12 VAC 30-50-480.

§8. Case Management for Foster Care Children.

A. Target Group: Children or youth with behavioral disorders or emotional disturbances who are referred to treatment foster care by the Family Assessment and Planning Team of the Comprehensive Services Act for Youth and Families (CSA). 'Child' or 'youth' means any Medicaid eligible individual to 21 years of age who is otherwise eligible for CSA services. Family Assessment and Planning Teams (FAPT) are multidisciplinary teams of professionals established by each locality in accordance with §2.1-754 of the *Code of Virginia* to assess the needs of referred children. The FAPT shall develop individual services plans for youths and families who are reviewed by the team. The FAPT shall refer those children needing treatment foster care case management to a qualified participating case manager.

B. Areas of State in which services will be provided.

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the *Act* is invoked to provide services less than Statewide:

C. Comparability of Services.

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the *Act* is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the *Act.*

D. Definition of Services. Case management shall assist individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of a child. Case management services will coordinate services to minimize fragmentation of care, reduce barriers, and link children with appropriate services to ensure comprehensive, continuous access to needed medical, social, educational, and other services appropriate to the needs of the child. The foster care case manager will provide:

1. Periodic assessments to determine clients' needs for psychosocial, nutritional, medical, and educational services.

2. Service planning by developing individualized treatment and service plans to describe what services and resources are needed to meet the service needs of the client and help access those resources. Such service planning shall not include performing medical and psychiatric assessment but shall include referrals for such assessments. The case manager shall collaborate closely with the FAPT and other involved parties in preparation of all case plans.

3. Coordination and referral by assisting the client in arranging for appropriate services and ensuring continuity of care for a child in treatment foster care. The case manager shall link the child to services and supports specified in the individualized treatment and service plan. The case manager shall directly assist the child to locate or obtain needed services and resources. The case manager shall coordinate services and service planning with other agencies and providers involved with the child by arranging, as needed, medical, remedial, and dental services.

4. Follow-up and monitoring by assessing ongoing progress in each case and ensuring services are delivered. The case manager shall continually evaluate and review each child's plan of care. The case manager shall collaborate with the FAPT and other involved parties on reviews and coordination of services to youth and families.

5. Education and counseling by guiding the client and developing a supportive relationship that promotes the service plan.

E. Provider Participation. Any public or private child placing agency licensed or certified by the Department of Social Services for treatment foster care may be a provider of treatment foster care case management.

Providers may bill Medicaid for case management for children in treatment foster care only when the services are provided by qualified treatment foster care case managers. The case manager must meet, at a minimum, the case worker qualifications found in the Minimum Standards for Child Placing Agencies Who Render Treatment Foster Care (22 VAC 40-130-10 through 22 VAC 40-130-550). In addition, the case manager must possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following minimum knowledge, skills, and abilities. The following must be documented or observable in the application form or supporting documentation or in a job interview (with appropriate documentation).

1. Knowledge of:

a. The nature of serious mental illness and serious emotional disturbance in children and adolescents;

b. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

c. Different types of assessments, including behavioral and functional assessments, and their uses in service planning;

d. Childrens' rights;

e. Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, medical, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups); and

f. Types of mental health treatment services.

2. Skills in:

a. Interviewing;

b. Negotiating with children and service providers;

c. Observing, recording, and reporting behaviors;

d. Identifying and documenting a child's needs for resources, services, and other assistance;

e. Identifying services within the established service system to meet the child's needs;

f. Coordinating the provision of services by diverse public and private providers;

g. Using information from assessments, evaluations, observations, and interviews to develop service plans;

h. Formulating, writing and implementing individualized case management plans to promote goal attainment for individuals with behavioral disorders or emotional disturbances. This individualized case management plan is performed by the foster care case manager to guide his work in monitoring and linking the child to the services identified in the child's individualized service plan; and

i. Using assessment tools designated by the state; and

j. Identifying community resources and organizations and coordinating resources and activities.

3. Abilities to:

a. Demonstrate a positive regard for children and their families (e.g. treating children as individuals, allowing risk taking, avoiding stereotypes of people in treatment foster care, respecting childrens' and families' privacy, believing children can grow);

b. Persist in applying service plan objectives towards goal attainment and remain objective;

c. Work as team member, maintaining effective inter- and intra-agency working relationships;

d. Work independently, performing position duties under general supervision;

e. Communicate effectively, verbally and in writing, and;

f. Establish and maintain ongoing supportive relationships.

F. Freedom of Choice. Section 1915(g)(1) of the *Act* specifies that there shall be no restriction on free choice of qualified providers, in violation of §1902(a)(23) of the *Act.*

The State assures that there will be no restriction on a recipient's free choice of qualified providers of case management services. In addition, the State assures that case management services will not restrict an individual's free choice of providers of other Medicaid services.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible recipients will be free to refuse case management services.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. The case management services will be funded from Medicaid service funds, not administrative. This case management service shall not be construed as case management under EPSDT.

12 VAC 30-60-170. Utilization review of foster care case management services (FC). Service description and provider qualifications. FC case management is a community based program where treatment services are designed to address the special needs of children. FC case management focuses on a continuity of services, is goal directed, results oriented, and emphasizes permanency planning for the child in care. Services shall not include room and board. Child placing agencies licensed or certified by the Virginia Department of Social Services and which meet the provider qualifications for treatment foster care set forth in these regulations shall provide these services.

A. Utilization control.

1. Assessment. Each child referred for FC case management must be assessed by a Family Assessment and Planning Team (FAPT) under the Comprehensive Services Act or by an interdisciplinary team described in this section. The team must: (i) Assess the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; (ii) Assess the potential for reunification of the recipient's family; (iii) Set treatment objectives; and (iv) Prescribe therapeutic modalities to achieve the plan's objectives.

2. Qualified Assessors: A Family Assessment and Planning Team as authorized by the Code of Virginia under Section §2.1-754.

3. Preauthorization. Preauthorization shall be required for Medicaid payment of FC case management services for each admission and will be conducted by DMAS or its utilization management contractor. Failure to obtain authorization of Medicaid reimbursement for this service prior to onset of services may result in denial of payments or recovery of expenditures.

4. Medical Necessity Criteria. Children whose conditions meet this medical necessity criteria will be eligible for Medicaid payment for FC case management. FC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs, would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. The child must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on a state designated uniform assessment instrument. The child's condition must meet one of the three levels described below.

a. Level I: Moderate impairment with one or more of the following moderate risk factors as documented on the state designated uniform assessment instrument:

(1) Needs intensive supervision to prevent harmful consequences;

(2) Moderate/frequent disruptive or noncompliant behaviors in home setting which increase the risk to self or others;

(3) Needs assistance of trained professionals as caregivers.

b. Level II: The child must display a significant impairment with problems with authority, impulsivity and caregiver issues as documented on the state designated uniform assessment instrument. For example, the child must:

(1) Be unable to handle the emotional demands of family living;

(2) Need 24-hour immediate response to crisis behaviors; or

(3) Have severe disruptive peer and authority interactions that increase risk and impede growth.

c. Level III: Child must display a significant impairment with severe risk factors as documented on the state designated uniform assessment instrument. Child must demonstrate risk behaviors that create significant risk of harm to self or others.

5. FC case management admission documentation required. Before Medicaid preauthorization will be granted, the referring entity must submit to DMAS the following documentation. The documentation will be evaluated by DMAS or its designee to determine whether the child's condition meets the Department's medical necessity criteria

a. A completed state designated uniform assessment instrument; AND

b. All of the following documentation:

(1) Diagnosis, (Diagnostic Statistical Manual, Fourth Revision (DSM IV), including Axis I (Clinical Disorders); Axis II (Personality Disorders/Mental Retardation); Axis III (General Medical Conditions); Axis IV (Psychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning;

(2) A description of the child's immediate behavior prior to admission;

(3) A description of alternative placements tried or explored;

(4) The child's functional level;

(5) Clinical stability; and

(6) The level of family support available. AND

c. Written documentation that the Community Planning and Management Team (CPMT) has approved the admission to treatment foster care;

6. Penalty for failure to obtain preauthorization or to prepare and maintain the previously described documentation. The failure to obtain authorization of Medicaid reimbursement for this service or to develop and maintain the documentation enumerated above prior to the onset

of services may result in denial of payments or recovery of expenditures.

12 VAC 30-80-111.

Foster Care (FC) Case Management. The Medicaid agency will reimburse providers for the covered services for FC case management for each eligible child at the daily rate agreed upon between the local Community Policy and Management Team (CPMT) in the locality which is responsible for the child's care and the FC case management provider. This daily rate shall be based upon the intensity of the case management needed by the child and be subject to an upper limit set by the Medicaid agency. DMAS shall pay the lesser of the rate negotiated by the CPMT or the maximum rate established by the Department.

12 VAC 30-129-100.

Definitions. The following words and terms when used in these regulations shall have the following meanings unless the context indicates otherwise:

"Case management" means an activity, including casework, which assists Medicaid eligibles in gaining and coordinating access to necessary care and services appropriate to his needs.

"Casework" means both direct treatment with an individual or several individuals, and intervention in the situation on the client's behalf. The objectives of casework include: meeting the client's needs, helping the client deal with the problem with which he is confronted, strengthening the client's capacity to function productively, lessening distress, and enhancing opportunities and capacities for fulfillment.

"Child" means any individual less than eighteen years of age or under twenty-one if placed by a local department of social services or through referral from a Family Assessment and Planning Team.

"Child's family" means the birth or adoptive parent, or parents, legal guardian, or guardians, or family to whom the child may return.

"Child-placing agency" or "agency" or "agencies" means any person who places children in foster homes, adoptive homes, child-caring institutions or independent living arrangements in response to §§ 63.1-204, 63.1-205, and 63,1-220.2 of the *Code of Virginia* or a local board of public welfare or social services that places children in foster homes or adoptive homes pursuant to §§ 63.1-56, 63.1-204, and 63.1-220.2. Officers, employees, or agents of the Commonwealth, or of any county, city, or town, acting within the scope of their authority as such, who serve as or maintain a child-placing agency shall not be required to be licensed, if authorized by the *Code of Virginia* to provide the services of a child-placing agency.

"Client" means Medicaid-eligible and enrolled individual.

"Code" means the *Code of Virginia*, 1950, as amended.

"Community Planning and Management Team" means a team described in §2.1-750 of the *Code of Virginia*.

"Comprehensive Services Act" means the *Code of Virginia* § 2.1-745 et seq.

"Department" or "DMAS" means the Department of Medical Assistance Services.

"Family Assessment and Planning Team" means a team described in §2.1-754 of the *Code of Virginia*.

"Foster care services" means the provision of a full range of casework, treatment and community services for a planned period of time to a child under age 21 who is abused or neglected as defined, except for age, in § 63.1-248.2 of the *Code of Virginia* or in need of services as defined in § 16.1-228 of the *Code of Virginia* and his family when the child (i) Has been identified as needing services to prevent or eliminate the need for foster care placement, (ii) Has been placed through an agreement between the local board of social services or the public agency designated by the community policy and management team and the parents or guardians, (iii) Has been committed or entrusted to a local board of social services or child-placing agency.

"Foster care placement" means placement of a child through (i) An agreement between the parents or guardians and the local board or the public agency designated by the community policy and management team where legal custody remains with the parents or guardians, or (ii) An entrustment or commitment of the child to the local board or child-placing agency.

"Foster home" means the place of residence of any individual or individuals approved by a local department of social services or licensed child placing agency in which any child, other than a child by birth or adoption resides as a member of the household.

"Records" means the written information assembled in a file relating to the agency, staff, volunteers, the child, the child's birth family, foster family, treatment foster family, and adoptive family.

"Treatment" is the coordinated provision of services and use of professionally developed and supervised interventions designed to produce a planned outcome in a person's behavior, attitude, emotional functioning or general condition.

"Treatment foster care (TFC)" means a community-based program where services are designed to address the special needs of children. Services to the children are delivered primarily by treatment foster parents who are trained, supervised, and supported by agency staff. Treatment is primarily foster family-based, is planned and delivered by a treatment team.
Treatment foster care focuses on a continuity of services, is goal-directed, results oriented, and emphasizes permanency planning for the child in care.

"Treatment and service plan" means a written comprehensive plan of care, based on an assessment of the medical, psychological, social, behavioral and developmental aspects of the child's situation, containing measurable goals, procedures and interventions for achieving them, and a process for assessing the results. The treatment plan must state the treatment objectives, prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives and must include coordination with related community services to ensure continuity of care with the child's family, school and community.

"Treatment team" means the group that may consist of the child, professional agency staff, other professionals, the child's family members (where appropriate), the child-placing agency and treatment foster parents who provide mutual support, evaluate treatment, and design, implement and revise the treatment and service plan.

12 VAC 30-129-110. Targeted case management for foster care children in treatment foster care covered services and utilization control:

A. Service description. Case management is a component of treatment foster care (TFC) through which a case manager or caseworker provides treatment planning, treatment services, monitors the treatment plan and links the child to other community resources as necessary to address the special identified needs of the child. Services to the children shall be delivered primarily by treatment foster parents who are trained, supervised and supported by professional child placing agency staff. TFC case management focuses on a continuity of services, is goal directed, results oriented, and emphasizes permanency planning for the child in care. Services shall not include room and board. The following activities are considered covered services related to TFC case management services.

1. Placement activities, which may include, but are not restricted to, care planning, placement monitoring, and discharge planning;

2. CASE MANAGEMENT AND CASEWORK SERVICES; AND

3. Supervision of foster parents to evaluate the effectiveness of the child's plan of treatment.

B. Provider Qualifications.

1. License or certification. Treatment foster care case management shall be provided by child placing agencies with treatment foster care programs that are licensed or certified by the Virginia Department of Social Services to be in compliance with the Minimum Standards for Licensed Child-Placing Agencies (22 VAC 40-130-10 et seq.) and meet the provider qualifications for treatment foster care set forth in these regulations.

2. Caseload size.

a. The treatment foster care case manager shall have a maximum of 12 children in his caseload for a full-time professional staff person. The caseload shall be adjusted downward if:

1) The caseworker's job responsibilities exceed those listed in the agency's job description for a caseworker, as determined by the supervisor; or

2) The difficulty of the client population served requires more intensive

supervision and training of the treatment foster parents.

3) Exception: A caseworker may have a maximum caseload of 15 children as long as not more than ten of the children are in treatment foster care and the above criteria for adjusting the caseload downward do not apply.

b. There shall be a maximum of six children in the caseload for a beginning trainee that may be increased to nine by the end of the first year and 12 by the end of the second year.

c. There shall be a maximum of three children in a caseload for a student intern, if any student intern works in the agency.

C. Utilization Control.

1. Assessment. Each child referred for TFC case management must be assessed by a Family Assessment and Planning Team (FAPT) under the Comprehensive Services Act. The team must (i) Assess the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; (ii) Assess the potential for reunification of the child's family; (iii) Set treatment objectives; and (iv) Prescribe therapeutic modalities to achieve the plan's objectives.

2. Qualified Assessors: A Family Assessment and Planning Team as authorized by the *Code of Virginia* under § 2.1-754;

3. Preauthorization. Authorization shall be required prior to the onset of Medicaid payment for TFC case management services for each admission and will be conducted by DMAS or its utilization management contractor.

4. Medical Necessity Criteria. Children whose conditions meet this medical necessity criteria will be eligible for Medicaid payment for TFC case management. TFC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs, would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. The child must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on a state designated uniform assessment instrument. The child's condition must meet one of the three levels described below.

a. Level I: The child must display a moderate impairment in functioning with one or more of the following moderate risk factors documented on the state designated uniform assessment instrument:

(1) Needs intensive supervision to prevent harmful consequences;

(2) Moderate/frequent disruptive or noncompliant behaviors in home setting which increase the risk to self or others;

(3) Needs assistance of trained professionals as caregivers.

b. Level II: The child must display a significant impairment in functioning with problems with authority, impulsivity and caregiver issues documented on the state designated uniform assessment instrument. For example, the child must:

(1) Be unable to handle the emotional demands of family living;

(2) Need 24-hour immediate response to crisis behaviors; or

(3) Have severe disruptive peer and authority interactions that increase risk and impede growth.

c. Level III: Child must display a significant impairment in functioning with severe risk factors documented on the state designated uniform assessment instrument. Child must demonstrate risk behaviors that create significant risk of harm to self or others.

5. TFC case management admission documentation required. Before Medicaid preauthorization will be granted, the referring entity must submit to DMAS the following documentation. The documentation will be evaluated by DMAS or its designee to determine whether the child's condition meets the Department's medical necessity criteria.

a. A completed state designated uniform assessment instrument; AND

b. All of the following documentation:

(1) Diagnosis, (Diagnostic Statistical Manual, Fourth Revision (DSM IV), including Axis I (Clinical Disorders); Axis II (Personality Disorders/Mental Retardation); Axis III (General Medical Conditions); Axis IV (Psychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning;

(2) A description of the child's immediate behavior prior to admission;

(3) A description of alternative placements tried or explored;

(4) The child's functional level;

(5) Clinical stability; and

(6) The level of family support available. AND

c. One of the following:

(1) Written documentation that the CPMT has approved the admission to treatment foster care; OR

(2) Certification by the FAPT that TFC case management is medically necessary.

12 VAC 30-129-120. Reimbursement Methodology. Medicaid will reimburse enrolled providers for the covered services of case management for treatment foster care for each eligible child at the daily rate agreed upon between the Community Policy and Management Team (CPMT) in the child's responsible locality and the treatment foster care provider, subject to an upper limit set by the Department.

12 VAC 30-129-130. Organization and administration requirements. These standards shall be met by any enrolled provider signing an agreement with DMAS to provide case management services to children in treatment foster care.

A. A Medicaid enrolled Treatment Foster Care case management provider must be licensed by the Department of Social Services (DSS) as a child-placing agency with treatment foster care as defined in these regulations or shall be certified by DSS as designated by DMAS to meet all the requirements of these regulations. Officers, employees, or agents of the Commonwealth, or of any county, city, or town acting within the scope of their authority as such, who serve as or maintain a child-placing agency shall not be required to be licensed but shall be required to be certified to meet all the requirements of these regulations by the DSS.

B. Treatment and service plans in treatment foster care.

1. The treatment foster care case management provider shall prepare and implement an individualized treatment and service plan for each child in its care. When available, the parents shall be consulted unless parental rights have been terminated. If the parents cannot be consulted, the agency shall document the reason in the child's record.

2. When the treatment foster care case management provider holds custody of the child, a service plan shall be filed with the court within 60 days after the agency receives custody unless the court grants an additional 60 days, or the child is returned home or placed for adoption within 60 days. Providers with legal custody of the child shall follow the requirements of *COV* §§ 16.1-281 and 16.1-282.

3. The permanency planning goals and the requirements and procedures in the Department of Social Services Service Programs Manual, Volume VII, Section III, Chapter B, "Preparing the Initial Service Plan" may be consulted.

4. Comprehensive treatment and service plan. The case manager and other designated child placing agency staff shall develop and implement for each child in care an individualized comprehensive treatment and service plan within the first 45 days of placement that shall include:

a. A comprehensive assessment of the child's emotional, behavioral, educational, nutritional, and medical needs;

b. The treatment goals and objectives including the child's specific problems, behaviors and skills to be addressed, the criteria for achievement and target dates for each goal and objective;

c. The treatment foster care case management provider's program of therapies, activities and services, including the specific methods of intervention and strategies designed to meet the above goals and objectives, and describing how the provider is working with related community resources including the child's primary care physician to provide a continuity of care;

d. The permanency planning goals and objectives, services to be provided for their achievement, and plans for reunification of the child and the child's family, where appropriate.

e. The target date for discharge from the program.

f. For children age 16 and over, the plan shall include a description of the programs and services that will help the child transition from foster care to independent living.

g. The plan shall include the dated signature of the case manager and identify all members of the treatment team that participated in its development.

5. The case manager shall include and work with the child, the custodial agency, the treatment foster parents and the parents, where appropriate, in the development of the treatment and service plan and a copy shall be provided to the custodial agency. A copy shall be provided to the treatment foster parents as long as confidential information about the child's birth family is not revealed. A copy shall be provided to the parents, if appropriate, as long as confidential information about the treatment foster parents is not revealed. If any of these parties do not participate in the development of the treatment and service plan, the case manager shall document the reasons in the child's record.

6. The case manager shall provide supervision, training, support and guidance to foster families in implementing the treatment and service plan for the child;

7. The case manager shall arrange for and encourage contact and visitation between the foster child, his family and others as specified in the treatment and service plan.

C. Progress report and ongoing services plans.

1. The case manager shall complete written progress reports beginning 90 days after the date of the child's placement and every 90 days thereafter.

2. The progress report shall specify the time period covered and include:

a. Progress on the child's specific problems and behaviors and any changes in the methods of intervention and strategies to be implemented;

(1) Description of the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement and target dates for each goal and objectives

(2) Include a description of the therapies, activities, and services provided during the previous 90 days toward the treatment goals and objectives; and

(3) Any changes needed for the next 90 days;

b. Services provided during the last 90 days towards the permanency planning goals, including plans for reunification of the child and family or placement with relatives, any changes in these goals, and services to be provided during the next 90 days;

c. The child's assessment of his progress and his description of services needed, where appropriate;

d. Contacts between the child and the child’s family, where appropriate;

e. Medical needs, specifying medical treatment provided and still needed and medications provided;

f. An update to the discharge plans including the projected discharge date; and.

g. A description of the programs and services provided to children 16 and older to help the child transition from foster care to independent living, where appropriate.

3. Annually, the progress report shall address the above requirements as well as evaluate and update the comprehensive treatment and service plan for the upcoming year.

4. The case manager shall date and sign each progress report.

5. The case manager shall include each child who has the ability to understand in the preparation of the child's treatment and service plans and progress reports or document the reasons this was not possible. The child's comments shall be recorded in the report.

6. The case manager shall include and work with the child, the treatment foster parents, the custodial agency and the parents, where appropriate, in the development of the progress report. A copy shall be provided to the placing agency worker and, if appropriate, to the treatment foster parents.

D. Contacts with child.

1. There shall be face-to-face contact between the case manager and the child, based upon the child's treatment and service plan and as often as necessary to ensure that the child is receiving safe and effective services.

2. Face-to-face contacts shall be no less than twice a month, one of which shall be in the foster home. One of the contacts shall include the child and at least one treatment foster parent and shall assess the relationship between the child and the treatment foster parents.

3. The contacts shall assess the child's progress, provide training and guidance to the treatment foster parents, monitor service delivery and allow the child to communicate concerns.

4. A description of all contacts shall be documented in the narrative.

5. Children who are able to communicate shall be interviewed privately at least once a month.

6. Unless specifically prohibited by court or custodial agency, foster children shall have access to regular contact with their families as described in the treatment and service plan.

7. The case manager shall work actively to support and enhance child-family relationships and work directly with the child's family toward reunification as specified in the treatment and service plan.

8. The case manager shall record all medications prescribed for each child and all reported side effects or adverse reactions.

E. Professional clinical or consultative services. In consultation with the custodial agency, the case manager or caseworker shall provide or arrange for a child to receive psychiatric, psychological, and other clinical services if the need for them has been recommended or identified.

F. Narratives in the child's record.

1. Narratives shall be in chronological order and current within 30 days. Narratives shall include areas specified in these regulations and shall cover:

a. Treatment and services provided;

b. All contacts related to the child;

c. Visitation between the child and the child's family; and

d. Other significant events.

2. There shall be a monthly summary of the child's progress towards the goals and objectives identified in the treatment and service plan.

G. Treatment teams in treatment foster care.

1. The treatment foster care case management provider shall assure that a professional staff person provides leadership to the treatment team that includes:

a. Managing team decision-making regarding the care and treatment of the child and services to the child's family;

b. Providing information and training as needed to treatment team members; and

c. Involving the child and the child's family in treatment team meetings, plans, and decisions, and keeping them informed of the child's progress, whenever possible.

2. Treatment team members shall consult as often as necessary, but at least on a quarterly basis.

12 VAC 30-129-140. Discharge from Care.

A. A discharge summary shall be developed for each child and placed in the child's record within 30 days of discharge. It shall include the date of and reason for discharge; the name of the person with whom the child was placed or to whom he was discharged; and a description of the services provided to the child and progress made while the child was in care. Written recommendations for aftercare shall be made for each child prior to the child's discharge. Such recommendations shall specify the nature frequency and duration of aftercare services to be provided to the child and the child's family.

B. The summary shall also include an evaluation of the progress made towards of the child's treatment goals.

C. Discharge planning shall be developed with the treatment team and with the child, the child's parents or guardian, and the custodial agency.

D. Children in the custody of a local department of social services or private child-placing agency shall not be discharged without the knowledge, consultation, and notification of the custodial agency.

12 VAC 30-129-150.

Entries in case records. All entries shall be dated and shall identify the individual who performed the service. If a treatment foster care case management provider has offices in more than one location, the record shall identify the office that provided the service. Each child's record shall contain documentation that verifies the services rendered for billing.

CERTIFIED:

___November 8, 1999___ __/s/ Dennis G. Smith_____

Date Dennis G. Smith, Director
Dept. of Medical Assistance Services