320-W – THERAPEUTIC FOSTER CARE FOR CHILDREN

EFFECTIVE DATES: 10/01/20, UPON PUBLISHING[1]

APPROVAL DATES: 04/16/20, 07/07/22[2]

I. PURPOSE

This Policy applies to ACC, ACC-RBHA[3], ALTCS E/PD, DCS/~~CMDP~~ CHP[4] (~~CMDP~~CHP), and DES/DDD (DDD)~~, and RBHA~~ Contractors, This Policy establishes requirements for the provision of care and services to members in Therapeutic Foster Care (TFC).

II. DEFINITIONS

Definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.

~~**ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)**~~[5]	~~The department established pursuant to A.R.S. §8-451 to protect children and to perform the following:~~ ~~1. Investigate reports of abuse and neglect.~~ ~~2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.~~ ~~3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.~~ ~~4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthening the family and provide prevention, intervention and treatment services pursuant to A.R.S. Title 8, Chapter 4.~~
~~**ASSESSMENT**~~	~~An analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient as specified in A.A.C. R9-10-101.~~

[1] Date policy is effective
[2] Date approved at APC
[3] Revised to align with the Competitive Contract Expansion YH20-0002 to expand the provision of services for the awarded ACC Contractors.
[4] Revised to apply name change for CMDP from Comprehensive Medical and Dental Program to Comprehensive Health Plan (CHP) effective April 1, 2021, due to CHP behavioral health integration.
[5] Removed from Policy; all term can be found in Contract and Policy Dictionary

~~**CAREGIVER**~~	~~For the purposes of this policy, a Caregiver is an adult who is providing for the physical, emotional and social needs (i.e. caring for) a child who is under the care, custody and contr. Examples of Caregivers can include birth parent(s), foster parent(s), adoptive parent(s), kin or relative(s), group home staff. Caregivers can be licensed or unlicensed.~~
~~**CHILD**~~	~~Individual under the age of 18, unless the term is given a different definition by status, rule or policies adopted by AHCCCS.~~
~~**CHILD AND FAMILY TEAM (CFT)**~~	~~A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health provider, and any individuals important in the child's life that are identified and invited by the child and family to participate. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, or mosques, agents from other service systems like the Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.~~
~~**CRISIS PLAN**~~	~~A written plan established by the member that is designed to prevent or reduce the effects of a behavioral health crisis. This Plan identifies what is or is not helpful in crisis prevention through the identification of contacts and resources, and actions to be taken by the member, family, parents, guardians, friends, or others.~~
~~**HEALTH CARE DECISION MAKER**~~	~~An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§8-514.05, 36-3221, 36-3231 or 36-3281.~~

~~**INDIVIDUALIZED SERVICE PLAN (ISP)**~~	~~A comprehensive written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life. The ISP is created and managed by the CFT. It is a dynamic document that is regularly updated to adequately match the strengths and needs of the member and family.~~
~~**THERAPEUTIC FOSTER CARE (TFC)**~~	~~A family-based placement option for children with serious behavioral or emotional needs who can be served in the community with intensive support.~~
~~**THERAPEUTIC FOSTER CARE (TFC) AGENCY PROVIDER**~~	~~TFC Agency Provider credentialed by MCOs to oversee professional TFC Family Providers and holds contracts with pertinent health plans and/or DCS to provide TFC services to children.~~
~~**THERAPEUTIC FOSTER CARE (TFC) FAMILY PROVIDER**~~	~~Specially trained adult(s) in a family unit licensed by DCS and endorsed to provide TFC services to children. Also known as TFC Parent(s).~~
~~**THERAPEUTIC FOSTER CARE (TFC) TREATMENT PLAN**~~	~~The plan details the specific behavioral goals that the TFC Family and TFC Agency Providers will help the member achieve during member's time in TFC. These TFC treatment goals will be explicit, observable, attainable, tailored to the member's strengths and needs; and will align with the comprehensive ISP of the CFT. The TFC Treatment Plan will outline the steps the TFC Family and TFC Agency Providers will implement to help member attain the FTC treatment goals and thus successfully discharged from TFC.~~

III. POLICY

TFC is a covered behavioral health service that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Individualized Service Plan (ISP) as appropriate (Arizona State Plan for Medicaid).

Programmatic support is available to the TFC f~~F~~amily p~~P~~roviders 24 hours per day, seven days per week. Care and services provided in TFC are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board. The Contractor~~s~~ shall refer to ACOM Policy 414 for information on timeframes and requirements regarding prior authorizations.

TFC service can only be provided for no more than three children in a p~~P~~rofessional f~~F~~oster h~~H~~ome (Arizona State Plan for Medicaid).

The Contractors and TFC aAgency pProviders shall ensure appropriate notification is sent to the Primary Care Provider (PCP) and bBehavioral hHealth hHome/aAgency/TRBHA/Tribal ALTCS program upon intake/admission to, and discharge from TFC.

TFC fFamily pProviders and TFC aAgency pProviders shall adhere to DCS policies and procedures for children involved with the Arizona Department of Child Safety (DCS).

A. CRITERIA FOR ADMISSION

The Contractors shall develop admission criteria for medical necessity, which at a minimum includes the below elements. The Contractors shall submit admission criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the Contractor's website.

1. Criteria for Admission:
   a. The recommendation for TFC shall come through the Child and Family Team (CFT) process,
   b. Following an aAssessment by a licensed Behavioral Health Professional (BHP), the member has been diagnosed with a behavioral health condition, which reflects the symptoms and behaviors necessary for a request for TFC,
   c. As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought, or behavior that renders the member incapable of independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment per aAssessment by a BHP:
      i. Cannot be reasonably expected to improve in response to a less intensive level of care, and
      ii. Does not require or meet clinical criteria for a higher level of care, or
      iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
   d. At time of admission to TFC in participation of Health Care Decision Maker (HCDM) and all stakeholders, there are documented plans for discharge and transition which includes:
      i. Tentative disposition/living arrangement identified, and
      ii. Recommendations for aftercare treatment based upon treatment goals.

B. EXCLUSIONARY CRITERIA

Admission to TFC shall not be used as a substitute for the following:

1. An alternative to detention or incarceration.

2. As a means to ensure community safety in an individual exhibiting primarily conduct disordered behaviors.

3. As a means of providing safe housing, shelter, supervision, or permanency placement.

4. As an alternative to ~~parents'[6]/Health Care Decision Makers~~HCDM's or other agencies' capacity to provide for the member.

5. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/~~Health Care Decision Maker~~HCDM is unwilling to participate in the less restrictive alternative~~, or~~

~~6. An intervention for member runaway behaviors unrelated to a behavioral health condition.~~[7]

C. EXPECTED TREATMENT OUTCOMES:

1. Treatment outcomes shall align with:
   a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 100, and
   b. The member's individualized physical, behavioral, and developmentally appropriate needs.
2. Treatment goals for the member's time in TFC shall be:
   a. Specific to the member's behavioral health condition that warranted treatment,
   b. Measurable and achievable,
   c. Cannot be met in a less restrictive environment,
   d. Based on the member's unique needs,
   e. Include input from the member's ~~family~~[8]/~~healthcare decision maker~~HCDM and D~~d~~esignated R~~r~~epresentative (DR)'s choices where applicable, and
   f. Support the member's improved or sustained functioning and integration into the community.
3. Active treatment with the services available at this level of care can reasonably be expected to:
   a. Improve the member's condition in order to achieve discharge from the TFC at the earliest possible time, and
   b. Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

D. CRITERIA FOR CONTINUED STAY

The Contractor~~s~~ shall develop medically necessary criteria for continued stay which, at a minimum, includes the below elements. The Contractor~~s~~ shall submit continued stay criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the Contractor's website.

1. All of the following shall be met:
   a. The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to TFC,
   b. There is an expectation that continued treatment at the TFC shall improve the member's condition so that this type of service shall no longer be needed, and

[6] Removed; redundant with definition of Health Care Decision Maker
[7] Removed as an exclusionary criteria to be less stringent.
[8] Removed; redundant with the definition of Health Care Decision Maker

c. The CFT is meeting at least monthly to review progress, and have revised the TFC tTreatment pPlan ~~and Individualized Service Plan (~~ISP~~)~~ to respond to any lack of progress, and for members, the cCaregiver to whom the member shall be transitioned after discharge from a TFC has been identified and is actively involved in the member's care/treatment, if applicable.

2. All of the following are met:
   a. The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or age appropriate self-care or self-regulation, and
   b. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to TFC, and treatment at the TFC is empowering the member to gain skills to successfully function in the community.

E. CRITERIA FOR DISCHARGE

The Contractor~~s~~ shall develop medical necessity criteria for discharge from TFC settings which, at a minimum, includes the below elements. The Contractor~~s~~ shall submit discharge criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the Contractor's website.

1. Sufficient symptom or behavior relief is achieved as evidenced by completion of the TFC treatment goals.

2. The member's functional capacity is improved and the member can be safely cared for in a less restrictive level of care.

3. The member can participate in needed monitoring and follow-up services or a cCaregiver is available to provide monitoring in a less restrictive level of care.

4. Appropriate services, providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.

5. There is no evidence to indicate that continued treatment in TFC would improve member's clinical outcome.

6. There is potential risk that continued stay in TFC may precipitate regression or decompensation of member's condition.

7. A current clinical aAssessment of the member's symptoms, behaviors, and treatment needs has been reviewed by the CFT and has established that continued care in TFC is setting no longer adequate to provide for the safety and treatment. The CFT will then discuss if a higher level of care is necessary.

F. PROGRAM REQUIREMENTS - DISCHARGE PLANNING

1. Discharge planning details shall be included in the TFC tTreatment pPlan and be updated monthly. Discharge plans shall be completed using the approved standardized criteria across all providers. The CFT shall review and approve the plans as their support is required to successfully implement the details:
   a. Discharge planning is considered the successful completion of treatment goals such that sustainable transition into a less restrictive setting is possible:
      i. Discharge planning shall be developed as part of the TFC Treatment Plan and shall be in alignment with the ISP,
      ii. The dDischarge pPlan shall include identification of and consistent work with ~~Health Care Decision Maker(s)~~HCDM(s), and
      iii. The TFC team shall continue to plan for discharge from the TFC fFamily pProvider as soon as an appropriate lower level of community-based care is identified.
   b. Successful discharge planning for TFC shall include engagement of receiving cCaregiver(s) to participate in transitionary visits. It is important to understand the needs of the receiving cCaregiver(s), and to provide them the appropriate coaching and mentorship, and
   c. In the event that the member has not been successful in TFC and the decision is made to move the member to a higher level of care, the TFC fFamily pProvider and TFC aAgency pProvider in collaboration with the CFT will work to make this transition as seamless as possible.

G. PROGRAM REQUIREMENTS – TREATMENT PLANNING

1. The TFC tTreatment pPlan shall:
   a. Be developed in conjunction with the CFT,
   b. Describe strategies to address TFC fFamily pProvider needs and successful transition for the member to begin service with TFC fFamily pProvider, including pre-service visits when appropriate as well as respite planning,
   c. Complement and not conflict with the ISP and other defined treatments, and include reference to the member's:
      i. Current physical, emotional, behavioral health, and developmental needs,
      ii. Current educational placement and needs,
      iii. Current medical treatment,
      iv. Current behavioral treatment through other providers, and
      v. Current prescribed medications.
   d. Update member's current cCrisis pPlan in alignment with TFC setting,
   e. Address safety, social, and emotional well-being, discharge criteria, acknowledgement of member's permanency objectives and post-discharge services,
   f. Include short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the ISP,
   g. When age and developmentally appropriate, youth and biological, kinship, and adoptive family participation in development of the TFC tTreatment pPlan is required,
   h. Include specific elements that build on the members' strengths, while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,

i. Include specifics to coordinate with natural supports and informal networks as a part of treatment,
j. If the TFC t~~T~~reatment p~~P~~lan includes co-parenting engagement with the member's c~~C~~aregiver(s), specific goals shall be developed to prepare the receiving c~~C~~aregiver(s) and successfully transition the member to the new placement,
k. Include plans for engagement of the member's biological family, kinship family, adoptive family, and/or transition foster family and other natural supports that can support the member during TFC placement and after transition,
l. Include respite planning,
m. Be reviewed by:
   i. The TFC f~~F~~amily p~~P~~rovider and TFC a~~A~~gency p~~P~~rovider at every home visit,
   ii. The TFC a~~A~~gency p~~P~~rovider and c~~C~~linical s~~S~~upervisor at each staffing, and
   iii. The TFC a~~A~~gency p~~P~~rovider~~,~~ and CFT at each revision, or at a minimum quarterly.
n. Include documentation of the TFC Treatment Plan which shall be kept by the TFC f~~F~~amily p~~P~~rovider and the TFC a~~A~~gency p~~P~~rovider and shared with the CFT.

2. For after care planning for DCS involved members, the TFC f~~F~~amily p~~P~~rovider may be the discharge placement. In such cases where the TFC f~~F~~amily p~~P~~rovider is the discharge placement, DCS foster care rates, policies and procedures apply. Licensing agencies shall coordinate these actions through the CFT and DCS as they are not governed by this Policy. Ongoing appropriate and approved relationship and communication with the TFC f~~F~~amily p~~P~~rovider after discharge is encouraged. This is determined with ~~Health Care Decision Maker~~HCDM approval and in the best interest of the member.

IV. TFC REQUIREMENTS

A. ROLES/RESPONSIBILITIES/QUALIFICATIONS

1. The TFC f~~F~~amily p~~P~~rovider will be licensed through the DCS and will not require AHCCCS credentialing.

2. The TFC a~~A~~gency p~~P~~rovider will require credentialing with the ~~MCOs~~Contractor[9].

3. The TFC a~~A~~gency p~~P~~rovider plays a critical role in providing clinical supports to the TFC f~~F~~amily p~~P~~rovider as they meet the daily needs of the member. This is in addition to fulfilling the administrative requirements of the c~~C~~ontracting Medicaid entity, the State, and Tribal licensing authority. These services include but are not limited to:
   a. Ensuring TFC f~~F~~amily p~~P~~rovider(s) comply with all state and local licensing requirements including application, training, life safety inspections, and administrative requirements,
   b. Submission of deliverables,
   c. During initial six weeks of placement, the TFC a~~A~~gency p~~P~~rovider shall conduct one home visit per week; these visits may occur in-person or via telemedicine (i.e. interactive audio/video communications). For continued stay beyond the initial six weeks, the TFC a~~A~~gency p~~P~~rovider shall conduct a minimum of two home visits per month, (or more frequently as needed) with supporting documentation of each visit, including:

[9] Replacing with Contractors

i. Review of the TFC tTreatment pPlan with TFC fFamily pProvider,
ii. Review case files and required documentation, and
iii. Check medical records and medication logs.

d. Complete all AHCCCS required group biller requirements,
e. Conduct TFC fFamily pProvider recruitment to maintain and increase number of providers that can meet the needs of members placed in TFC services, and
f. Conduct ongoing training per state Licensing rule that develops the skills TFC fFamily pProviders to enable them to meet the needs of members.

4. The TFC aAgency pProvider shall:
   a. Have staff to operate resource teams to support the TFC fFamily pProvider as follows:
      i. Beginning at the level of the aAgency wWorker, extending to the cClinical sSupervisor,
      ii. Provide oversight by one or more independently licensed BHPs,
      iii. Work in concert, applying their specialized skills and knowledge for:
         1) Service planning,
         2) Training, and
         3) Support of direct service providers, as well as to the CFT.
      iv. Each member of the team shall have in-depth familiarity with the strengths and needs of the TFC fFamily pProvider, in order to be effective resources to them in the provision of:
         1) Care,
         2) Developing training plans, and
         3) Assisting in matching members to service environments.
   b. Have a documented agency crisis response policy. This shall include:
      i. Supervisor's availability and the use of crisis response provider to augment hours of availability,
      ii. The TFC aAgency pProvider fulfilling the role of first line support for TFC fFamily pProvider and member during times of crisis,
      iii. Access to a TFC aAgency pProvider and/or appropriate agency staff shall be on a 24/7 basis, and
      iv. Ensuring that escalation to appropriate TFC aAgency pProvider clinical leadership is available at all times.
   c. Coordinate the TFC tTreatment pPlan with the ISP and incorporate TFC fFamily pProvider participation in CFT meetings,
   d. Support the TFC fFamily pProvider(s) through clinical supervision available upon request and/or as TFC aAgency wWorker that identifies needs including but not limited to:
      i. Provide training and specific skill building to enhance family's ability to stabilize behaviors and intervene as challenges arise,
      ii. Facilitate respite,
      iii. Attend all CFT, cCourt, and professional meetings with or on behalf of the family, and
      iv. Contact between TFC fFamily pProvider and other cCaregiver(s) in preparation for discharge.
   e. Ensure documentation, aAssessments, and records are updated and available including but not limited to the member's:
      i. Current TFC tTreatment pPlan,
      ii. Current ISP,
      iii. Crisis pPlan,

iv. Discharge pPlan,
v. Social history information,
vi. Previous and current (within a year of referral date) behavioral health annual aAssessments, psychiatric evaluations, psychological evaluations,
vii. School and educational information,
viii. Medical information,
ix. Previous placement history and outcomes, and
x. Member and family strengths and needs, including skills, interests, talents, and other assists.

5. The TFC aAgency wWorker shall:
   a. Be qualified at minimum, at the level of Behavioral Health Technician (BHT) with a minimum of one year experience in a human services field,
   b. Be supervised by staff that possess a mMaster's degree in a behavioral health field, and licensed in the state of Arizona, with a minimum of two years' experience in a human services field,
   c. Be the primary agency representative at the CFT, who shall:
      i. Be present to review the ISP,
      ii. Document progress to those plans,
      iii. Support the CFT,
      iv. Support the TFC fFamily pProvider(s), and
      v. Participate in the CFT meetings.
   d. Lead the development of the TFC tTreatment pPlan with the TFC fFamily pProvider and obtain clinical supervisor review,
   e. Ensure TFC fFamily pProvider(s) complete full and accurate clinical documentation of interventions on the TFC tTreatment pPlan to demonstrate progress toward meeting treatment needs is captured to ensure full and accurate record of case progress,
   f. Ensure the TFC tTreatment pPlan be shared with the bBehavioral hHealth aAgency, other treating providers, and stakeholders as part of the member's ISP to assure care coordination,
   g. Monitor memberClient[10] lLoad (client member is identified as the TFC member placed in the TFC placement)
      i. The preferred maximum number of members that may be assigned to a single aAgency wWorker is 10, and
      ii. The client member load shall be adjusted downward if evaluation by the sSupervisor deems additional time is needed for one or more assigned families/members for oversight and support.
   h. Shall have contact with the TFC member and TFC fFamily pProvider minimum of once a week for the first six weeks of placement; these visits may occur in-person or via telemedicine (i.e. interactive audio/video communications),
   i. Shall have contact with the TFC member and TFC fFamily pProvider every other week or as needed for the remainder of the treatment, with one visit per month with the TFC member to assess physical, emotional, and behavioral health needs are being met; these visits may occur in-person or via telemedicine (i.e. interactive audio/video communications), and

[10] Revised to member throughout policy

j. Encourage coordination/collaboration/advocacy with the eEducational sSystem to support the TFC fFamily pProvider and member in meeting treatment and educational goals.

6. The TFC aAgency pProvider – sSupervisor Rrequirements:
   a. Clinical sSupervision requires bBehavioral pProfessional or higher with a graduate degree in a human services field, and be licensed with a minimum two years of experience:
      i. Clinical supervision of TFC aAgency staff that directly supports TFC fFamily pProviders shall be completed by a qualified clinical professional through regular direct clinical supervision. An agency may employ a shared supervision model where administrative supervision is conducted by a non-clinical professional.
   b. Administrative sSupervision requires a master's degree in a human service field and a minimum of two years of experience,
   c. Treatment planning for all TFC fFamily pProviders shall be overseen by a qualified clinical professional as specified below:
      i. The TFC aAgency pProvider shall define and document minimum frequency of TFC tTreatment pPlan reviews, which shall occur ~~no less than once per quarter~~at a minimum quarterly[11],
      ii. The clinical supervisor shall have direct contact with the TFC fFamily pProvider minimum once per month; these visits may occur in-person or via telemedicine (i.e. interactive audio/video communications), and
      iii. The clinical supervisor is part of the treatment team and as such shall be active in the case review and not solely an independent reviewing of the TFC tTreatment pPlan. The Supervisor shall participate in the CFT on an as needed basis depending on the progress of the TFC tTreatment pPlan.

7. The TFC fFamily pProvider shall:
   a. Have the following qualifications:
      i. Minimum one year of experience as an active licensed foster home working directly with members, or professional experience working directly with members that have behavioral health and/or developmental challenges,
      ii. Shall adhere to the AHCCCS requirements of registration and assure they meet the requirements as an AHCCCS registered provider, and
      iii. Complete all required trainings and evaluations in preparation to effectively and safely provide TFC services to members and their families, as well as ongoing training as identified/required by agencies in collaboration the CFT.
   b. TFC fFamily pProviders have the following responsibilities:
      i. Abide by all licensing regulations as outlined in current and relevant state and federal statutes for fFamily fFoster pParent lLicensing rRequirements, therapeutic level of licensure,
      ii. Provide basic parenting functions (e.g. food, clothing, shelter, educational support, meet medical needs, provide transportation, teach daily living skills, social skills, the development of community activities, and support cultural, spiritual/religious beliefs),

[11] Revised to align with above language

iii. Provide behavioral interventions (e.g. anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and behavioral intervention) that shall aid the member in making progress on TFC t~~T~~reatment p~~P~~lan goals,
iv. Provide a family environment that includes opportunities for:
    1) Familial and social interactions and activities,
    2) Use of behavioral interventions,
    3) Development of age appropriate living and self-sufficiency skills, and
    4) Integration into a family and community-based setting.
v. Meet the individualized needs of the member in their home as defined in the member's TFC t~~T~~reatment p~~P~~lan,
vi. Be available to care for the member 24 hours per day, seven days a week for the entire duration that the member is receiving out of home treatment services including times the member is with respite c~~C~~aregivers,
vii. Ensure that the member's needs are met when member is in respite care with other TFC f~~F~~amily p~~P~~roviders,
viii. Participate in planning processes such as CFTs, TFC discharge planning, Individualized Education Programs (IEPs),
ix. Keep documentation, per expectations of the TFC a~~A~~gency p~~P~~rovider including:
    1) Record behavioral health symptoms,
    2) Incident reports,
    3) Interventions utilized,
    4) Progress toward the TFC t~~T~~reatment p~~P~~lan goals, and
    5) Discharge plan.
x. Assist the member in maintaining contact with ~~his/her~~their family and natural supports,
xi. Assist in meeting the member's permanency planning or TFC discharge planning goals,
xii. Advocate for the member in order to achieve TFC Treatment Plan goals and to ensure timely access to educational, vocational, medical, or other indicated services,
xiii. Provide medication management is consistent with AHCCCS guidelines for members in out of home care,
xiv. Report allegations of misconduct toward members shall be managed according to all state and federal regulations,
xv. Maintain confidentiality according to statutory, HIPAA and AHCCCS requirements,
xvi. Any request to move a member from placement prior to successful completion of TFC t~~T~~reatment p~~P~~lan shall be made through the CFT and written notice shall be provided and following contractual time frames with the only exception being immediate jeopardy. TFC f~~F~~amily p~~P~~roviders shall follow the c~~C~~risis p~~P~~lan and work to preserve the placement to the best of their ability, including consultation with the CFT for consideration of additional in-home supports and services as appropriate, and necessary to support the member and family, and
xvii. TFC f~~F~~amily p~~P~~rovider(s) shall utilize the c~~C~~risis p~~P~~lan and accept a~~A~~gency w~~W~~orker and s~~S~~upervisor support, including the use of respite to maintain the placement until an emergency CFT is convened, services implemented, and the placement is preserved. In the event the TFC placement cannot be preserved, the TFC a~~A~~gency p~~P~~rovider shall support the member and TFC f~~F~~amily p~~P~~rovider(s) until a proper transition is identified.

B. CONTRACTOR REPORTING REQUIREMENTS

~~1. Contractors shall monitor and report TFC bed utilization as specified in ACOM Policy 415, Attachment G or as requested by AHCCCS.~~[12]

~~2.~~1. The Contractor~~s~~ shall report medical necessity criteria for admission, continued stay, and discharge for prior approval as specified in Contract.

[12] Deleted; reporting requirement is no longer applicable