= 10-12

Level of Parenting: _____

CFS/Case Manager: _____
(Print) (Sign) (Date)

CFS/Case Manager Supervisor: _____
(Print) (Sign) (Date)

Nebraska Permanency Resource Responsibility Tool (NPRRT)

Child's Name:_____ Child's Master Case # _____

Child's Age: _____ Child's Date of Birth: _____

Today's Date: _____ Last Assessment Date: _____ Previous Score: _____

Assessment Type:

☐ Initial

☐ New or Corrected Diagnosis

☐ Request of Parent

☐ Request of Agency/Department

☐ Change in Child or Family Circumstance

☐ Change in law or regulation indicates a need for revision

Parent 1: _____
(Print) (Sign) (Date)

Parent 2: _____
(Print) (Sign) (Date)

Worker (*pre-finalization)*: _____ Service Area: _____

Nebraska Permanency Resource Responsibility Tool

This tool is used by the Nebraska Department of Health and Human Services (NDHHS) to determine and modify the amount of financial assistance for eligible children. This tool is based on the Nebraska Caregiver Responsibility Tool that is used to determine foster care maintenance payments by NDHHS.

Adoption and Guardianship Assistance

The Adoption and Guardianship Assistance Programs support the well-being of children and families by ensuring that financial barriers and costs do not prevent children with special needs from achieving permanency in stable homes. The program provides or continues financial assistance for an eligible child aged 18 or under after finalization.

Rates are determined according to *Expenditures on Children by Families, 2015*[1], by applying 65% of the USDA rate based on the child's age, referenced in "Table 4. Estimated annual expenditures on a child by married-couple families, urban Midwest, 2015." For the purpose of the subsidy program, the Health Care and Child Care, expenses were removed from the determination. The child's eligibility for federally funded assistance and Medicaid is also integrated into the agency's rate determination.

Request for Increased Assistance

After adoption or guardianship, circumstances may change over time and additional assistance may be necessary. To discuss options for increasing financial assistance provided through DHHS, please contact the Income Maintenance worker (IM-FC worker) assigned to your family.

[1] Lino, M., Kuczynski, K., Rodriguez, N., and Schap, T. (2017). *Expenditures on Children by Families, 2015*. Miscellaneous Publication No. 1528-2015. U.S. Department of Agriculture, Center for Nutrition Policy and Promotion.

Support

All families need support and help to face life's difficulties, including the challenges that may arise parenting a child with special needs. If you or your family need support, there are many resources available statewide and in the community. Creating a written list of resources is a first step in accessing the support needed to maintain the child in the family home. These organizations can provide support and help you identify resources:

Right Turn: (888) 667-2399
Nebraska Foster and Adoptive Parent Association: (NFAPA) (877) 257-0176
Nebraska Department of Health and Human Services Adoption Specialist: (402) 471-3121

Right to a Fair Hearing

If you disagree with the rate of your adoption/guardianship assistant payment, you may have the right to an appeal and request a fair hearing within 90 days. Refer to Nebraska Administrative Code Title 479 Chapter 7[2] (guardianship assistance) and Chapter 8[3] (adoption assistance).

Terminology

The term "parent" includes adoptive parents, prospective adoptive parents, guardians and prospective guardians.

[2] "Subsidized Guardianship Program," *Nebraska Administrative Code,* Title 479 (2015): Chapter 7
http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-479/Chapter-7.pdf
[3] "Subsidized Adoption Program," *Nebraska Administrative Code,* Title 479 (2004): Chapter 8
http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-479/Chapter-8.pdf

LOR1 Medical/Physical Health & Well-Being	
L1	Parent arranges and participates, as appropriate in routine medical and dental appointments; provides basic healthcare and responds to illness or injury; administers prescribed medications; maintains health records; shares developmentally appropriate health information with child. Definition: • Parent follows established policies to ensure child's physical health needs are met by providing basic healthcare and response to illness or injury. • Parent contributes to ongoing efforts to meet the child's needs, by arranging, and participating in doctor's appointments. • Parent will administer medications as prescribed, understand the medications administered, and attend monthly medication management appointments with the child.
L2	Parent arranges and participates with additional visits with medical specialists, assists with treatment and monitoring of specific health concerns, and provides periodic management of personal care needs. Examples may include treating, supporting and monitoring severe cases of asthma, physical disabilities, and/or pregnant/parenting teens. Definition: • Additional health concerns must be documented and parent's role in meeting these additional needs will be reflected in the child's case plan and/or treatment plan. • Parent will participate in additional medical appointments, and monitor health concerns as determined by case professionals. • Parent participates in physical, occupational and/or speech therapy.
L3	Parent provides hands-on specialized interventions to manage the child's chronic health and/or personal care needs. Examples include using feeding tubes, physical therapy, or managing HIV/AIDS. Definition: • Any specialized interventions provided by the parent should be reflected in the child's case plan and/or treatment plan. • Records should include narrative as to the training and/or certification of the parent to provide specialized levels of intervention specific to the child's heath needs. • Parent will provide specific documentation of specialized interventions utilized to manage chronic health and/or personal care needs.

LOR1 Medical/Physical Health & Well-Being
Outline the parent responsibilities:

LOR2 Family Relationships & Cultural Identity	
L1	The parent maintains existing connections to family of origin, including siblings and extended family, and/or other significant people. Parent encourages a healthy perception of the blended family identity and treats/speaks about family of origin respectfully. Parent provides opportunities for youth to engage in the cultural activities of his or her choice. Definition: • Parent maintains ongoing contact with biological siblings and/or family of origin. This could include arranging events, play dates, get-togethers, trips, telephone and/or web-based visitation, and/or providing supervision as developmentally appropriate. • Parent assists with the integration and development of the child's identity. Activities could include working together on the child's lifebook, advocating for the child in school, medical and other settings when appropriate, collecting and sharing photo/videos of family members. • Parent fosters connections to members of the child's racial, ethnic, religious, cultural, and tribal heritage. • Child's heritage of origin is incorporated and integrated into the family lifestyle. Examples could include family activities, TV, movies, music, home décor, meals, friends of the family, spiritual and religious activities, etc.
L2	The parent helps re-establish a previously disconnected or new relationship with family of origin and/or culture. Parent actively supports child in forming familial bonds and assisting the child to process and accept his or her identity. Parent helps the child to form a healthy view of his/her family of origin, and his/her identity. Definition: • Parent helps the child work through dynamics of family of origin. This could include seizing teachable moments, coaching the child/family, and seeking services to assist the child in understanding healthy coping skills for managing challenging and meaningful relationships. • Parent helps the child establish a connection with his/her cultural, racial, ethnic, or religious heritage. This could include seeking out community activities, books, films, music, meal preparation, and other materials; sharing pictures and information about those who are disconnected from the child/youth. • Parent seeks information to learn about identity, intercultural and interracial families, and the importance of cultural connections for adopted children and youth. • Parent engages in activities to connect the child to their heritage, including participating in events, groups, and other activities outside the home. • Parent conducts outreach and/or responds to family of origin in the early stages of relationship development.

LOR2 Family Relationships & Cultural Identity	
L3	The parent supports the child through challenging relationships with family of origin. A relationship which is inconsistent, and/or disruptive and requires special care and attention to support the child/youth. Parent helps the youth develop cultural identity not previously explored. Definition: • Parent actively participates in facilitating connections with siblings or family of origin. • Parent helps child make sense of challenging and meaningful relationships by seeking services, interventions, and other supports. • Parent takes youth/child to places of worship, salons, community events and other cultural lifestyle activities and is willing to be an outsider in these situations in order to support the youth's identity formation and self-expression. • The parent helps the child and others in the family adapt to a blended family identity by seizing teachable moments, and advocating for the family identity when appropriate.
Outline the parent responsibilities:	

LOR 3 Supervision, Structure, & Behavioral	
L1	Parent provides routine direct care and supervision of the child, assists child in learning appropriate self-control and problem solving strategies; utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change, adapts schedule or home environment to accommodate or redirect occasional outbursts. Definition: • Parent provides age and developmentally appropriate supervision, structure, and behavioral and/or emotional support. • Parent utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change. • Parent can provide examples of strategies and interventions implemented. • Parent provides supervision that is appropriate and expected for the chronological age of the child. For instance, 24 hour supervision of an infant or two year old would be considered appropriate for the age of the child.
L2	Parent consults with medical, mental health, or behavioral health treating professionals to implement specific strategies of interacting with the child in a therapeutic manner to promote emotional well-being, healing, and understanding, and a sense of safety on a daily basis. Definition: • Parent follows current established treatment plan or safety plan to ensure child's safety and well-being are addressed. • Strategies and interventions are developed in accordance with the treatment plan. • Parent has monthly contact with mental health professionals and participates in mental health services for the child. • Parent can provide examples of therapeutic interventions and demonstrates ongoing monitoring. • In situations where the child refuses therapeutic intervention, parent continues to consult with medical professionals and implement identified strategies.

LOR 3 Supervision, Structure, & Behavioral	
L3	Parent provides direct care and supervision that involves the provision of highly structured Interventions such as using specialized equipment and/or techniques and treatment regiments on a constant basis. Examples of specialized equipment include using alarms, single bedrooms modified for treatment purposes, or using adaptive communication systems, etc.; works with other professionals to develop, implement and monitor strategies to intervene with behaviors that put the child or others in imminent danger or at immediate risk of serious harm. Parent accesses assistance from external sources to create specialized structure in the home that meets the child's behavioral and emotional needs. Definition: • Treatment plan requires immediate and ongoing interventions developed in accordance with treatment plan and must be followed to ensure the child's safety, behavioral and emotional needs are met. • Treatment plan also requires immediate, ongoing, and continuous monitoring and interaction outside of what should be expected for the age of the child. If plan is not followed, child is at risk of imminent danger. • Parent maintains frequent contact (at least two or more times per month) with mental health professionals and actively participates in mental health services for the child and monitors the child's behavioral health needs.
Outline Parent responsibilities:	

LOR 4 Education/Cognitive Development	
L1	Parent provides developmentally appropriate learning experiences for the child noting progress and special needs; assures school or early intervention participation as appropriate; supports the child's educational activities; addresses cognitive and other educational concerns as they arise. Definition: • Parent ensures child meets established education goals. • Routine educational support includes providing a structured homework routine and help with homework; maintaining regular, ongoing contact with school to ensure age-appropriate performance and progress. This includes participation in regularly scheduled parent- teacher conferences with the parents (as appropriate). For non-school age children, the parent will ensure the child is working on developmental goals (i.e. colors, ABCs, counting, etc.) • Educational goals may include both school-based as well as job training goals (for older youth).
L2	Parent maintains increased involvement with school staff to address specific educational needs that require close home/school communication for the child to make progress AND responds to educational personnel to provide at-home supervision when necessary; or works with others to implement program to assist youth in alternative education or job training. Definition: • Parent implements monitoring in the home to reflect established learning plan objectives or collaborates with professionals to ensure child's educational goals are met. • Parent provides examples of efforts to support education. Parent provides support and structure for child if suspended or expelled from school. • Parent participates in the IEP development and review. • Parent implements intense interventions per an established alternative education plan, IEP or 504 plan which involves specialized activities and/or strategies outside of the educational setting. Implementation of this plan requires regular communication with school and is not considered routine educational support.
L3	Parent works with school staff to administer a specialized educational program AND carries out a comprehensive home/school program (more than helping with homework) during or after school hours. Definition: • Parent may require specialized training or certification in order to meet the child's educational and cognitive needs.

LOR 4 Education/Cognitive Development
Outline the parent responsibilities:

LOR 5 Socialization/Age-Appropriate Expectations	
L1	Parent works with others to ensure child's successful participation in community activities; ensures opportunities for child to form healthy, developmentally appropriate relationships with peers and other community members, and uses everyday experiences to help child learn and develop appropriate social skills. Definition: • Parent encourages and provides opportunities for child to participate in age- appropriate peer activities at least once per week. • Parent can give examples of the child's participation in the activity. Parent monitors negative peer interactions. Examples may include: school-based activities, sports, community-based activities, etc.
L2	Parent provides additional guidance to the child to enable the child's successful participation in community and enrichment activities AND provides assistance with planning and adapting activities AND participates with child when needed. Examples include shadowing, coaching social skills, sharing specific intervention strategies with other responsible adults, etc. Definition: • Parent's intervention and participation is beyond what would be expected for the chronological age of the child in order to ensure the child's participation in the activity. Examples may include: educating coaches, camp counselors, etc on higher needs of child, characteristics of an under-socialized child, be available (i.e. on call) to assist the child in participation. • The child may not be able to participate without adult support requiring the parent to attend and potentially shadow or intervene when necessary. Parent can give examples of the child's participation in the activity.
L3	Parent provides ongoing, one-to-one supervision and instruction (beyond what would be age appropriate) to ensure the child's participation in community and enrichment activities AND parent is required to participate in or attend most community activities with other responsible adults, etc. Definition: • Parent must participate and fully supervise child during all community and enrichment activities beyond what is expected for the chronological age of the child. • Participation in the community and enrichment activities provides a normalized child experience. Parent can provide examples of child's normalized involvement in the activity.

LOR 5 Socialization/Age-Appropriate Expectations
Outline the parent responsibilities:

LOR 6 Support/Nurturance/Well-Being	
L1	Parent provides nurturing and caring to build the child's self-esteem; engages the child in constructive, positive family living experiences; maintains a safe home environment with developmentally appropriate toys and activities; provides for the child's basic needs and arranges for counseling or other mental health services as needed. Definition: • Parent meets child's established basic needs to assure well-being. • Parent understands and responds to the child's needs specific to removal from their home. • Parent participates in mental health services as needed.
L2	Parent works with professionals to develop, implement and monitor specialized behavior management, support, and/or intervention strategies to address ongoing behaviors that interfere with support/nurturance and well-being needs. Definition: • Parent provides supervision, structure, and behavioral and/or emotional support beyond what is considered to be age and developmentally appropriate, in accordance with a formal behavioral management or support plan as directed by the child's needs and outlines by professional. • Parent is able to provide examples of strategies and interventions implemented and professional who is guiding the plan.
L3	Parent works with services and programs to implement intensive child-specific in-home strategies of interacting in a therapeutic manner to promote emotional well- being, healing, and understanding, and sense of safety on a constant basis. Definition: • Parent provides immediate and ongoing interventions which are developed in accordance with Service/Support plans and are developed in consultation with service providers and/or treatment professionals (if applicable) and must be followed to ensure the child's well-being. • If interventions are not followed, the child is at risk of emotional harm or dysregulations. • Parent maintains frequent contact (at least two or more times per month) with involved professionals and actively participates in activities designed to support, nurture and enhance the child's well-being. • Parent can provide examples of strategies implemented and their relevance to the child's specific support, nurturance and well-being needs.

LOR 6 Support/Nurturance/Well-Being
Outline the parent responsibilities:

LOR 7 Specialized Skills	
L1	Parent maintains open communication with professionals when needed to support the child. Parent assesses the child's progress and adjustment to the adoptive home and contacts appropriate supports with identified concerns when necessary. Definition: • Parent creates a written community resource list of local supports and specialized adoption resources that will assist the family in meeting the child's needs. • Parent works to maintain the stability of the adoption. • Parent communicates openly with professionals when needed to support the child. • Parent seeks out knowledge and skills to support the youth in the home.
L2	The child's/youth's needs require parental expertise that is developed through participating in adoption support groups (or group specific to another need of the child), a mentor support, and/or other adoption specific preparation training in order to better understand and meet the needs of the child. Definition: • Parent attends training(s) to better understand the current and potential future needs of children and families in adoption/ guardianship. • Parent must utilize specialized knowledge, skills, and abilities relevant to the specific needs of the child. Interventions provided by the parent must be based upon training recommendations or be in collaboration and/or consultation of other relevant professionals. • Documentation from the involved professional and/or certificates of specialized training relevant to the child is required. • Parent participates in a support group specific to the child's needs. • Parent participates in family support services to learn skills to better meet the child's needs.
L3	The child's/youth's needs currently require daily or at least weekly involvement/participation by the parent as determined by professionals treating the child/youth. Definition: • Parent provides intensive treatment, as directed by involved professionals, in the home to maintain the child in the home. • Parent participates in Intensive Family Preservation Services in the home. • Parent provides medically necessary services in collaboration with medical professionals such as use of feeding tubes and other specialized medical equipment. • Post-adoption, the family works with adoption support services to keep the family intact.

LOR 7 Specialized Skills
Outline the parent responsibilities:

LOR 8 Life Skills/Developmental Transitions	
L1	Parent provides active, routine, ongoing efforts to facilitate the development of life skills appropriate for the age of the child between the ages of infant and five years old. Definition: • Parent facilitates the development of life skills that are appropriate for the age or developmental stage of the child.
L2	Parent provides active, routine, ongoing efforts to facilitate the development of life skills appropriate for the age of the child for the ages of six to eleven years old. Definition: • Parent facilitates the development of life skills that are appropriate for the age or developmental stage of the child. • Parent and child engage in daily activities that promote development of life skills to include assistance with budgeting, education, self-care, housing, transportation, employment, accessing community resources, and lifelong connections.
L3	Parent provides active, routine, ongoing efforts to facilitate the development of life skills and transition to living independently as an adult for the age of the child of twelve to eighteen years old. Definition: • Parent facilitates the development of life skills that are appropriate for the age or developmental stage of the child. • Parent provides assistance and interventions on an ongoing basis to include assistance with budgeting, education, self-care, housing, transportation, employment, community resources and lifelong connections. • Parent demonstrates role in preparing youth for living independently as an adult by providing concrete examples of provided intervention and youth skills acquisition.
Outline the parent responsibilities:	

Nebraska Permanency Resource Responsibility
Summary and Level of Responsibility

Child's Name:_____ Child's Master Case # _____

Child's Age: _____ Child's Date of Birth: _____

Today's Date: _____ Last Assessment Date: _____ Previous Score: _____

Assessment Type:

☐ Initial

☐ New or Corrected Diagnosis

☐ Request of Parent

☐ Request of Agency/Department

☐ Change in Child or Family Circumstance

☐ Change in law or regulation indicates a need for revision

Worker Completing Tool: _____ Service Area: _____

Parent(s): _____

Child Placing Agency:_____ CPA Worker: _____

Circle the Age Range of the Child: 0-5 6-11 12-18

Take the scores for each of the LOR categories on the Nebraska Adoptive Parent Responsibilities tool and record them below:

LEVEL OF Responsibility (LOR)	**SCORE**
LOR 1: Medical/Physical Health & Well-Being (weighted score)	
LOR 2: Family Relationships & Cultural Identity	
LOR 3: Supervision, Structure & Behavioral (weighted score)	
LOR 4: Education/Cognitive Development	
LOR 5: Socialization/Age-Appropriate Expectations (weighted score)	
LOR 6: Support/Nurturance/Well-Being	
LOR 7: Specialized Skills	
LOR 8 Life Skills/Developmental Transitions	
TOTAL LOR SCORE	

Circle the scores for LOR 1, 3 and 5. Add these three scores together to determine the weighted score.

Weighted Score: _____

Record the Total LOR Score from page 1: _____

Using the Total LOR Score above, determine what column to reference below. Once a column has been chosen, use the weighted score to determine Level of Parenting required.

	Total Score 1-8	**Total Score 9-17**	**Total Score 18-23**	**Total Score 24**
Essential	Weighted score =3	Weighted score =3		
Enhanced		Weighted score =4-5	Weighted score =4-5	
Intensive		Weighted score =6-9	Weighted score =6-9	Weighted score =9

Level of Parenting: _____

Additional Eligibility (select one):

☐ **IV-E Federally Funded Subsidy and eligible for Medicaid**
☐ **State Funded Subsidy and ineligible for Medicaid**
☐ **State Funded Subsidy and eligible for Medicaid**

NAME:_____ NAME: _____

CFS or IM-FC Worker CFS or IM-FC Supervisor

DATE:_____ DATE:_____

Nebraska Caregiver Responsibility Survey for Foster Parents

FOSTER CARE REIMBURSEMENT RATE COMMITTEE

DECEMBER 30, 2019

Purpose & Disclaimer

- The Foster Care Reimbursement Rate Committee of the Nebraska Children's Commission conducted a survey of foster parents in Nebraska. The information herein is intended to help inform the work and recommendations of the Foster Care Reimbursement Rate Committee.

- The information contained within this PowerPoint and any accompanying documents is meant to represent an aggregate of information received through the Nebraska Caregiver Responsibility Survey, and not meant to represent the viewpoints or recommendations of the Foster Care Reimbursement Rate Committee, its individual members, or staff.

Background Information

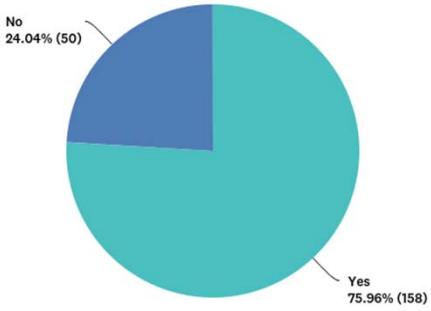
- Survey planning began with the intention to gather information on the experiences of foster parents with the Nebraska Caregiver Responsibility (NCR) Tool.
- During survey planning, members identified a need to expand the scope of the survey to include more specific information regarding the NCR, and more general information about foster parent experiences.
- This survey does not capture information regarding Probation foster care placements.

Survey Information

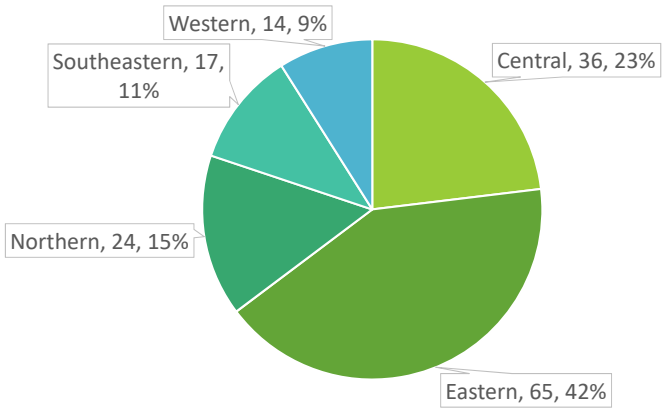
- The survey is 13 questions long, with sections including Foster Parent Information, Nebraska Caregiver Responsibility Tool, Transportation Experiences, and Foster Parent Experiences.
- The survey was administered through HHS, FFTA, and NFAPA. Responses were collected by NCC staff.
- No identifying information was required to participate in the survey. Participants were given the option to provide an email address for follow up contact.
- The survey opened on July 26th and closed on August 25, 2019.
- 211 foster parents responded to this survey.

FOSTER PARENT INFORMATION

Have you had an NCR Tool completed on a child in your home in the last twelve months?

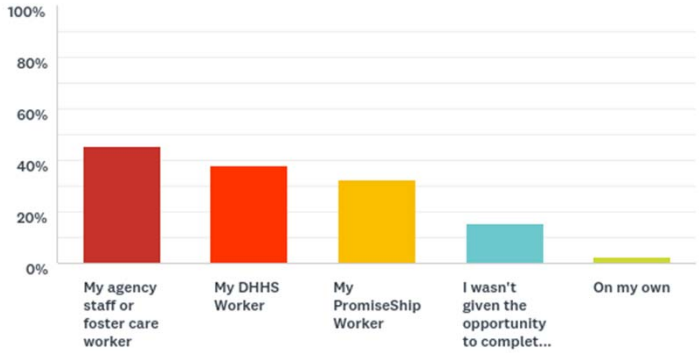


Foster Parent Service Area of Residence



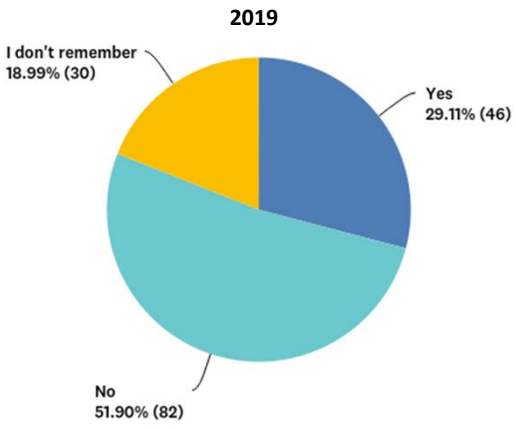
Appendix F

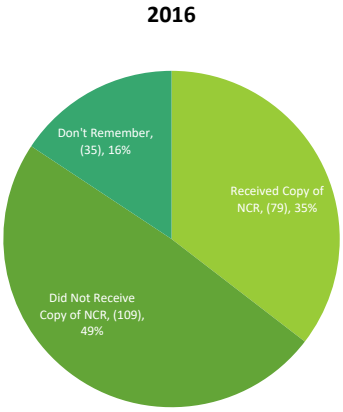
Who Completed the NCR with the Foster Parent?



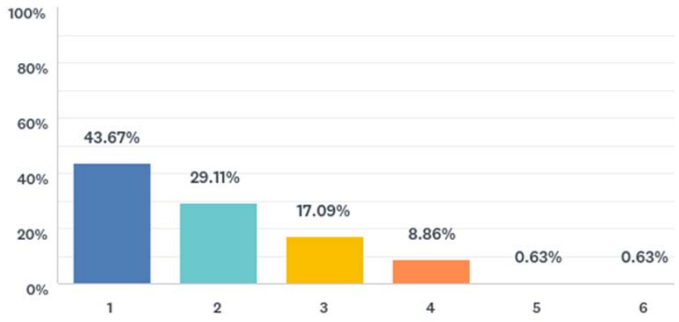
Total Responses	160
My agency staff or foster care worker	73
My DHHS worker	61
My PromiseShip Worker	52
I wasn't given the opportunity to complete it before it was finalized.	25
On my own.	4

"Did you receive a copy of the NCR?"





Number of Children Being Fostered in the Home at the Time of the Last NCR

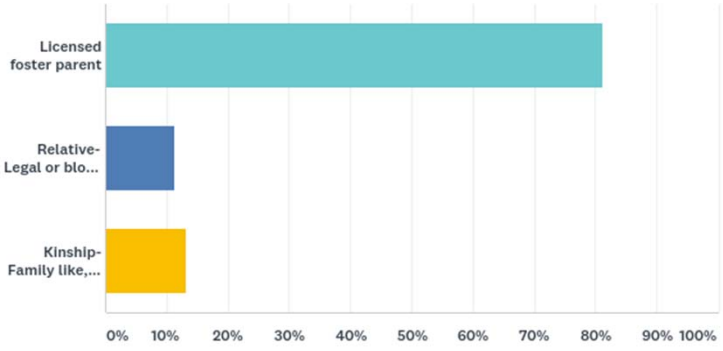


Licensed, Relative & Kinship

Licensed Foster Parent= 125

Relative Approved & Licensed= 21

Kinship Approved & Licensed= 20

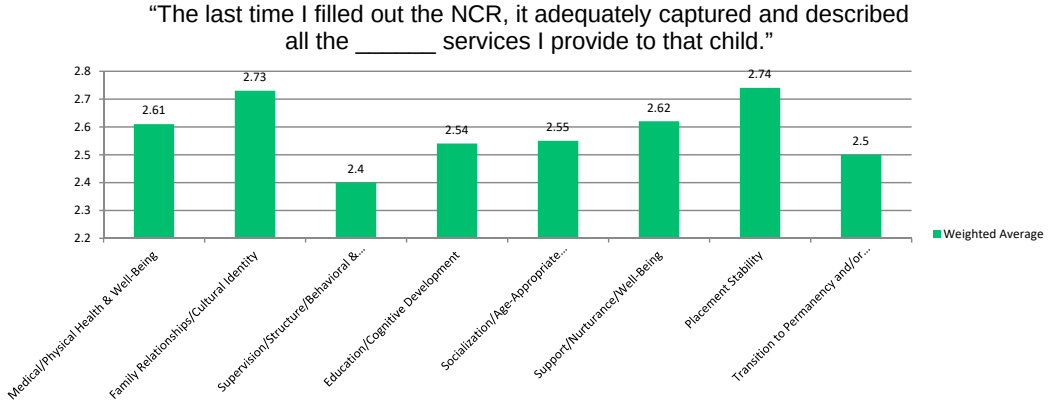


Appendix F

Nebraska Caregivers Responsibility Tool- Level of Responsibility Categories

- Participants were asked to rank the statements pertaining to specific sections of the NCR.
- "The last time I filled out the NCR, it adequately captured and described the _____ services I provide to that child."
  - Completely = 4Not at all = 0
  - For the most part = 3
  - About half = 2
  - Only somewhat = 1
  - Not at all = 0
- Each question had a link to a copy of the NCR for reference.

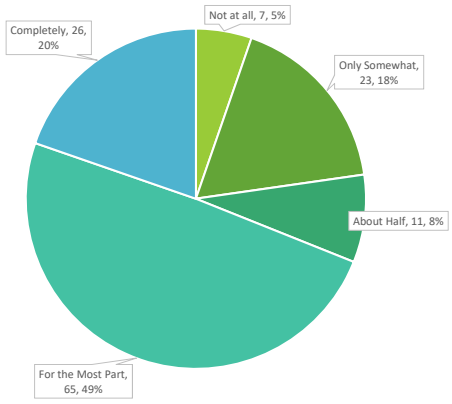
NCR Level of Responsibility Categories



PREPARED BY: C. JONES, NCC

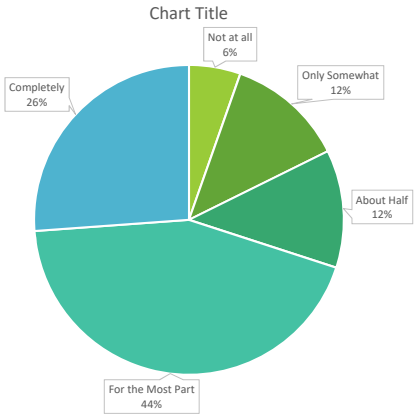
LOR1 Medical/ Physical Health & Well-Being

- "It adequately captured and described all the medical and physical health well being services I provided to that child."
  - Weighted Average Response: 2.61
  - Weighted Average in 2016: 2.34



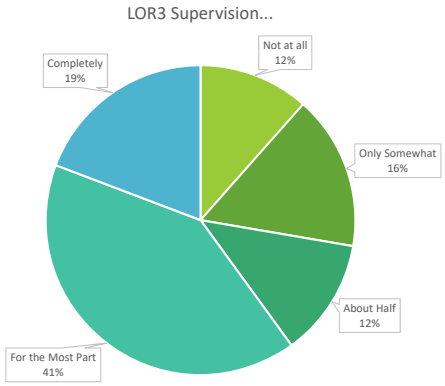
LOR 2 Family Relationships & Cultural Identity

- "It adequately captured and described all the family relationships and cultural identity services I provided to that child."
  - Weighted Average Response: 2.73
  - Weighted Average in 2016: 2.39



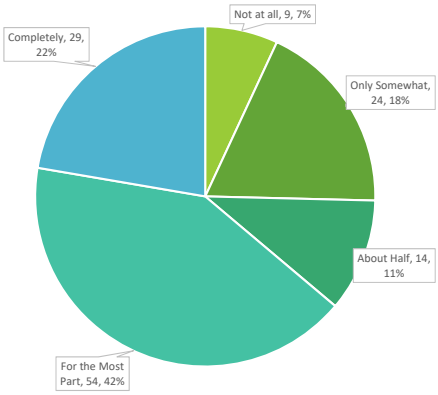
LOR 3 Supervision/ Structure/ Behavioral and Emotional Services

- "It adequately captured and described all the supervision, structure, behavioral and emotional services I provided to that child."
  - Weighted Average Response: 2.4
  - Weighted Average in 2016: 2.19



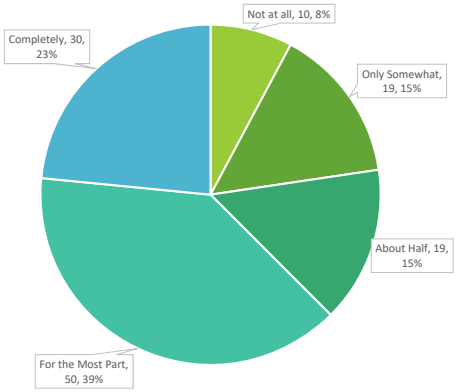
LOR 4 Education/ Cognitive Development

- "It adequately captured and described all the education and cognitive development services I provided to that child."
  - Weighted Average Response: 2.54
  - Weighted Average in 2016: 2.20



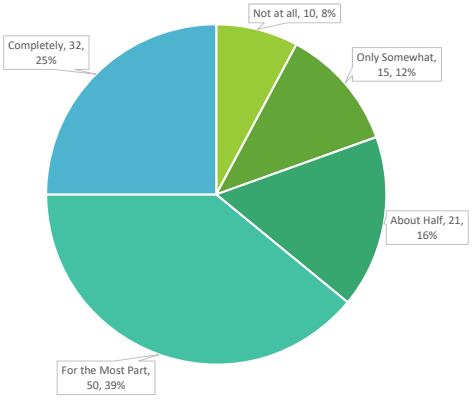
LOR 5 Socialization/ Age-Appropriate Expectations

- "It adequately captured and described all the socialization and age appropriate expectation services I provided to that child."
  - Weighted Average Response: 2.54
  - Weighted Average in 2016: 2.27



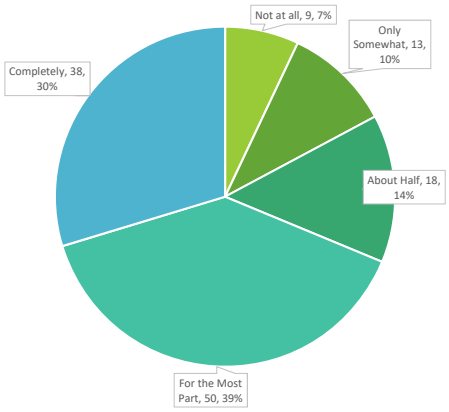
LOR 6 Support/ Nurturance/ Well-Being

- "It adequately captured and described all the support, nurturance and well being services I provided to that child."
  - Weighted Average Response: 2.62
  - Weighted Average in 2016: 2.34



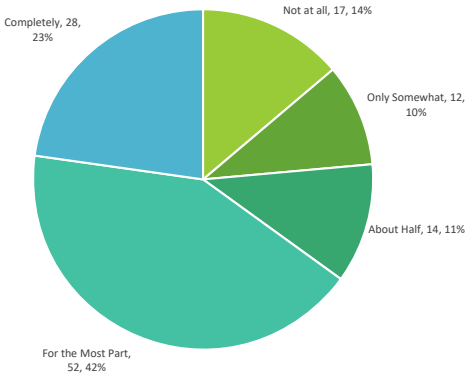
LOR 7 Placement Stability

- "It adequately captured and described all the placement stability services I provided to that child."
  - Weighted Average Response: 2.74
  - Weighted Average in 2016: 2.48



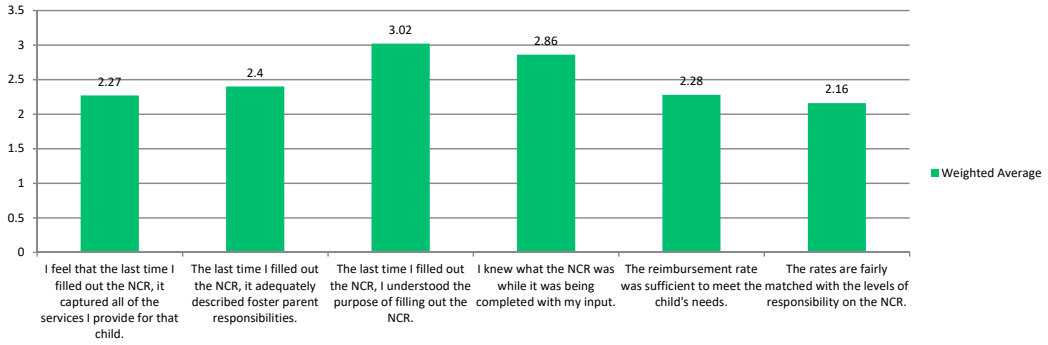
LOR 8 Transition to Permanency and/or Independent Living

- "It adequately captured and described all the transition to permanency and/or independent living services I provided to that child."
  - Weighted Average Response: 2.5
  - Weighted Average in 2016: 2.43



NCR Tool, Rates and Administration

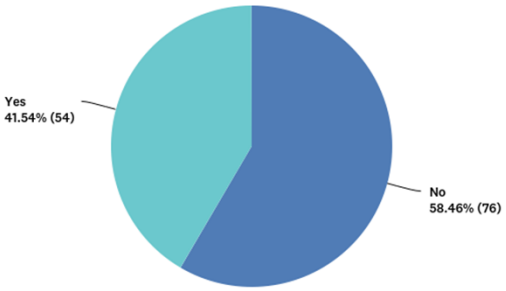
Thinking of the last time you filled out the NCR, please indicate your agreement with the following statements:



Completely = 4; For the most part = 3; About half = 2; Only somewhat = 1; Not at all = 0

Transportation Experiences

Thinking of the child for which you last completed the NCR, have you experienced any challenges in providing transportation for this child?



Appendix F

Foster Parent Comments and Feedback

- The NCR does not adequately capture or compensate for the care of children with very high medical or behavioral needs.
- The NCR does not adequately address transportation challenges, especially in the rural areas of the state.
- In some instances, the timing of the NCR was completed before the needs of the child were well known.
- Foster parents reported not being involved in the completion of the NCR prior to its finalization.
- It was recommended there be a starter stipend for goods needed for emergency placements such as infant gear, car seats and clothing.

PREPARED BY: C. JONES, NCC

Foster Care Reimbursement Rate Committee: Essential Rate Workgroup Rate

Proposed Essential Foster Care Reimbursement Rate, Rational and Methodology

Age of Child	Essential Annual Rate (effective July 1, 2019)	Proposed Annual Reimbursement Rate
0 - 5	$ 7,446.00	$ 8,124.72
6 - 11	$ 8,562.90	$ 9,876.57
12 - 18	$ 9,307.50	$ 10,485.87

Age of Child	Essential Daily Rate (effective July 1, 2019)	Proposed Daily Reimbursement Rate
0 - 5	$ 20.40	$ 22.26
6 - 11	$ 23.46	$ 27.06
12 - 18	$ 25.50	$ 28.73

Methodology and Rational:

1. Needed one rate for all Nebraska divided into 3 age groups (0-5 years, 6-11 years, and 12-17 years).
2. As a starting point, the *USDA's Expenditures on Children by Families (2017)* estimates were used.
    a. Report estimates what families actually spend on their children rather than the minimum cost of raising a child. This provides a more realistic estimate of a rate needed for foster parents to support children in their care.
    b. Report divides expenditures into income groupings of families, number of parents, and geographic regions – for our purposes, we were interested in low- and middle-income two-parent family expenditures and the rural and Midwest urban geography categories.
3. Expenditures from the report were based on 2015 figures. This workgroup updated using 2019 figures. The Bureau of Labor Statistics inflation calculator was used to update dollars from January 2015 to January 2019.
4. Expenditures on children by families are categorized into Housing, Food, Transportation, Clothing, Health Care, Child Care and Education, and Miscellaneous expenses.
    a. Housing: Kept expenditures estimate as is
    b. Food: Kept expenditures estimate as is
    c. Transportation: Foster parents are able to claim for reimbursement excessive mileage driven in order to meet the needs of the children in their care. Kept expenditures estimate as is.
    d. Clothing: Kept expenditures estimate as is
    e. Health Care: Since most foster children receive Medicaid, health care expenses were deleted from the total in every case.
    f. Child Care and Education: It is assumed most non-school aged children will receive a child care subsidy. School aged children attending public school will likely have

education expenses. Many 6-11-year-olds will have also child care expenses due to before- and/or after-school care that will likely be covered by subsidy. To account for this, the child care and education expense was removed from the total for children 0-5. For children 6-17, the averaged education expenditures for the 12-14, and 15-17 age groups for low-income families remained in the total. Expenditures estimates for 6-11 were not included in the average due to anticipated before- and after-school care costs.

   g. Miscellaneous: Kept expenditures estimate as is

5. Low- and middle-income expenditures were then averaged while accounting for the education expense special circumstance as detailed above.
6. Age groups were averaged to reduce age grouping from six groups to three (original groups: 0-2, 3-5, 6-8, 9-11, 12-14, 15-17 were averaged to: 0-5, 6-11, and 12-17).
7. In order to determine the weights of expenditures based on geography, DHHS' definition of urban and rural counties was used (Dakota, Douglas, Lancaster, and Sarpy counties are considered urban). Data from Nebraska DHHS- DCFS was collected to determine the distribution of children in out-of-home care in urban vs. rural counties. This distribution was then applied to the two total expenditures geography groups (Midwest urban and rural) to combine into one rate with three age groups for the whole state.
8. Finally, an inflation adjustment was applied to adjust the dollar amount for the midpoint for the years in which the proposed rate will be potentially used.
   a. Increase of 6% assuming 2% inflation annually over a 6-year period (2019-2025).
   b. This 6-year time period estimates the time between the Rate Committee's legislative report, introduced legislation, and when it is anticipated to go into effect, if passed.
   c. The Rate Committee offers a legislative report every 4 years. The duration of the recommendations of the July 2020 report will last until a decision is made to take legislative action or inaction on the 2024 legislative report, which could be as long as 2026.

Rate Change Timeline

2012 FCRRC submitted their first legislative report. FCRRC recommended the essential rates used today.

2013 Legislation was passed and signed into law enforcing the use of the recommended rates proposed by the FCRRC in 2012.

2014 Essential, Enhanced and Intensive rates were implemented statewide

2016 FCRRC submitted their second legislative report indicating **no recommended rate change**

2019 DHHS implemented an 'across the board' 2% rate increase for all services including the essential, enhanced and intensive rates for foster care

2020 FCRRC will make recommendations for rates in their third legislative reports

Foster Care Reimbursement Rate Committee: Essential Rate Workgroup Rate

2021 In order for changed rates to be implemented, legislation must be introduced in the 107th Legislature, 1st session

2022 If passed, rates would go into effect, likely at the beginning of 2022

2024 FCRRC will submit their fourth legislative report

2025 In order for changed rates to be implemented, legislation must be introduced in the 109th Legislature, 1st session

2026 If passed, rates would likely go into effect at the beginning of 2026

FOSTER CARE CALCULATIONS TO DETERMINE ADMINISTRATIVE AND SUPPORT RATE

4/7/2020

a	b	c	d	e	f	g	h
	Foster Care Specialist					Total	(g / b / 365)
Ratio	% Full Case Load				28.1%	Wages	Per Placement
	0.85		Hourly	Annual	Benefits	Taxes Bens	Per Day Calc
15.84	13.46	Essential	16.80	34,936	9,816.88	44,752	9.11
12.67	10.77	Enhanced	17.28	35,933	10,097.15	46,030	11.71
10.25	8.71	Intensive	18.16	37,777	10,615.36	48,392	15.22
6	5.10	Specialized	19.46	40,477	11,373.98	51,851	27.85
	Foster Care Specialist Supervisor					Total	(g / a / 365)
Ratio	Ratio				27.2%	Wages	Per Placement
1 to x children	1 to X Specialists		Hourly	Annual	Benefits	Taxes Bens	Per Day Calc
63.4	4.71	Essential	22.39	46,580	12,670	59,249	2.56
50.7	4.71	Enhanced	22.72	47,249	12,852	60,101	3.25
39.0	4.48	Intensive	23.01	47,860	13,018	60,878	4.27
20.4	4	Specialized	29.62	61,610	16,758	78,367	10.52
	Licensing/Training/Recruitment Specialist					Total	(g / b / 365)
					27.2%	Wages	Per Placement
	# of clients supported by 1 avg FTE		Hourly	Annual	Benefits	Taxes Bens	Per Day Calc
	25.61	Essential	18.37	38,203	10,391	48,594	5.20
	25.61	Enhanced	18.37	38,203	10,391	48,594	5.20
	20	Intensive	18.37	38,203	10,391	48,594	6.66
	12	Specialized	18.37	38,203	10,391	48,594	11.09

Summary Staffing	specialist	supervisor	licensing training recruitment	Total FC Staffing
Essential	9.11	2.56	5.20	16.87
Enhanced	11.71	3.25	5.20	20.15
Intensive	15.22	4.27	6.66	26.15
Specialized	27.85	10.52	11.09	49.47

	Total FC Staffing	39% of FC Staffing All Other FC Costs	Total	0.08 Indirect	Cost of Living Increase (Midpoint of 2% for 6 yrs)	FINAL RATE	Current Rate
Essential	16.87	6.58	23.44	1.88	1.60	26.92	22.20
Enhanced	20.15	7.86	28.01	2.24	1.91	32.16	28.73
Intensive	26.15	10.20	36.35	2.91	2.48	41.73	39.53
Specialized	49.47	19.29	68.77	5.50	4.69	78.95	

Agency Level of Responsibility

The Level of Responsibility workgroup of the Foster Care Reimbursement Rates Committee was assigned to develop agency expectations to correspond with the tiered level of responsibilities within the Nebraska Caregiver Responsibility Tool. The expectations outlined in this document are recommendations for agency supported foster care responsibilities to the Department of Health and Human Services and responsibilities to the family.

Each level of responsibility builds off of and includes the lower tiered levels of responsibility. For example a level three would include levels one, two and three respectively. Each level of responsibility includes training, documentation and support expectations.

Level 1: Essential
This Essential level is derived from the existing DHHS CFS Agency Supported Foster Care and Pre-Adoption Service Attachment (effective July 1, 2019)
Training
Providing and ensuring that caregivers complete the necessary pre-service educational curriculum. Providing and ensuring that caregivers have the necessary ongoing training and/or relative and kinship training to become licensed or maintain licensure. Training is relevant and enhances the foster or adoptive family's ability and capacity to meet the unique needs of children age 0 to 5 years old, and all other youth for whom they are providing care, including • use of the Reasonable and Prudent Parent Standard • how to talk with children placed in their home about setting healthy physical boundaries and how to talk to children about healthy boundaries. Ongoing training can be offered through a combination of face-to-face training, classroom training, web-based training, and reading materials.
Documentation to be provided to DHHS
• Agencies will ensure the Youth Care Bill of Rights is provided to age appropriate children in foster homes within 72 hours. • Develop a communication plan between the caregiver and the family of origin to ensure consistent communication to support the children, or document why a plan does not exist. • Respite plan including the use of regularly scheduled and crisis respite. • Specific and individualized Placement Support plan for each child to prevent disruption. • Provide information to the caregiver about transportation reimbursement • Written Summary Reports of supportive services, concrete supports, resources, training, one-on-one instruction, and guidance, medical, vision and dental check-ups, mental or behavioral health needs and services. • Support the Caregiver in completing the Court Caregiver Information Form and Youth Court Forms for the child's review court hearings. • All medical information including medication and dosage changes.

Services and Support
Agency will be readily accessible and responsive to caregivers for which support is being provided including: • Face-to-face visits in the caregiver's home at minimum once per month and more frequently by request and/or as needed based on the needs of the caregiver, child or any combination thereof. • More frequent phone calls may be necessary to maintain communication • Review and discuss strengths, stressors and problem solve • Assess for the current suitability • Offer, refer or provide concrete supports such as transportation, more frequent face-to-face visits, and other resources to ameliorate the stressors • Encourage and facilitate the use of planned respite • Identify the need for, provide or make arrangements for, ongoing training and one-on-one instruction and guidance to help provide normalcy and meet the needs of the youth in their care • Individualized caregiver support based on the needs of the caregiver and the child, and the unique circumstances experienced by the caregivers Support will include ongoing communication (by phone, email or text) and will include being available to caregivers 24 hours a day, 7 days per week including holidays and weekends. Support includes assisting the caregiver with transport the child as needed to, but not limited to: • Behavioral health appointments • Medical appointments, • Extra-curricular activities, and • Events with family of origin Contributing to the well-being of the caregiver and the child in placement by: • Communicating all known information about the child • Assist the caregiver in making contact with the child's parent(s) following placement into the caregiver's home, barring any known safety concerns communicated in writing by DHHS • Provide input in case planning and discharge planning by participating in Family Team Meetings, Case Planning, attending court hearings, Transitional Living Planning, when requested by DHHS or the family • Proactively participate in discharge planning, including using a trauma-informed approach to prepare youth for transition

Levels 2 & 3: Enhanced & Intensive
Training
• Increased training is provided for caregivers as needs of the child increase and enhances the knowledge and experience level of the caregiver to meet the needs and maintain placement. • Ensure the caregivers receive a minimum of 12 hours annually will be provided. • Enhanced training is identified and provided to caregivers to support meeting the child's needs. • Condition-specific training is expected for individualized caregiving support, including one on one coaching, mentoring and modeling interventions, such as de-escalation techniques. • Agency staff receive training in condition specific medical needs to support caregiver
Documentation to be provided to DHHS
• Detailed summary of child's appointments, caregiver's interventions and training, and support provided by the agency to the caregiver to meet the enhanced and intensive needs of the child in placement. • Documentation of condition specific training and certification obtained by Agency staff working with the caregivers and children. • Case plans and monthly summaries demonstrate the increased frequency of contact, interventions and support provided by the Foster Care Specialist and supporting Agency.
Services and Support
• Agency provides altered levels of support, services and interventions depending on the child and caregiver's enhanced and intensive needs. • This includes increased contacts with the caregiver and visits to the home depending on the required level of support to maintain the stability of the placement. • Support caregiver's at child's appointments, as appropriate, and support caregiver's understanding of child's unique needs, techniques and interventions required of the child's medical and behavioral needs. • Agency staff assigned to the caregiver are trained and can demonstrate and model specialized skills to support the child, including modeling skills for caregivers and parents. • Agency is expected to provide staff experienced with supporting caregivers of children with trauma, and common behavioral needs commonly associated with child abuse and neglect and the foster care experience to adequately support caregiver's ability to meet the child's needs. • Agency can seek out and provide suggestions for community resources and respite that matches the child's enhanced and intensive needs. • For caregivers supporting transitional aged teenagers, the Agency will ensure the caregiver has access to life skills assessments and related findings, classes, and services. The Agency will ensure the caregiver has the skills to demonstrate, mentor and coach teens ages 14-19 to prepare the youth and their parents for success following discharge. • Agency consistently demonstrates the importance of caregivers engaging, mentoring and coaching parents to prepare them for the child's return, and/or to support their participation in transitional planning.

Level 4: Specialized

The Specialized Level is derived from service agreements for Professional Foster Care through PromiseShip and the Administrative Office of the Courts and Probation.

At this level, it would not be appropriate to provide care for more than two children at the specialized level of responsibility.

Training

Caregivers must have at least two years of experience being a Caregiver or have career/life experience relevant to meeting the needs of youth.

Ensure caregivers receive training specific to child such as:

- Complex behavioral needs who have been, or at risk of being placed in, a congregate care facility,
- Significant physical, and/or developmental disabilities requiring specialized in-home medical care,

Minimum of 18 hours of annual advanced training such as:

- Medical equipment, medical interventions
- Certified technique in verbal de-escalation
- Supervision and support of high and very high risk probation youth, and specialized populations such as youth who have sexually harmed and youth with developmental disabilities
- Caring for youth after institutional placements

Documentation

Foster Care Agency will submit a monthly report that contains:

1. Summary of the service and contacts for the month
2. Descriptions of the interventions provided, including any behavioral health services and psychotropic medications
3. Description of any critical incidents or crisis interventions;
4. Documentation of progress by the youth and family;
5. Details of engagement and collaboration with the family;
6. Description of barriers impacting progress;
7. An assessment of the continued need for Specialized level of responsibility;
8. Any other recommendations or information.

Ensure the support plan contains Restorative Goals**.** These may include:

- Behavioral Goals (increase or decrease in identified behaviors),
- Medical treatment (medical regimes),
- Educational and community goals and/or
- Reintegration goals.

Services and Support

- Enhanced support to caregivers include more frequent contacts, hands on training, coaching, modeling, or other individualized support.

- Through the Agency Provider, the youth, caregiver(s) and family will receive
  - A Specialized Caregiving Support Plan;

- Enhanced respite planning;
- Clinical interventionist components and appropriate supports such as:
    - Nurse oversight, clinical oversight, clinical consultations, clinical or behavioral interventions, and/or Family Preservation.
- Specialized supervision;
- Skilled training.

- Arrange for, facilitate, and coordinate qualified respite to meet the specialized needs of the child.
- Additional Supports to meet the child's needs are provided and paid for by the Agency.

Treatment Family Care Service Definition

Service Name	Treatment Family Care (TFC)
Setting	Treatment Family Care home
Facility License	The community based agency that operates the TFC program as required by Department of Public Health; and the individual treatment family care homes as licensed by Department of Health and Human Services.
Basic Definition	TFC is an all-inclusive rehabilitative model of care that provides intensive care for youth provided by trained and supported treatment parents. TFC must be a community based behavioral health program under the clinical direction of a psychiatrist, psychologist, or LIMHP. TFC is a Medicaid eligible, highly supportive, and individualized approach serving youth ages 20 and younger who have a history of trauma in addition to complex mental health or substance use disorders that are causing functional impairment. Children and youth with co-occurring developmental or intellectual disabilities and/or who are medically fragile are included. The youth have a history of psychiatric residential or inpatient treatment, or have been unsuccessful in remaining at home with outpatient services, and are clinically identified as requiring out of home treatment at the TFC level. This level of care will address the symptoms that affect the daily functioning of the youth and prevent further regression. This service requires intensive involvement and frequent contact between members of the treatment team. It is intended to provide a high degree of structure and supervision.

Service Expectations	• An Initial Diagnostic Interview (IDI) will be completed prior to the beginning of treatment and will identify TFC as the level of care needed. This IDI will serve as the initial treatment plan for the youth until a comprehensive treatment plan is developed.
	• The discharge plan is to be defined at intake and is reviewed and updated at each 30 day treatment team meeting, or sooner, as clinically indicated.
	• Utilization of a team approach to decision making is used in this program.
	• The treatment team will develop the comprehensive treatment plan within 30 days of admission.
	• Treatment shall address the mental health/substance use and bio psychosocial issues that have contributed to the youth's need.
	• The treatment plan will identify goals, objectives, and interventions necessary to improve or prevent regression in the mental health status of the youth.
	• Ongoing treatment meetings will be held at a minimum of every 30 days until treatment services are no longer necessary or the youth is no longer demonstrating benefit from this level of treatment.
	• In cases where parental rights are intact and the permanency plan is reunification, the reunifying family is the parent. In cases where reunification is not the permanency plan, the reunifying family is identified as the home with which the youth will experience permanency. When the youth enters TFC without an identified reunifying home upon discharge, one of the goals of the plan must be to develop that resource while TFC is being provided.
	• The treatment team will consist of the youth, TFC parents, licensed clinician, agency staff, reunifying family, and other support networks deemed appropriate to the treatment review and planning process.
	• Clinical expectations include: 1) oversight of the treatment plan, 2) collaboration with formal and informal networks, 3) provision of treatment and rehabilitative interventions, 4) ongoing assessment of the youth to determine progress in the treatment, 5) regular review, and updating, if necessary, of the diagnosis and treatment interventions.
	• A licensed clinician provides treatment services in the youth's home, the TFC home and/or in the community. Clinical services are provided for the youth, the reunifying family, and the TFC parents as deemed appropriate in the treatment plan. The frequency of this service is to be no less than weekly for each or as otherwise defined by the treatment plan and endorsed by the clinical supervisor. Frequency of services can be titrated as needed during the termination phase of treatment.
	• The licensed clinician will also serve as the liaison for communication and a treatment consultant for all treatment team members.
	• The licensed clinician will provide the reunifying family and the TFC parent(s) assistance in understanding clinical issues that impact the youth.
	• A TFC member will be available to provide rehabilitative intervention for the youth.
	• The clinical director or the licensed clinician will be available to provide crisis intervention to support all members of the treatment team at all times.
	• The reunifying family is involved, as clinically appropriate, and is active in service decisions for the youth.
	• The service is all inclusive and will be reimbursed at a daily rate for treatment services in the TFC home.
	• The following criteria must be met for a client's admission to a TFC program:
	  ○ The need for TFC must be identified on an Initial Diagnostic Interview based on the following criteria: The client must have sufficient need for active treatment at the time of intake to justify the expenditure of the client/family's and program's time, energy, and resources; Of all reasonable options for active treatment available to the client, active treatment in this program must prevent placement in a more restrictive setting and be reasonably expected to improve the client's condition;
	  ○ The proposed or revised treatment plan must be the most efficient and appropriate use of the program to meet the client/family's particular needs;
	  ○ The plan must address active and ongoing involvement of the family in care provision; and
	  ○ The program is designed to meet the needs of clients age 20 and younger.
	• The community based behavioral health program that operates the TFC program, and trains and supports the TFC family, provides a 20 hour initial training on mental health and substance use disorders, including the effects of trauma on youth, suicide prevention, emotional and behavioral interventions, in addition to training topics required by the agency.
	• It is the responsibility of the TFC parent(s) to attain 12 additional training hours per year to be determined and approved by the agency which the program is operated out of.
	• In addition to the biological, adoptive or guardianship children, the TFC parent(s) will have no more than two youth receiving TFC treatment residing in their home at a time (special consideration is given to sibling groups).
	• The TFC program shall have a director and an adequate number of non-licensed staff to provide administration, training, and any additional support of the TFC program.

	• Length of service is individualized according to the needs of the youth. • When TFC treatment is complete, the youth will be discharged from TFC treatment.
Staffing	• Licensed Program Clinical Director (psychiatrist, psychologist or LIMHP) • Licensed and/or provisionally licensed clinician • Child placing agency staff • TFC parents
Hours of Operation	• 24/7 with the availability of clinical assistance.
Desired Individual Outcome	• The youth has met the treatment plan goals and objectives. • The condition that brought the child to this treatment level is stabilized, and the child is able to successfully maintain at home and in the community in the absence of the supportive services and interventions provided in the TFC home. • The youth has support systems secured to help maintain safety and stability at home and in the community.
Admission guidelines	All of the following guidelines are required to be met: • The youth has a current edition DSM diagnoses for a disorder that is causing functional impairment requiring TFC level of intervention. • The youth has been unsuccessful in a lower intensity of services and/or is clinically identified as requiring TFC care treatment to prevent regression and improve symptoms and functioning. • The youth has a history of psychiatric residential or inpatient treatment or is at risk of requiring a higher level of care in the absence of this program. And one or more of the following: • The youth is experiencing or is at risk for self-harming, aggressive, or destructive behaviors • The youth has a significant history of trauma Excluding factors include the following: truancy and law violations in the absence of other symptoms.
Continued stay guidelines	• The youth is making progress toward the goals but has not made sufficient progress to consider discharge; and/or • There is sufficient clinical information to show that TFC level of care continues to be the least restrictive level of care that can meet the individual needs of the youth.

Discharge Criteria	• The youth no longer meets admission criteria or meets criteria for a more or less intense level of service;
	• And one of the following:
	  ○ Youth has not benefited from the TFC program and there is not a reasonable expectation of further progress at this level of care.
	  ○ The youth has met the goals of TFC and can be safely discharged from treatment.

FCRRC Treatment Family Care Rate Recommendations

Recommended Medicaid Rate

(Developed from prior Medicaid CBAR service components which are now unbundled services):

- 6 hrs of CTA @ 11.98 per 15 minute increment (Medicaid Rate)
  - 6 hrs x 4 to equal an hour = 24 (15 minute sessions per week)
  - 24 x $11.98 = $287.52 per week
- 2 Individual therapy sessions per week (60 min. session with LMHP)
  - 2x $112.08 (Medicaid Rate) = $224.16
- 2 Family sessions per week (potentially one with foster family and one with birth family)
  - 2 x$90.42 (Medicaid Rate) = $180.84
- 1 IDI (Initial Diagnostic Interview – 1x)
  - $125.52 (Medicaid Rate)/4 months = $31.35 (Anticipated 4 months ALOS)
- Clinical Consultation ($42.31-$87.25/hr Medicaid rate) –
  - 2 hrs/month @ $87.25 = $174.50/4.5 wks = $38.77

$287.52 + $224.16 + $180.84 + $31.35 + $38.77	= $762.64 (weekly total)
$762.64/7 (days in a week)	= $108.95/day

Therapist Salary: $48,518 (Nebraska Average according to www.indeed.com)

- Covered within the Medicaid daily rate
- 20-25 hours of direct client contact (sessions) with average of 2 sessions per week would equate to an average caseload of 1:10-
  - Need to factor in crisis on-call response, which may reduce case load to 1:8

Clinical Supervisor Salary: $65,659 (National Average according to www.ziprecruiter.com)

- A percentage of this salary is covered within the Medicaid rate (Clinical consultation)
  - 53%
- The remaining percentage should be covered within the Level 4 rate
  - 47%
- Anticipate 1 Supervisor to 8 FCS (1 FCS:6 youth) = 48 youth \
- 40 hrs/wk x 4.5=180 hours - 2 hrs. Consultation per youth (96 hours) = 84 hours non consultation
  53% Clinical consultation (96/180) = $34,799
  47% Level 4 rate (84/180) = $30,860

Recommended Administration and Support Rate:

Clinical Supervisor Salary: See above

- 47% included in the Level 4 rate ($30,860)

FCRRC Treatment Family Care Rate Recommendations

**recommended that the Clinical supervisor NOT be a requirement given the challenges to obtain clinicians in rural areas

Respite

- Costs should be included in Admin and Support Rate to be paid directly by agency so caregivers are trained and supported according to child specific needs.
- Keeping it separate from the Foster Parent rate allows for birth families to utilize respite if TFC provided in Family Home
- Recommend 4 days per month
    - Can be utilized as partial or full
        - 12 hours or more = full day
        - 11:59 or less = partial day
    - Overnights would not automatically equate to a full day