Treatment Foster Care

Handbook

Denali Family Services
1251 Muldoon Rd. Suite 116
Anchorage, Alaska 99504
(907) 274-8281
Fax: (907) 274-4055

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Welcome to

Denali Family Services *(DFS)* became a non-profit organization in August of 1995. At that time, *DFS* was providing outpatient therapy and had a visitation program as well.

DFS is currently a community mental health center providing wrap-around services for children and youth who experience significant emotional or behavioral problems in the home, school or community and are classified as Severely Emotionally Disturbed (SED). Services at DFS include:

- medication management provided by staff psychiatrist(s);
- therapy (individual, family and group) provided by mental health clinicians; case management provided by case managers on staff;
- individual and/or group skill development provided by behavioral health associates;
- therapeutic child foster homes licensed and trained by foster care licensing specialists who also provide added support.
- Little Steps Day School Day School a quality inclusive child care for children ages 12 months through 5 years.
- Day treatment program services are available during the summer as well as winter break and spring break.

DFS's mission is ñSupporting children and families through individualized, community-based services.ò

The target population is children ages 3 years to 19 years of age who are deemed severely emotionally disturbed.

This handbook is designed to outline the expectations *DFS* has of treatment foster parents, as well as give a summary of how *DFS* operates.

Treatment Foster Care Is:

- An intensive rehabilitation service for severely emotionally disturbed children from age three (3) to eighteen (19) years of age that is provided in a licensed, trained foster home, working together with the childôs treatment team at all times.
- A service that is meant to prevent hospitalization or institutionalization, assist with transitions into the community after residential treatment, hospitalization or institutionalization, and/or assist the child in remaining in the community.
- A service that assists the child in working diligently on treatment goals as well as family reunification or the childôs permanency plan.
- Consistent structure, collaboration with other treatment providers (N. Star Hospital, Providence Discovery, Southcentral Foundation etc.), treatment interventions and a high quality of care.
- A treatment service that a child receives when other treatment services have been tried and failed or are still not enough to stabilize the child in the community.
- Working with the childôs treatment team regarding their individualized goals and objectives.

DENALI TREATMENT FOSTER PARENTS ARE:

- Licensed with DFS Child Placement Agency and are willing to receive training and act as a treatment provider, as well as participate with a consumerôs treatment team. Ability to be empathetic and to supervise children when they are suspended from school and require extra supervision.
- Have at least three positive references, have a clear criminal history background, no history of domestic violence nor sexual offending behaviors, no patterns of DUI nor a pattern of multiple traffic violations.
- Trained in de-escalation, therapeutic interventions and Managing Aggressive Behaviors (MAB). Use of passive restraints are only to be used if the client is in danger of harming themselves or others.
- Willing to work on the strengths of the child and family.
- Participate as a member of the childôs treatment team to help the child achieve their goals. Meet with the childôs clinician and be open and accepting of suggestions to help deal with a childôs specific behaviors.
- A willingness to be open minded and willing to set firm boundaries for dangerous behaviors while still being empathetic, patient and tolerant.
- Provide a warm, nurturing, and positive environment.
- Willing to learn or possess a basic knowledge of typical child development.
- Be an honest role model of appropriate expression of anger and good communication skills.

- Able to model socially acceptable hygiene and cleanliness.
- People willing to receive and attend on-going specialized training before and after receiving a foster child.

Treatment Foster Parent Responsibilities to *DFS* as a Child Placement Agency

1. Complete progress notes daily in the Harmony computer program, as determined by the foster care .
2. Regarding sanitation, (page 10, #9) in Treatment foster parent Responsibilities to Consumers and Service Team Members.
3. Regarding safety,
   a. store all cleaning supplies and any other hazardous materials in a safe location, inaccessible to children .
   b. maintain hot water delivered to plumbing fixtures accessible to children at a maximum temperature of 120 degrees Fahrenheit at all times.
   c. maintain all furniture and equipment in the facility in durable, safe, and good repair;
   d. maintain all floors, doors, and structures in the facility in good repair with no exposed nails, insulation, or other hazardous material;
   e. provide suitable lighting in each room of the home;
   f. maintain suitable ventilation in the bathrooms and kitchen;
   g. properly dispose of garbage, in a refuse container with a tight-fitting lid which is taken from the property weekly following the Municipalities guidelines;
   h. maintain grounds so that there is no evidence of sewage running on the ground;
   i. maintain child safe coverings on electrical outlets in a home with children younger than 6 years;
   j. keep firearms unloaded and locked, storing ammunition separately from firearms and inaccessible to children and locked. A written gun safety plan must be submitted and approved by *DFS's* foster care department as well as the Office of Children's Services approval. If a foster parent has a permit to carry a concealed weapon, the weapon may not be in the presence of a *DFS* consumer at any time;
   k. neither smoke nor allow smoking in or around your foster home nor in your vehicle and protect children from second-hand smoke at all times. Foster Parents will not smoke in their vehicles used in transporting clients. Foster children will not be allowed to ride in any vehicle in which smoking occurs. Foster children can not smell of cigarette smoke at any time.
   l. at all times, maintain working smoke detectors in each bedroom and in the common area on each level of the foster home, a working carbon monoxide detector on each level of the foster home and a 2A:10BC dry chemical fire extinguisher on each level of the home, mounted in an accessible area. Foster parents must complete a fire drill within 24 hours of each new foster child placed, to include each new respite placement, with on-going, documented monthly fire drill. Fire drills must use the client's initials only and be turned in to the Foster Care Department at DFS by the 1st of each month for the previous month.

m. Any animals in the foster home must be free from aggression. Foster parents must notify in writing to *DFS* within 24 hours if their animals have any contact with Animal Control, or if the animal bites anyone. All immunizations for animals in the foster home must be up to date and shown to the DFS Licensing Specialist upon request;
n. Maintain at all times a fully equipped first aid kit for emergencies kept in the foster home according to State regulations and an abbreviated kit must be kept in vehicles used to transport foster children and a portable kit used for hikes. Maintain an emergency disaster kit in the foster home to comply with State of Alaska regulations.
o. Comply with home visits from *DFS's* staff. Foster parents can expect a minimum of one non-scheduled, unannounced visit annually, and monthly scheduled visits by the foster care department. Case managers from DFS generally visit twice a month and Social Workers and the child's Guardian Ad Litem may visit at their discretion. It is required by regulation to allow access to the foster home at any time, as needed.

4. Annually review the HIPPA regulations and sign the required confidentiality agreement.
5. Annually review and abide by *DFS's* TFC Handbook and sign the required Obligatory agreement.
6. Use *DFS's* 24-hour on-call crisis line when needed or required for assistance. Any contact with on-call requires a written incident report to the agency within 24 hours or the next working day. If there is an injury of the child, an injury report is also required. These are to be documented in the Harmony computer system.
7. Report within 24 hours to *DFS's* foster care department and the child's case manager any changes in the home environment; such as, address, phone number, income, family illness, vacation arrangements, sleeping arrangements, additional occupants in the home, or any other changes as outlined in the Alaska Department of Health and Social Services Foster Care/Assisted Living Regulations.
8. Notify *DFS's* foster care department of any investigations of the foster home by the Office of Children's Services or any other entity within 24 hours of having knowledge of such investigation.
9. Notify *DFS's* foster care department within 24 hours of any police contact with any member of the foster home, or any person staying in the foster home for visits.
10. Notify *DFS's* foster care department within 24 hours of any domestic violence that occurs as well as any restraining petitions filed affecting anyone in the foster home.
11. Foster Parent's must give the DFS Foster Care Department, DFS case manager and legal guardian 14 days advance notice of any planned absence from the home. Coverage for care of the foster children will be developed and approved by *DFS and the child's parent/guardian* prior to such periods of 24 hours of absence or more. Treatment foster parents do not receive the *DFS* stipend during periods of their absence. *DFS* does **not** pay stipends if clients go outside of the state of Alaska with their Foster Parents.
12. Caregivers that are not licensed must be 21 years old to babysit a *DFS* consumer. At no time may a foster child or previous client babysit another client (or other children in the foster home) of any age.

13. For regular and/or ongoing babysitting, a caregiver must sign consent for a background check called Clearance for Licensing.
    - Finger printing for babysitters is at the OCS or DFS foster care departmentôs discretion.
    - The babysitter must be given the *DFS's* crisis on-call number by the foster parent.
    - *DFS* reserves the right to review and/or discontinue use of any babysitter.
14. Notify *DFS's* foster care department and the childôs DFS case manager of requests or arrangements for regular periods of respite. The clientsôtreatment team will discuss and help determine the amount of respite authorized.
15. Give *DFS* 30 days written notice to discontinue Treatment Foster Care for their consumer. If there is risk to the child or family, this notice may be waived by the Clinical or Foster Care Director.
16. Each Treatment foster parent shall attend mandated *DFS* agency trainings and mandated monthly foster parent support/education groups. If you are signed up for training and do not cancel within 24 hours of the training, the no-show will assess a $50.00 fee and will be deducted from your next stipend.
17. Ensure your personal vehicles used to transport *DFS* consumers are safe to drive, insured, and driven only by licensed adults with safe driving records. All citations for violations must be reported to the foster care department by the next working day.
18. Provide *DFS* with a current copy of foster care license and post the license in the foster home, visible at all times.
19. Pay all federal, state and local taxes, if any are incurred in the performance of this agreement. Report foster care earnings to the IRS as non-taxable income received.

ON-GOING REQUIREMENTS OF A TREATMENT FOSTER PARENT:

- Provide a copy of current Alaska driverôs licenses. No suspended driverôs licenses or licenses from another state or country will be accepted. *DFS* reserves the right to do background checks of treatment foster parentsôdriving records.
- Ongoing proof of the foster parents current automobile insurance.
- Ongoing proof of a current foster care license.
- Pass and obtain a certificate of completion of Annual training in MAB. Ongoing proof of CPR/First Aid training certification and a copy is given to DFS for the licensing file.
- Yearly proof of approved physical health through a physical exam to include a negative TB test.
- A *minimum* of 30 hours of therapeutic training completed by each foster parent (this includes the MAB hours). The foster parent must provide proof of all training to The Alaska Center for Resource Families.
- Attendance of all treatment team meetings and school meetings for the foster child in the foster home.
- Active participation as a treatment team member (i.e. giving input to the team and following therapeutic recommendations, supporting team decisions).
- Opening the foster home to ongoing home visits from the SW, Guardian Ad Litem, DFS case manager and from the DFS foster care department at any time, allowing inspection if requested.

Following the childôs treatment plan and completing progress notes daily, which are due each Friday in Harmony program. Notes are deemed late if not entered by midnight on Sunday.

- Immediately reporting to the childôs SW and DFS case manager any hospitalizations, accidents, pregnancies, sexual behavior, suspected child abuse or neglect or death of the child in care.
- Provide good parental care and safe transportation for the consumer placed in the foster home.

PLACEMENT AGREEMENTS:

The placement agreement is similar to a contract between the treatment foster parent and *DFS*. It states the responsibilities of all parties involved in the agreement and the amount of money to be exchanged for the service.

This means that the person taking on these duties will receive a stipend for the time worked as specified in the Treatment Foster Care Placement Agreement. This agreement does not offer health insurance, workmanôs compensation, or other benefits commonly offered to salaried or hourly positions. This is not a contract employment position in the traditional sense. It is a placement agreement, for each specific foster child placed.

PROGRESS NOTES

- A progress note has many blank spaces that need to be filled in by foster parentôs; such as, the date of service, signatures, etc. that must be completed by the treatment foster parent of the service. Notes must be signed and dated in order to be billed to Medicaid.
- Notes should be completed daily, but no later than 24 hours after the service is provided. They are considered due each Friday by 5:00 p.m.
- All notes are completed in the DFS Harmony computer system, entered by the Foster Parent daily.
- The actual content of the progress note discusses the childôs daily behavior, interventions used to help the child, how the child responded to those interventions & the dates of service. Medications must be listed in detail, the name of the medication, the amount given or taken, and the time of day given.
- Progress notes will **not** be accepted that are *boiler plated*. This means that each note has to be specific to the day of service, and not copied from previous notes.
- Only licensed *DFS* foster parents or a DFS approved caregiver trained to write the notes can write progress notes and submit them for payment.
- The progress note is a document that is filed in the childôs medical chart and could be subpoenaed for court. Notes must be written in an accurate, legible and professional manner.

DUE DATES:

- Progress notes must be completed daily in the Harmony system and payments will be made on a weekly basis for the notes turned in two weeks prior.

- Failure to complete notes in Harmony on time will delay the treatment foster parentôs stipend reimbursement and will result in no bonus.
- Notes are due daily but no later than Friday by 5:00 p.m. for the previous week (Friday through Thursday). Notes are considered late if they are submitted after midnight on Sunday, and no bonus is paid.
- If notes are not entered on time each week, the foster parent will not receive their $25 daily bonus. The excuse of their computer not working properly will not be accepted. If the computer is not working, you may request permission from your licensing worker to submit hard copy progress notes. These handwritten hard copy notes must be legible and turned in by 5:00 p.m. on Fridays, not Monday morning, in order to receive the bonus.

DETERMINING STIPEND RATES:

- After the childôs treatment team has made a determination that the child needs more intensive treatment; such as Therapeutic treatment foster care, a DFS case manager or clinician puts in a request to the Foster Care Department Director. A pre-placement request form is reviewed by the Foster Care Department. The Foster Care Department researches the availability of a TFC foster parent home to make the best match for the child and foster home.
- The daily rates (stipends) are based on acuity level of the consumer placed in a treatment foster home. A clinician completes a CANS level assessment quarterly for consumers. There are three different levels: Level 1 ($35 a day), Level 2 ($50 a day) and Level 3 ($60 a day). The more acute a child is, the higher their CANS score will be.
- Foster Parents also receive a $25 daily bonus if they are compliant with all the training and licensing requirements as well as submitting their notes on time. Thirty hours of required training includes MAB, CPR and First Aid (these must be current to be able to receive the training bonus) and a course offered by DFS in working with children having sexual boundary issues, Clinical Orientation and the six (6) modules of review of the DFS Foster Care Handbook. Foster parents are required to remain in compliance with all state regulations as well as providing a current drivers license, current auto insurance, monthly fire drills, annual HIPPA and annual F.C. Handbook review certifications. If you are found to be noncompliant, you will not receive the daily compliance bonus. The daily compliance bonus can not be back paid for the time a Foster home is not compliant.

Treatment Foster Parent Responsibilities to Consumers and Service Team Members

Treatment foster parents for *DFS* have many responsibilities to consumers and teams with which they must comply.

1. Work with the childôs family, and / or significant relationships to achieve a successful permanency plan.

2. Report immediately to the childôs SW or parent/guardian and to the *DFS's* foster care department any hospitalization, accident, severe depression, pregnancy, suspected incidents of child abuse or neglect, or the death of the child, or other critical incident.
3. Provide appropriate supervision for the child, make good judgments regarding discipline, bed times, eating habits, homework, appropriate activities, which encourage an overall healthy child.
4. Follow the childôs specific treatment service plan created by the treatment team.
5. Participate in pre-placement treatment planning and ongoing case planning, if available, regarding proposed placement.
6. Once placement occurs, attend all treatment team meetings and service plan reviews.
7. Participate in treatment plan designing, data collection and progress noting toward the goals and objectives on a daily basis.
8. Implement in-home treatment strategies that are part of the overall treatment plan.
9. Regarding sanitation,
    a. comply with current medical and sanitation advice and regulations on contagious or infectious diseases;
    b. adhere to the Occupational Safety & Health Administration (OSHA) standards for blood borne pathogens;
    c. wash their hands before food handling, preparation, serving, eating or table setting; after toileting and assisting a child with toileting or diapering; after handling pets or other animals; attending to a sick member of the home; and whenever hands are contaminated with bodily fluids, including nose wiping;
    d. encourage children to wash their hands and encourage the use of additional hand sanitizer.
    e. maintain a supply of disposable gloves and disinfectants for use when handling bedding material, sorting laundry, assisting a child with toileting or diapering, and handling any body fluids such as blood, vomit, urine or feces; clean bedding must be supplied for the foster child at all times.
    f. maintain a clean and sanitary facility;
    g. maintain sanitary facilities for proper care, storage, refrigeration, and preparation of food;
10. Cooperate with home visits from the childôs treatment team and foster care department. These generally occur twice per month, but may occur more often. One annual unannounced home visit is required by State of Alaska licensing regulations, but may occur more often if deemed necessary by the licensing department at DFS or OCS.
10. Maintain open communication with the natural family, if appropriate as well as the legal guardian, as indicated by the service team.
11. Maintain the confidentiality of the individual in your care, the natural family, the guardian, and the agency with respect to written and verbal information. There is no release of documents without authorization from DFS, then going through procedures of Medical Records department at DFS.
12. Use the treatment team process as a means of communication and advocacy for the child. Ongoing communication with the team allows for success and possible changes in interventions to be implemented as needed. The foster parents may call for a team meeting at any time they deem necessary for the well being of the child.

13. Use *DFS's* 24-hour on-call crisis line when needed or required for assistance. Any contact with on-call requires a written incident report submitted in Harmony within 24 hours or the next working day.
14. Assume primary responsibility for communication with, transportation to, and advocacy with the childôs school and engage the case manager with school meetings.
15. Implement independent living skills for children 16 and older as indicated in the treatment plan.
16. Comply with identified medical needs of the child, in cooperation with the legal guardian, including scheduling and participating in medical appointments and following all medication prescriptions as ordered by a physician or psychiatrist.
17. *DFS* requires a 30 day written notice to discontinue Treatment Foster Care for their foster child. If there is risk to the child or family, this notice may be waived by the DFS Foster Care Director, CEO or Clinical Director.
18. Protect the childôs rights by allowing incoming and outgoing mail in the home without censorship (unless suspected of containing unauthorized, injurious or illegal material, and then only supervising the opening of this mail).
19. Protect the childôs rights by allowing visits with the natural family in person or telephonically, and visits from friends, as ordered by the Courts or indicated by the treatment team. Maximum efforts will be made by members of the treatment team to work towards the childôs permanency plan. The foster parents should always ask what the permanency plan is for their foster child.
20. Protect the childôs rights by allowing freedom from exploitation in employment-related training or gainful employment.
21. Protect the childôs rights by allowing the child to express their opinions on issues concerning his/her care or treatment.
22. Protect the child and familyôs rights to religious preference. Children shall be free from coercion by the treatment foster parent with regard to religious decisions. Children ages 9 and older are allowed to decline participation with the foster family in regards to religious activities. The foster parents must set up an approved alternative if the child does not wish to accompany the foster parents to church activities.
23. Protect the childôs rights to ethnic and cultural activities by allowing and transporting to events. Actively seek cultural and other activities of interest to the child and document such efforts in the daily notes in Harmony. It is o.k. for the child to decline to attend, but the foster parents must show their efforts to keep children connected to cultural activities. If the foster parents and family are enthusiastic about attending the Ak. Native / Eskimo Olympics each year as a family activity, chances are the foster children will also be excited to attend.
24. Upon placement of each new child, foster parents will review *DFS's* Consumer Rights Handbook, discussing it in an age appropriate manner with their foster child. A copy of the consumer rights will be given to the foster parents in their Orientation notebook.
25. Provide all transportation to medical, psychological, social, recreational and educational events or appointments. Treatment foster parents may be held financially responsible for improper cancellation of appointments. 24 hours notice is required for cancellation of appointments at DFS agency with the psychologist or mental health

clinicians as these are ñmedicalò appointments and a critical part of the childôs treatment. Cancellations should only occur for emergencies or an illness. If a pattern of cancellations occurs the foster parents may be deemed as not cooperating with the treatment plan.

26. It is the foster parents responsibility to have a back-up plan and to make arrangements for child care when the foster child is out of school or suspended.
27. Provide the child with reasonable access to a telephone. This child may be charged for unapproved, long distance phone calls he/she makes.
28. Provide the child with a reasonable weekly allowance (age appropriate) as suggested by the treatment team.

DISCIPLINE AND BEHAVIOR MANAGEMENT:

Treatment foster parents for *DFS* shall help children in their care to develop age appropriate patterns of behavior that foster constructive relationships and increasing ability to deal with everyday life. Treatment foster parents shall provide positive reinforcement, redirection, and the setting of realistic expectations and clear and consistent limits for behaviors. A treatment foster parent may not use discipline or a behavior management technique that is cruel, humiliating, or otherwise damaging to the child. **A child in care may not be:**

a. removed from the other children for more than 10 minutes if the child is 8 or younger. A good rule of thumb is 1 minute per age of the child for ñtime outò. A child of any age should not be sent to their room for the day.
b. disciplined in association with food or rest. You may not with-hold a meal, or snack because of discipline. You may not put children to bed early as discipline. The childôs DFS clinician or case manager should be notified of all disciplinary measures used for your foster child as well as documenting this in the daily progress notes in Harmony.
c. punished for soiling clothing, bedwetting or actions in regard to toileting or toilet training;
d. subjected to discipline administered by another child;
e. deprived of family contacts, mail, clothing, medical care, treatment activities designed in their treatment plan, or contact with their placement worker or legal representative such as a SW or GAL;
f. subjected to verbal abuse, to derogatory remarks about the child or members of the childôs family, or to threats to expel the child from the foster home;
g. placed in a locked room;
h. physically restrained, except when necessary to protect a child 8 or younger from accident, to protect persons on the premises from physical injury, or to protect property from serious damage; and then only MAB techniques a passive physical restraint may be used;
i. mechanically restrained, except for protective devices such as seat belts; or
j. chemically restrained, except on the order of a physician.
k. corporal punishment may not be used on a child in treatment foster care. Corporal punishment includes any kind of physical hit, push, no ñbopping on the headò, no pulling a child by his shirt or jacket (unless to stop a young child from running into the street) or otherwise contact with a childôs body as a form of discipline or behavior management.

Denaliôs also enforces a policy regarding power struggling with consumers. Do not engage in verbal power struggles; state the house rule, expectation, consequence (etc.) and remove yourself from the situation. The foster parent may take a time out of their own, allowing the child space to follow through. Monitor for safety of the child towards self and others. It is not o.k. to yell at the child, curse at the child, or become involved in an emotionally charged struggle between the child ad the foster parents.

HEALTH SERVICES FOR THE CHILD IN CARE:

Children in foster care often miss out on normal health care services. They move from home to home and often do not get regular dental, medical or optometry care. The following are the requirements of Treatment foster parents at *DFS* for each child that is placed in their home.

1. An appointment for a health assessment consisting of a physicianôs examination shall be attained within 2 days (48-hours) of placement if one has not been done within the previous 30-days. The health assessment shall be redone every 12 months.
2. The childôs dental history shall be researched and noted in the in-home childôs file. An appointment for the child to receive a dental cleaning within the first 30-days of placement if the history cannot be located. The child will then receive a dental cleaning annually (or upon recommendation of the dentist) while in care with any follow-up needed as recommended.
3. The Treatment foster parent shall review the child and the natural familyôs known medical history, including immunization, operations, and childhood illness. This can be done in coordination with a Case Manager, clinician or Licensing Worker at DFS.
4. The Treatment foster parent shall maintain a locked and confidential file in their home that includes all medical, dental and optometry care that the child receives while in the foster home. This file shall be given to *DFS's* Case Manager or to the foster care department when the child leaves a home. A copy must be kept for three years in the foster home, and then destroyed.
5. If a voluntary placement and parents are taking their child for medical, dental or vision care a Medical Event Log is kept by the foster parent giving dates and a signature of the F.P. on this log. Again this is kept locked in the foster parentsô child file in the foster home. A copy of this log is give monthly to the case manager or foster care licensing specialist for inclusion in the childôs DFS medical file in medical records. A copy should be given the parents or OCS social worker of the child.
6. The Treatment Team, including the foster parent, shall document that the child has received age-appropriate instructions regarding teen pregnancy prevention, AIDS prevention, and general information about the prevention and treatment of disease.

NUTRITION AND DAILY LIVING OF THE CHILD IN CARE:

Children in foster care sometimes also miss out on some of the basics that we take for granted, such as a daily routine, nutrition, and basic provisions. It is the responsibility of

treatment foster parents to provide these. Children in treatment foster care through *DFS* will have the following:

1. provide a minimum of two Nutritious snacks daily and three meals daily according to the U.S. recommended nutritional standards;
2. provide a family atmosphere which is pleasant and nurturing;
3. provide an orderly daily schedule in which positive participation in appropriate school and community activities and the development of personal and interpersonal skills can occur;
4. provide provision of basic personal needs and an allowance, age appropriate;
5. provide an opportunity for the childôs choice of observance in their faith;
6. Opportunities to participate in activities consistent with his/her cultural ethnic and racial heritage, according to ICWA guidelines.

FEDERAL INCOME TAXES

www.irs.ustreas.gov publication 17: Youth Federal Income Tax; Chapter 13 ï Other Income, Income Not Taxed reads the following:

ñPayments you receive from a state, political subdivision or tax-exempt child-placement agency for providing care to qualified foster individuals in your home generally are not included in your income. You must include in your income payments received for the care ofé certain difficulty-of-care payments.

Difficulty-of-care payments are additional payments that are designated by the payer as compensation for providing the additional care that is required for physically, mentally, or emotionally handicapped qualified foster individuals. A state must determine that the additional compensation is needed, and the care for which the payments are made must be provided in you home.

Maintaining space in home: If you are paid to maintain space in your home for emergency foster care, you must include the payment in your income.ò

Denali Family Services pays foster parents an augmented daily rate. A foster home **can not** receive a Difficulty of Care payment from the State of Alaska as well as the daily rate from *DFS*. *DFS* foster parents **can** receive the Stateôs Room and Board monthly rate, in addition to the Denaliôs daily stipend.

The Impact of Foster Care[1]

What would it feel like if a stranger came into your home and told you that you had to go with them and that your parents could not stop them from taking you? What if this person took you to a house you had never seen and that you had to stay with people you have never known? Imagine not knowing when you will see your parents again.

Each child reacts differently to being removed from their homes depending on their age, the degree of attachment they feel to their parents, and the events that lead up to the removal. Many may feel scared, confused, guilty, or angry.

[1] Self-Instructional orientation for new foster parents (distributed by the Division of Family and Youth Services)

Children placed in foster care go through a condition known as ñseparation traumaò. This condition is caused by the sense of loss that is felt by the child when they are separated from the people most important to them. When someone or something important is lost in this way, the child grieves. Most children in placement work through a grieving process for the lost parent(s) much the same way that adults grieve the death of a loved one.

Foster Children often feel threatened by the foster parent. Their new home is unknown; thus making the foster child feel helpless and out-of-control. The child may expect you to treat them the same as their parents did. They become puzzled when your reactions are different. The child will test the limits to see if the foster parent will behave the same way as their parent. Foster parents need to be very consistent for the child to begin to feel safe.

Children who come from another foster home and have had multiple placements usually have difficulty trusting or attaching to the new foster parent. These feelings of mistrust and frustration will worsen with each move. The children may build a protective emotional wall so that they do not feel the hurt of moving from home to home.

Many children in foster care have experienced quite a bit of trauma in their lives. After being in foster care for a while some children begin to forget the bad times and only remember the good times with their parents. This is a strength that can be built upon to reunify this family with a new structure of emotions and love. Foster parents can be an integral part of this process.

Impact of Placement on <u>YOUR</u> Family

An important part of becoming a foster parent is the impact it will have on your family. The following is a list of important things to discuss with your family members and to put in writing within the household.

1. Normal one-to-one time between biological parent and child. Often a foster child can demand a lot of the attention in the home. How will you ensure that your biological children get special time with you or your spouse? Sit with your child and write up a plan, arrange the schedules in the house to accommodate this.
2. Economic strain on the family. While foster parents often receive both a stipend from *DFS* and room and board from the state, foster children could still add to economic strain in the house.

3. Private time for spouse or significant other. Donôt forget that a family can fall apart if the adult relationship doesnôt get attention also. Plan for this. Are there friends who will sit with your kids and foster kids one Saturday night a month so that the two of you can go on a date? Adult relationships are critical to prevent burnout.
4. Planning for transporting all of these kids everywhere. Sometimes the treatment team will want the foster child to attend a school separate from your biological children. How are you going to transport this child to school and still get to work on time?

Preparing yourself and your family for the extra person living in your home can make a more successful experience for all concerned.

The Child Needing Treatment Services

DETERMINING THAT A CHILD NEEDS TREATMENT:

In most agencies a parent or a social worker will make an appointment for an intake assessment. A clinician will meet with the child and parent or other referring person to talk about the childôs problems. The clinician asks questions about the childôs school, home and community functioning, history of other services, family history, trauma history, etc. The clinician will then use the Diagnostic and Statistical Manual to determine whether the child meets the criteria for a diagnosis. If the child does not meet any criteria in this manual then he/she does not need Denali Family Services. If he/she does meet enough criteria for a particular diagnosis in the manual then the child may be referred for services. One such service that a child could be referred is treatment foster care.

HOW A CHILD IS QUALIFIED FOR TREATMENT FOSTER CARE:

- A *DFS's* Clinician completes an intake assessment evaluation for wrap-around or foster care services.
- The childôs treatment team (the child, individual therapist, case manager, teacher, parent, grandparent, social worker, guardian ad litem, etc.) recommends treatment foster care.
- The child is insured by Medicaid, another insurance provider or grantor. This is a reimbursable service and so must be authorized as being medically necessary.

FUNCTIONING OF THE TREATMENT FOSTER CHILD:

DFS's children are different in their ability to function on a daily basis. The three main areas of functioning are at home, school and in the community. *DFS's* children generally have little ability to function appropriately in at least two out of the three areas defined. Other children can usually make the necessary adjustments to adapt in these three areas. *DFS's* children often have had poor role models, untrusting relationships with adults or experienced traumatic events and in the process have developed a poor self-image.

When *DFS's* child attempts to make adjustments to fit into an environment, they become easily frustrated, are confused by their own illogical thinking, and generally donôt have the mental ability to accomplish the task successfully. This is where treatment foster parents step in and assist the child with their struggle.

The treatment foster parent helps them with every day tasks, like hygiene, eating at the dinner table, school attendance and getting homework done, and bedtime. Some of these children have never had the structure of a normal childhood such as this. Treatment foster care helps the child become just like other kids (something many of us have taken for granted).

COMMON DIAGNOSIS:

Oppositional Defiant Disorder is defined in the Diagnostic and Statistical Manual as a pattern of the following: often losing temper; often arguing with adults; often actively defying or refusing to comply with adult requests or rules; often deliberately annoying people; often blaming others for their mistakes or misbehavior; often touchy or easily annoyed by others; often angry and resentful and often spiteful or vindictive.

Posttraumatic Stress Disorder is defined in the Diagnostic and Statistical Manual as a person exposed to a traumatic event or persistently re-experienced a trauma (i.e. chronic neglect). The following is a list of some of the symptoms of the disorder: recurrent and intrusive distressing recollections; recurrent distressing dreams of the event; acting or feeling the traumatic event is recurring; persistent avoidance of stimuli associated with the trauma (avoiding thoughts or feelings, activities, attachments to people, places, or inability to recall events). Some of the outwardly behavioral symptoms may be difficulty falling asleep, irritability or outbursts of anger, difficulty concentrating, hyper-vigilance, and exaggerated startle response.

Attention-Deficit/ Hyperactivity Disorder is defined in the Diagnostic and Statistical Manual as ña persistent pattern of inattention and/ or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of developmentò. Common symptoms are: often fails to pay close attention to details; often has difficulty sustaining attention in tasks or play; often does not seem to listen when spoken to directly; often does not follow through on instructions or tasks; often has difficulty organizing tasks; often avoids, dislikes, or is reluctant to engage in tasks; often loses things; often easily distracted; and often forgetful. Physical symptoms might include fidgeting, leaving seat, running about or climbing, talking excessively, blurting out answers, impatient when waiting, interrupts, and cannot be quiet.

The training on Clinical Diagnosis and interventions gives more in-depth understanding of the SED diagnosis.

THE CHILD'S INTERPRETATION:

Children who suffer from these symptoms often do not feel like they fit in with the crowd. They have low self-esteem, and feel frustrated that they cannot make friends or be popular. Sometimes they compensate for the inability to feel good or fit in by becoming a bully, class clown, shut down, shy away, and/or become suicidal. Any behavior could result from the emotions and frustrations they feel inside.

It is the treatment foster parentôs job to be patient and learn about the child. Ask yourself how they must feel on the inside. Sometimes the child who is a bully, swearing all of the time, and very difficult to get along with is the child with the lowest self-esteem.

The Treatment team

The treatment team is the group of people who are closest to the child. The team helps the child and the family make decisions about treatment in the foster home, the school and in the community.

TEAM MEMBERS:

- The child (client) themselves, depending on the age, plays a critical role in the planning and review process.
- The biological parents or natural guardians (adoptive parents, grandparents, etc.), regardless of any abuse or neglect that may have occurred, still maintain legal rights. They are involved in case reviews usually have visitation with the child, and often the goal is reunification of the family.
- The guardian ad litem (GAL) assigned by the court, advocates for the child. It is their responsibility to protect the childôs interests. They make independent investigations and make a report to the court suggesting what they think would be best for the child.
- The social worker from OCSôs role is to work for the safety of the child and to work toward reunification of the family or permanency for the child. If there is a social worker, they are the custodian of the child and must sign all documents as the final approver.
- Foster parents provide stability and nurturing environment for the foster child and play an integral role as child advocates. Foster parents who are performing the duties

of a treatment foster parent have an even more important role as a treatment provider on top of their normal foster parent responsibilities.

- Case Managers are advocates and coordinators who work for mental health centers or other social service organizations. Their job is to coordinate treatment, services and facilitate communication between all other team members. They are also an important advocate for the child and the family.
- Therapists or Clinicians often lead the service team decisions by giving the best clinical advice for the benefit of the child. They may be family therapists, individual or home-based therapists.
- Probation officers play a similar role as the social worker when the child is in the custody of DHSS. They are responsible for providing direct services to the pre-adjudicated and adjudicated delinquents. These services provide for their safety and security and hold them responsible for their misconduct to help them develop the skills and abilities to live productively and responsibly in the community. There may be court ordered conditions of probation for the child to follow. All violations in probation must be reported to the PO by the foster parent.
- Teachers can provide another perspective on the behavior of the child. They may identify needs previously unexplored by the rest of the team. They may also be an excellent support for the child and provide essential continuity.
- Family friends and relatives may be valuable as a respite option for the child and family, and may be able to give insight into the family dynamics not otherwise seen by professionals.
- The Childôs Behavioral Health Associate (BHA), if they are available to share the childôs behaviors when the BHA provides services.

TEAM STRUCTURE:

The case manager (or sometime the social worker or probation officer) is the leader because they have the most contact with all the members. The parent, social worker/probation officer, or the legal guardian, has the ultimate say in service decisions because they have custody of the child. Other members may become the leaders of the group for various reasons, but as a team, all decisions should be handled in a democratic way. Once a decision has been made all other team members should support it, whether they agree with it or not.

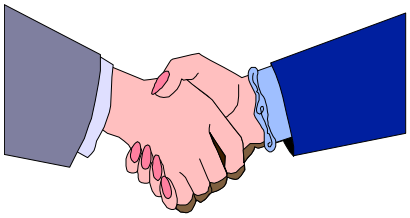
TEAM PROBLEMS:

One common problem is that assignments from service plans are not followed through. The team gets together regularly to talk about the child and how to best help the child. Specific plans are made to help the child and specific people are designated to complete the assignments. Often the assignments do not get done. A common mind-set on any kind of team is ñoh, I donôt have to do it, someone else will.ò It is up to each member to stay motivated and focused for the sake of the child and family.

Another common problem is called ñteam splittingò. An example might be that a treatment foster parent disagrees with the direction to place a child in a more restricted school. She begins calling other team members to rally support, even though the team met on the topic a week ago and decided it was in the best interest of the child. The solution for team splitting is to remember that a team is a democracy and even if you

donôt agree with the majority decision you must support it for the sake of good teamwork and to show the child that they cannot split the team.

It is an expectation at *DFS* that treatment foster parents will discuss any specific treatment team problems with their Linician and case manager and with their licensing supervisor in the treatment foster care department and to work toward resolution to those problems that are in the best interest of the child.



Funding

- *DFS* bills Medicaid, insurance, or a grantor for a childôs daily services. Treatment foster parents are required to write a progress note for the services they provide. The billing department then submits that bill to the reimbursing entity for reimbursement of services provided. *DFS* then pays the foster parent provider. This Medicaid progress note the treatment foster parent writes is a legal document and there are strict rules about how they are written and signed. The foster parents must sign your notes each week.

DFSôs Services

(In addition to Treatment Foster Care other services may be put in place)

ASSESSMENTS: Upon DFS receiving a request and Intake packet for services, the DFS Intake Coordinator and Intake committee reviews the referral and determines if our agency is able to address the needs of a child. If accepted, a masterôs level clinician will be assigned to complete a mental health assessment of the child which gives the childôs diagnosis, looks at the needs of the child and the ability of *DFS* to provide services to address the specific needs of the child. If declined for services, DFS makes referrals to other resources if appropriate.

INDIVIDUAL SKILL and GROUP SKILL DEVELOPMENT:

These services are limited to staffing availability within the DFS agency. Individual skill development (ISD) is a service that provides the child with a Behavioral Health Associate (BHA) to work on skills one-on-one. Group Skill development (GSD) is a service that provides more than one child working together in a group environment with the BHA. The child and the BHA participate in activities in the school and community. During these times, they work on the goals and objectives of the child as determined by the clinician and treatment team. These goals are written on the childôs progress notes. Examples are things such as social skills, manners, communication skills, friendship making skills, and other skills that match the childôs issues. The activities might be held at recreation centers (arts and crafts or sports), the library, skiing, riding

bikes, attending community functions, etc. No matter where the child and BHA are, they are working on the skills that are needed for this child to recover from his/her severe emotional disturbance and function better in the community.

Many people think of this as a babysitting service. It is **not** babysitting. The purpose of ISD or GSD is not to get the child out of the house for a few hours, but to teach them the skills they need to survive and adapt. This is why skill development is limited to a small amount of hours. It is not ethical, reasonable, or therapeutic for a child and counselor to work on skill building for eight hours per day, 5 days per week while the foster parent is at work.

The Behavioral Health Associate can be a great asset to the treatment foster parent. The BHA can follow-up on issues that are occurring in the foster home, although the BHA does not enforce punishments/restrictions imposed by the foster home unless the treatment team is in agreement with the plan. The BHA teaches skills to help them get along better with foster siblings, work on feelings and thoughts regarding particular behaviors exhibited in the home, etc. Communication between the BHA and the treatment foster parent is an essential part of the team concept.

CASE MANAGEMENT:

Case management is a service that is provided by a Case Manager. A case manager is the organizer of treatment. They set up team meetings, help create the treatment plan, and keep all the paperwork in order and submitted on time. They are also the link between team members, coordinating services as needed and keeping everyone informed. They can help the treatment foster parent advocate for the child in the school system, OCS and/or other agencies. They advocate for the child and his/her family in every aspect.

The case manager acts as one of the team leaders along with a clinician and social worker because they know most of the information from the home, school, community, courts, etc. and act as the hub of the team. Treatment foster parents should work closely with the case manager. Again, communication is a key to making case management work for the child.

INDIVIDUAL THERAPY:

Individual Therapy is offered at *DFS's* by Masters level clinicians. This is a service in which the child meets with the Clinician in their office usually once per week for approximately 50-minutes to an hour to work on deeper issues within the child. Some of these deeper issues might include exploring the trauma and the feelings regarding that trauma, or helping the child deal with grief and loss, anger, etc.

The Clinician also provides therapeutic services to adults, couples, whole families, and groups of people, as long as they are related to the primary consumer (the child). A foster parent may not cancel services (clinical or BHA) without treatment team approval unless the child is sick or unable to participate. If services need to be cancelled, please give 24 hours notice whenever possible. If there is a pattern of missed appointments, and upon the third missed appointment, the F.P. may be charged a cancellation fee.

24-HOUR CRISIS RESPONSE:

DFS offers a 24-hour crisis phone response to all treatment foster homes, regardless of the program with which they are affiliated. The response team consists of a case manager, clinician, or foster care licensing specialist, with the back-up support of the clinical Director. In most cases the on-call person will help you solve the problem over the phone and offer you some direction. The on-call person will **not** come to your location to help you.

PSYCHIATRIC SERVICES:

DFS has a psychiatrist on staff to assist the children in medication management and psychiatric care. The psychiatrists can also help treatment teams with clinical direction and planning. It is the foster parents responsibility to be aware of when the childôs medication needs to be renewed, and have an appointment with the doctor prior to expiration of the perscription. It is unacceptable to run out of medication because a previous appointment was cancelled.

Quality Assurance

Quality assurance is a term that is used in many professions that means the agency is concerned about maintaining quality services and has implemented ways to check and balance that quality. It is a required duty of *DFS* to maintain these checks and balances so that the agency can maintain accreditation and membership in associations and assist the consumers in receiving the highest quality of care.

INCIDENT REPORTS:

An incident report is a document that helps the agency to look at critical incidentôs in the foster homes, DFS office, home, school or elsewhere and make recommendations to change policy if needed, commend workers on a good job, or make other adjustments where needed.

Each time an employee or treatment foster parent uses a physical hold (MAB) to assist a child in being safe, an incident report must be completed. This can help the agency to determine whether the technique is being used properly, too often, or to change the childôs treatment plan.

Often a case manager will ask a treatment foster parent to write an incident report about other occurrences. This may be so that the agency can document and track severe behaviors and provide training or change policy.

A debriefing with staff and the consumer involved in a critical incident may be requested by the Clinical Director or Foster Care Director. This is to decrease the amount of secondary trauma staff and consumers may experience and to ensure that liability issues are addressed.

GRIEVANCES OR COMPLAINTS:

The agency has a formal grievance procedure and a form to be used for grievances. A Department Director or CEO is the person who will handle most of the complaints that a person has with the agency. All complaints or grievances will be handled in a professional manner to gain resolution.

Filing a grievance:

a. A treatment foster parent who wishes to file a grievance will contact a Director or the CEO and give written information about the grievance.
b. As soon as practical, the Director or CEO will attempt to arrange a meeting with the treatment foster parent to discuss the grievance. (If contact is unable to be made, the date and time of contact attempts will be noted.) .
c. The Director or CEO will review all aspects of the grievance or grievances, which may include meeting with a number of employees and/ or requesting written statements from employees regarding the grievance.
d. The Director or CEO will attempt to solve the problem stated in the grievance by meeting with the appropriate people and/ or mediating between appropriate people.
e. A full report of the grievance and procedure to solve will be written by the Director or CEO and will be given to the appropriate people involved as well as the CEO.
f. When a resolution cannot be found to the problem the CEO will make a decision.

REPORTING ABUSE OR NEGLECT:

By ethical guidelines and state law, all professionals are required to report suspected abuse or neglect of a child. This is true for case managers, clinicians, youth and family counselor, and treatment foster parents as well.

Failure to report such abuse or neglect could lead to legal outcomes as well as disciplinary action for the employee or treatment foster parent. Childrenôs safety will always be the top concern in the agency.

Treatment foster parents are encouraged to speak with their supervisor in the treatment foster care department about any concerns they might have in this area.

HOME VISITS:

The case manager of each child is required to visit the foster home at least once per month and have contact with the foster parents another time each month, but does not have to be in the foster home. The treatment foster care department will visit the home at least once per month. Behavioral Health Associates will sometimes visit the home every day. Compliance with home-visits is a part of the Treatment Foster Care Placement Agreement. Annual ñunannouncedò home visits are required by State licensing regulations and will be done by a foster care licensing specialist. These ñunannouncedò visits may occur more often if needed.

During home visits, a case manager is looking to see that the needs of the child are being met and to gather data about the childôs progress. The foster care licensing specialists also check to see that all licensing regulations are being followed. This is also a good time for the treatment foster parent and case manager to work as a team on any issues needed.

The treatment foster care department will visit the home to assure that all licensing regulations are being met. *DFS* is a placement agency and must supervise all placements made by this agency. They will look to see you have adequate clothing for the child, your water temperature maintains at under 120 degrees, you have a bed for each foster child with clean, appropriate bedding for the child, and will look at your

foster childôs file kept locked in your foster home. They will document all medical appointments and make sure you have given medical update information to the parents or guardian. You must notify your Licensing worker of any anticipated changes, a move to a new location, a family member who is visiting for a period of time, keeping them appraised of the situation within your foster home.

The Behavioral Health Associate will often visit the home every day. They may be dropping off the child or picking them up.

Home visits are a way to ensure that the childôs best interest, their treatment goals, and their safety are top priority as well as a way for the treatment foster parent to gain the support needed to maintain the placement.

TEAM MEETINGS:

The treatment foster parent is an integral part of the childôs treatment team. The treatment team meets about every 3 months (or as needed) to talk about the childôs progress and the treatment plan. The Treatment Foster Care Placement Agreement specifies that the treatment foster parent **must** be involved in these meetings.

The team meetings are a good time for the team to discuss the needs of the child to ensure that everyone is providing care and services in the best interest of the child.

MEDICATION:

The following is straight from the Policies and Procedures for Denali Family Services, I did not include the entire document, but I included the areas that seemed to pertain to employees and foster parents working directly with the children. I have attached the entire document to the email for your own records.

PROCEDURE:

1. Medication management is overseen by a board-certified psychiatrist.
2. When medication is prescribed or administered, the appropriate staff:
    a. Obtains a written, informed consent of the consumer or their legal guardian
    b. Fully explain the benefits, risks and alternatives;
    c. Documents the use of medication in the case record including when and by whom the medication is administered.
3. **All prescription medications are properly labeled and stored in original child proof bottles from a pharmacy with prescription labels including the following information:**
    a. The name of the consumer
    b. Dosage and name of medication
    c. The name of the prescribing physician;
    d. The expiration date
    e. A number or code identifying the written order when applicable.
4. **When medication must be transported for a consumer by an employee or is received by an employee from a foster parent or parent, the medication must be counted; receipt of medication must be documented including the names of all medications, the amount of each medication, the time of**

exchange and the persons involved in the exchange. Procedure #3 must also be followed.

5. Medications must be stored in a locking box, locking cabinet, or locking bag. This locked storage must restrict access to responsible staff members.
6. Consumers are not to carry or have access to their own medication unless they are 18 or older. It is NOT to be placed in the childôs backpack or lunch box.
7. **A consumer who is prescribed to take medication during the times then they are with Denali Family Service staff person excluding foster parents must be provided the medication for that day only, again in the proper prescription bottle.** In cases where the consumer will be away from their home/guardian/ parent for multiple days the exact amount of medication for the time away is to be provided. The medication must be placed in medication bottles as described in procedure #3.
    a. **The staff person receiving the medication must document their receipt of the medication, including the name of the medication, the amount of medication received the date and who from .**
    b. When medication is administered by personnel the following apply:
        i. **medication must be administered within ½ hour of the time specified on the label; if a dose is missed this must be documented, the consumers parent must be notified, an incident report must be completed and the prescribing physician or pharmacist must be contacted on recommendations regarding giving the medication or not.**
        ii. consumer is provided water to take the medication
        iii. consumer verbally verifies the medication staff is handing them is their medication, and is the correct dose
        iv. consumer takes the medication themselves
        v. The time, date, dosage given and person administering the medication must be documented;
        vi. Any side effects or changes in behavior, or consumer statement regarding changes they observe in themselves;
        vii. If a medication dosage was missed or is more than ½ hour late the reason for this must also be documented, the medication is not to be administered and the unused medication must be returned to the parent or legal guardian and then documented in the consumers file.
8. Medication may only be administered in the manner prescribed on the prescription bottle
9. Denali Family Services employees do not administer over the counter medication.

I understand it seems like a lot of information, but I believe that everyone needs to be on the same page when concerning medication. We are also asking foster parents to be more precise on their Harmony notes, being specific. If a child is taking medication the progress note must have exactly what was taken and when it was administered in the Medication Administration section of the note. To receive an extra prescription bottle

you can go to your pharmacist and ask for one. Often this is not a problem, but you may need to get the childôs Doctor to write that an extra bottle is needed on the prescription.

7 AAC 10.1075. Firs t aid kit and procedures .

(a) An entity shall review, and shall post or make readily available, first aid procedures. The entity shall post and keep current emergency telephone numbers, including the number for the poison control center, near one or more telephones in the entity. The entity shall maintain
(b) The entity shall restock each first aid kit after use to ensure compliance with this section.
(c) Each first aid kit must include at least the following items, checked regularly to ensure that any expiration date is not exceeded, and kept within a container that will hold all of the items:

(1) disposable nonporous, nonlatex gloves;
(2) sealed packages of alcohol wipes or antiseptic for thermometer cleaning only;
(3) scissors;
(4) tweezers;
(5) a thermometer;
(6) adhesive bandages;
(7) bandage tape;
(8) sterile gauze pads;
(9) flexible roller gauze;
(10) triangular bandages;
(11) safety pins;
(12) an eye dressing;
(13) a note pad with a pen or pencil;
(14) activated charcoal, for use only under the direction of a poison control center or another medical professional;
(15) a cold pack;
(16) a current American Red Cross standard first aid text or equivalent first aid guide;
(17) a CPR barrier device or mask;
(18) the telephone number for the poison control center;
(19) potable water;
(20) splints, including small child-size splints if children are in care;
(21) soap;
(22) a working flashlight;
(23) medical consent form;

(24) necessary medications.

Interventions for Community Based Therapeutic Care

- proximity control
- role modeling
- coping role modeling
- reflective listening
- coaching
- pre-teaching
- shaping positive behaviors
- praise, encouragement
- redirection
- teaching how to use self affirmations
- logical consequences
- limit setting
- natural consequences
- selective ignoring
- house rules
- verbal and written contracts
- rituals of care
- group (family) activities
- accountability checks
- sight and sound supervision
- teaching social skills
- teaching independent living skills
- prompting
- giving cues
- ABC plan
- behavior chart
- fading
- positive reinforcement
- differential reinforcement of alternate behaviors
- fading
- problem solving
- confrontation
- I feel statements
- victim mediation
- reality testing
- refocusing
- reframing
- adventure based activities
- biblio-theraphy
- goal setting
- urine analysis
- MAB
- nonphysical de-escalation
- money management

- budgeting
- tutoring
- processing feelings
- assisting in keeping an anger log
- 1-2-3 magic (as guided and recommended by the childsôclinician and team
- contingency planning
- use of primary and social reinforcement
- family meeting
- distraction
- side talk
- tracking antecedents
- behavioral tracking
- offering positive alternatives
- physical guidance
- CATCHING THE CHILD DOING GOOD 90% of the time
- memory book
- letter writing
- magic box
- cookie jar (giving written compliments and storing them in a place where child can review or go for comfort in crisis, gradually learning to give self affirmations)
- play
- humor
- companion chores
- success chart
- broken record in limit setting
- separating behavior from feelings about the child when limit setting
- cueing for self-control
- setting a sterile environment
- challenging thinking errors

OBLIGATORY CONSENT:
After reading this section of the Handbook and having the details within which explained, the treatment foster parent must sign the Obligatory Consent that attests to their obligation to comply herein. The Obligatory Consent will be filed in the foster parentôs file and with the treatment foster parent.

SATISFACTION SURVEYS:

Periodically *DFS* will mail treatment foster parentôs forms to complete that will provide the agency with feedback about the services and organization. This is very important for the agency to make improvements and changes to better meet the needs of consumers and foster parents. The agency asks for everyoneôs cooperation in these surveys.

This is the conclusion of the orientation handbook. This handbook was written to assist staff and treatment foster parents to learn about their responsibilities, the children served and the agency as a whole.