

Winchester CPMT Agenda

June 10, 2014, 2pm

Frederick/Winchester Health Department
10 Baker Street
Winchester, VA 22601

Approve Minutes from 5/13/2014

Announcements

Financial Report

- a. Review of May 2014 Financials

Old Business

- a. Strategic Planning & Assignment of Work Committees
 1. Foundation & Structure (Blowe, Dopkowski, Gleason)
 2. Education, Training, & Expectations (Roussos, Kiser)
 3. Data-Driven Accountability & Service Provision (Scardino, Bober)
 4. CPMT Service Development (Kish, Devine)
- b. Eligibility Evaluation for Non-Medicaid Children
- c. Intensive Care Coordination Services
- d. CPMT Chair and Vice Chair Rotation
- e. Appointment of Parent Representative for FAPT
- f. Process for Approval of CSA Expenditures
- g. CSA Policy Revision and Forms
- h. National Center for Missing and Exploited Children—Mark Gleason

New Business

- a. Reimbursement of June Expenditures (attachment)

Motion to Convene in Executive Session

Motion to convene in Executive Session pursuant to 2.2- 3711 (A) (4) and (15), and in accordance with the provisions of 2.2 – 5210 of the Code of Virginia for proceedings to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the family assessment and planning team and whose case is being reviewed by the community policy and management team.

Motion to Come Out of Executive Session & Immediately Reconvene in Open Session

Motion to Certify Compliance by Roll Call Vote

Move that the members of the Winchester City CPMT certify that to the best of each member's knowledge, (1) only public business matters lawfully exempted from open meeting requirements, and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.

Motion to Approve All Cases

Motion to Adjourn

Next Meeting: July 8, 2014 at 2:00pm, at Frederick/Winchester Health Department, 10 Baker Street, Winchester VA 22601

May

Minutes

Minutes
 Winchester CPMT
 411 N. Cameron Street, 2nd Floor
 Tuesday, May 13, 2014
 2:00 p.m.

Motion:

- Motion to Approve All Cases

- Motion to adjourn CPMT Meeting

Action:

- 1st: Dr. Devine
 2nd: Mr. Roussos
-
- 1st: Mr. Roussos
 2nd: Ms. Kiser

Status:

- Approved
 Mr. Scardino
 abstained
 from 2 cases
 Approved
 Unanimously

Item	Discussion	Action
<p>Call to Order/Additions to the Agenda</p> <p>Approval of Minutes</p> <p>Announcements</p>	<p>The meeting was opened by Chair, Amber Dopkowski, at 2:03 pm.</p>	<p>Dr. Devine motioned to approve the minutes from April 15, 2014. Mr. Scardino seconded. Motion to approve the minutes as corrected passed unanimously.</p> <p>Ms. Karen Farrell was introduced and welcomed as the new CSA Coordinator.</p> <p>There will be a Trauma Informed Care Training on May 20 at the Hampton Inn in Winchester. This training is sponsored by Winchester Department of Social Services.</p>
<p>Financial Report</p>	<p>The Financial Report was distributed and included expenditures for April, 2014</p> <p>Report: April, 2014 Gross Expenditures: \$155,899.50 Expenditure Refunds: \$3,649.50 Net Expenditures: \$152,250.00 Local Dollars: \$70,739.79 Regular Medicaid Payments to Providers: \$61,762.42 Local Match: \$17,706.51</p>	<p>Ms. Dopkowski reviewed the report.</p> <p>The City of Winchester requested a CSA supplement from OCS in the amount of \$40,839.00.</p>

Minutes
 Winchester CPMT
 411 N. Cameron Street, 2nd Floor
 Tuesday, May 13, 2014
 2:00 p.m.

Item	Discussion	Action
	Wrap Dollars Funds Beginning Balance: \$23,424.00 Encumbered: \$210.00 Disbursed: \$11,695.00 Remaining Funds: \$11,519.00 Non-Mandated Funds Beginning Balance: \$20,162.00 Encumbered: \$7,045.00 Disbursed: \$11,658.60 Remaining Funds: \$1,458.40	
Old Business: a. Strategic Planning Report-Assignment of Work Committees	Four Strategic Target Areas were identified as follows: <ol style="list-style-type: none"> 1. CPMT Foundation and Structure (Dopkowski, Gleason, Blowe) 2. Common Ground through Education, Training and Shared Expectations (Roussos, Kiser) 3. Data-Driven Accountability and Service Provision (Scardino, Bober) 4. CPMT Services Development (Kish, Devine) 	<ol style="list-style-type: none"> 1. The subcommittee met twice. The subcommittee is comparing current policy to the OCS audit findings and areas identified at the recent CPMT strategic planning retreat. 2. No report. The subcommittee will schedule to meet soon. 3. The subcommittee met once; they are reviewing vendor contracts, and would like to meet with FAPT teams regarding structuring measurable goals. Another meeting of the subcommittee to be scheduled soon. 4. No report The subcommittee will schedule to meet soon.
b. Eligibility Determination for Non-Medicaid Children	Mr. Gleason, Mr. Scardino and Ms. Dopkowski met regarding this topic. Recommendation was made to develop a Request for Proposal for vendors interested in providing these determination services to Winchester locality.	Members were requested to explore the RFP process.
c. Intensive Care Coordination Services	Mr. Gleason, Mr. Scardino and Ms. Dopkowski to meet regarding this topic.	Additional training from the State is forthcoming in June, which may result in community providers available to provide ICC Services.

Minutes
 Winchester CPMT
 411 N. Cameron Street, 2nd Floor
 Tuesday, May 13, 2014
 2:00 p.m.

Item	Discussion	Action
d. Appointment of Parent Representative for FAPT	A possible parent representative for FAPT was identified during the Citizen's Insight Academy	Ms. Dopkowski and Mr. Gleason to meet with interested parent representative this week. CPMT Members welcomed to attend.
e. Consent Agenda	Consider approving funding for cases via a Consent Agenda	Discussed reviewing cases in advanced via encrypted email prior to CPMT meetings then only discussing cases of concern during executive session. Requesting a legal opinion regarding Freedom of Information Act and executive session requirements
New Business a. CSA Supplemental Allocation Request		The City of Winchester placed a supplemental request for funding in the amount of \$40,839 with OCS on April 24, 2014
b. CPMT Authorization of FAPT recommendations	Motion to approve policy statement allowing services recommended by FAPT to begin prior to CPMT monthly meetings so that vital services may start or continue without interruption.	Motion by Ms. Kiser, seconded by Ms. Kish. Approved unanimously.
c. CSA Policy Revision and Forms		Ms. Dopkowski to upload to Winchester CPMT website for CPMT review prior to June CPMT meeting.
d. CPMT Chair Rotation	A new chair is eligible for appointment at July CPMT meeting.	Based on previous rotation of chair position, the community services board representative is the next to fulfill the role of CPMT chair.
e. CPMT Meeting Location	It was noted that CPMT has outgrown the current meeting space. Alternate meeting locations were suggested.	Dr. Devine to confirm if the Health Department conference room is available for upcoming CPMT meetings.
f. Terms of Certain CPMT Appointments		CPMT Chair to notify City Manager that provider and "other" representative are due for review. Both are willing to continue to serve.
Motion to Convene in Executive Session	Motion to convene in Executive Session pursuant to 2.2-3711 (A) (4) and (15), and in accordance with the provisions of 2.2 – 5210 of the Code of Virginia for proceedings to consider the appropriate provision of	Ms. Dopkowski asked that the meeting move into Executive Session. On motion by Ms. Kiser, seconded by Mr. Scardino, the

Minutes
 Winchester CPMT
 411 N. Cameron Street, 2nd Floor
 Tuesday, May 13, 2014
 2:00 p.m.

Item	Discussion	Action
	services and funding for a particular child or family or both who have been referred to the family assessment and planning team and whose case is being reviewed by the community policy and management team.	meeting moved into Executive Session.
Motion to Come Out of Executive Session & Immediately Reconvene in Open Session		Motion to come out of Executive Session by Mr. Roussos and seconded by Dr. Devine. Approved unanimously.
Motion to Certify Compliance by Roll Call Vote	Move that the members of the Winchester CPMT certify that to the best of each member's knowledge, (1) only public business matters lawfully exempted from open meeting requirements, and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.	Motion to Certify Compliance by Roll Call Vote was made by Dr. Devine, seconded by Ms. Bober, and unanimously approved.
Motion to Approve All Cases	Motion to Approve all cases Mr. Scardino – abstained from 2 cases	All cases were approved on motion by Dr. Devine, seconded by Mr. Roussos. Motion was approved with noted abstentions.
Motion to Adjourn/Next Meeting Date	The next CPMT meeting will be held Tuesday June 10, 2014 at 2:00 p.m., Our Health Campus, 2 nd Floor Conference Room, 411 N. Cameron St., Winchester VA	The meeting was adjourned on motion by Mr. Roussos and seconded by Ms. Kiser at 2:58 p.m.

Attachments: April 2014 Financials
 May Agenda Attachments

Transcribed by CPG

April

Financials

CSA Pool Reimbursement Request Report Worksheet

Date: April 24, 2014

Period Ending: April, 2014

Chart A

Part 1 - Expenditure Description

	Number of Clients	Gross Total Expenditures	Expenditure Refunds	Net Total Expenditures
1. Congregate Care/Mandated & Non-Mandated Residential Services				
1a. Foster Care - IV-E Child in Licensed Residential Congregate Care	1	2,142.50	2,680.15	-537.65
1b. Foster Care - all other in Licensed Residential Congregate Care	1	40,562.83	1,048.39	39,514.44
1c. Residential Congregate Care - CSA Parental Agreements; DSS Non-Custodial		0.00		0.00
1d. Non-Mandated Services/Residential/Congregate Care		0.00		0.00
1e. Educational Services - Congregate Care	4	61,194.01		61,194.01
2. Other Mandated Services				
2a. Treatment Foster Care - IV-E	8	20,408.00	45.00	20,363.00
2a.1 Treatment Foster Care	2	9,027.76	741.00	8,286.76
2a.2 Treatment Foster Care - CSA Parental Agreements; DSS Non-Custodial		0.00		0.00
2b. Specialized Foster Care - IV-E; Community Based Services		0.00		0.00
2b.1 Specialized Foster Care		0.00		0.00
2c. Family Foster Care - IV-E; Community Based Services	7	1,617.00	58.00	1,559.00
2d. Family Foster Care Maintenance Only	2	1,332.00	1,447.11	-115.11
2e. Family Foster Care - Children Receiving Maintenance/Basic Activities; IL	3	1,923.53	293.00	1,630.53
2f. Community Based Services	6	10,857.87	-2,663.15	13,521.02
2f.1 Community Transition Services		0.00		0.00
2g. Special Education Private Day Placement	1	6,354.00		6,354.00
2h. Wrap-Around Services for Students With Disabilities		0.00		0.00
2i. Psychiatric Hospitals/Crisis Stabilization Units		0.00		0.00
3. Non-Mandated Services/Community Based	3	480.00		480.00
4. Grand Totals: Sum of categories 1 through 3	38	155,899.50	3,649.50	152,250.00

Part 2 - Expenditure Refund Description (reported in line 4)

Vendor Refunds and Payment Cancellations	
Parental Co-Payments	
Payments made on behalf of the child (SSA, SSI, VA benefits)	2,306.00
Child Support Collections through DCSE	1,343.50
Pool prior-reported expenditures re-claimed under IV-E	
Other (specify)	
Total Refunds (must agree with line 4)	3,649.50



Chart B

[CSA Statistics Home](#) > [CSA Pool Reporting](#)

**CSA Reports
Pool
Reimbursement
Reports
FY14
Transaction
History for
Winchester -
FIPS 840**

Active Pool Report Preparers
Nancy Valentine (540) 686-4838
Donna Veach (540) 686-4826
Amber Johnson (540) 686-4823
Karen Farrell (540) 686-4832

Pended Forms are not
on this report

Transaction History

Match Rate:	Status	Period End	Date Filed	Total Amount	State	Local
0.4587						
Beginning Balance				\$1,218,121.00	\$659,331.00	\$558,790.00

Pool Reimbursement History

<u>9</u>	07/31/2013	08/02/2013	\$166.42	\$493.75	(\$327.33)
<u>9</u>	08/31/2013	09/05/2013	\$70,156.19	\$40,942.14	\$29,214.05
<u>9</u>	09/30/2013	10/01/2013	\$76,193.02	\$44,898.67	\$31,294.35
<u>9</u>	10/31/2013	11/01/2013	\$76,052.90	\$47,385.06	\$28,667.84
<u>9</u>	11/30/2013	12/02/2013	\$109,379.65	\$62,089.91	\$47,289.74
<u>9</u>	12/31/2013	01/07/2014	\$103,368.41	\$57,125.30	\$46,243.11
<u>9</u>	01/31/2014	02/04/2014	\$108,602.83	\$59,713.28	\$48,889.55
<u>9</u>	02/28/2014	03/05/2014	\$115,147.77	\$63,686.43	\$51,461.34
<u>9</u>	03/31/2014	04/01/2014	\$66,667.82	\$38,763.54	\$27,904.28
<u>1</u>	04/30/2014	05/01/2014	\$152,250.00	\$81,510.21	\$70,739.79
Pool Reimbursement Expenditure Totals			\$877,985.01	\$496,608.29	\$381,376.72

Supplement History

		04/25/2014	\$40,839.00	\$49,346.00	(\$8,507.00)
Supplement Totals			\$40,839.00	\$49,346.00	(\$8,507.00)

CSA System Balance \$380,974.99 \$212,068.71 \$168,906.28

Transaction History without WRAP Dollars

Match Rate: 0.4587	Status Period End	Date Filed	Total Amount	State	Local
Beginning Balance			\$1,194,697.00	\$646,652.00	\$548,045.00

Pool Reimbursement History

-	07/31/2013	08/02/2013	\$166.42	\$493.75	(\$327.33)
-	08/31/2013	09/05/2013	\$64,626.19	\$37,948.75	\$26,677.44
-	09/30/2013	10/01/2013	\$74,333.02	\$43,891.85	\$30,441.17
-	10/31/2013	11/01/2013	\$75,432.90	\$47,049.45	\$28,383.45
-	11/30/2013	12/02/2013	\$107,904.65	\$61,291.49	\$46,613.16
-	12/31/2013	01/07/2014	\$102,858.41	\$56,849.24	\$46,009.17
-	01/31/2014	02/04/2014	\$108,302.83	\$59,550.89	\$48,751.94
-	02/28/2014	03/05/2014	\$115,147.77	\$63,686.43	\$51,461.34
-	03/31/2014	04/01/2014	\$65,267.82	\$38,005.72	\$27,262.10
-	04/30/2014	05/01/2014	\$152,250.00	\$81,510.21	\$70,739.79
Pool Reimbursement Expenditure Totals			\$866,290.01	\$490,277.78	\$376,012.23

Supplement History

		04/25/2014	\$40,839.00	\$49,346.00	(\$8,507.00)
Supplement Totals			\$40,839.00	\$49,346.00	(\$8,507.00)

CSA System Balance (Non-WRAP):

\$369,245.99	\$205,720.22	\$163,525.77
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Transaction History WRAP dollars only

Match Rate: 0.4587	Status Period End	Date Filed	Total Amount	State	Local
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WRAP Allocation Additions History

		08/01/2013	\$19,138.00	\$10,358.00	\$8,779.00
		10/25/2013	\$4,286.00	\$2,319.00	\$1,966.00
WRAP Allocation Additions Totals			\$23,424.00	\$12,677.00	\$10,745.00

Pool Reimbursement History - WRAP only

-	07/31/2013	08/02/2013	\$0.00	\$0.00	\$0.00
-	08/31/2013	09/05/2013	\$5,530.00	\$2,993.39	\$2,536.61
-	09/30/2013	10/01/2013	\$1,860.00	\$1,006.82	\$853.18

-	10/31/2013	11/01/2013	\$620.00	\$335.61	\$284.39
-	11/30/2013	12/02/2013	\$1,475.00	\$798.42	\$676.58
-	12/31/2013	01/07/2014	\$510.00	\$276.06	\$233.94
-	01/31/2014	02/04/2014	\$300.00	\$162.39	\$137.61
-	02/28/2014	03/05/2014	\$0.00	\$0.00	\$0.00
-	03/31/2014	04/01/2014	\$1,400.00	\$757.82	\$642.18
-	04/30/2014	05/01/2014	\$0.00	\$0.00	\$0.00
Pool Reimbursement Expenditure Totals -WRAP only			\$11,695.00	\$6,330.51	\$5,364.49
CSA System Balance (WRAP only):			\$11,729.00	\$6,348.70	\$5,380.30

Wrap-Around Services for Students with Disabilities

2013 - 2014

Chart C

Child	7	2	9	11	13	12	6	TOTAL SPENT
Agency Worker	WPS-NREP Clatter	WPS-NREP Clatter	WPS-NREP Clatter	WPS Kish	WPS Kish	WPS-NREP Clatter	NWCBSB Hines	
JUL								0.00
AUG	1,620.00	260.00	480.00	40.00	400.00	2,490.00	240.00	5,530.00
SEP	1,260.00		600.00					1,860.00
OCT			180.00				440.00	620.00
NOV	1,140.00			80.00	255.00			1,475.00
DEC		130.00		40.00	340.00			510.00
JAN		130.00			170.00			300.00
FEB								0.00
MAR				100.00				1,400.00
APR						1,300.00		0.00
MAY								0.00
JUN								0.00
TOTAL/								
CHILD	4,020.00	520.00	1,260.00	260.00	1,165.00	3,790.00	680.00	11,695.00
				Beginning Balance				23,424.00
				Disbursed				11,695.00
				Encumbered				210.00
				Remaining Funds				11,519.00

Chart E

Nine Year Comparison Chart

	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013 - 2014
July	6,498.08	295.28	4,911.51	10,266.93	9,458.29	5,069.89	3,038.21	3,166.90	166.42
August	157,319.26	301,614.45	229,488.55	191,849.47	145,415.77	113,164.41	145,670.33	92,757.41	70,156.19
September	151,160.78	221,315.88	162,491.89	219,001.82	128,872.42	140,623.38	126,252.80	146,176.67	76,193.02
October	93,777.46	278,714.69	272,889.23	186,159.65	159,100.81	125,383.16	113,566.55	132,011.04	76,052.90
November	238,833.64	220,279.28	218,628.54	199,049.04	117,450.86	161,810.81	117,093.83	112,159.19	109,379.65
December	178,871.60	224,376.62	220,635.60	159,066.88	111,673.88	107,885.14	101,861.19	116,376.55	103,368.41
January	180,029.22	221,742.92	224,949.12	128,052.33	130,627.75	142,931.48	151,908.54	163,869.33	108,602.83
February	194,620.61	207,392.25	113,213.17	127,964.87	83,063.75	133,838.60	121,575.88	107,440.05	115,147.77
March	149,559.13	170,101.10	264,666.84	168,271.90	119,700.47	144,940.45	117,899.40	120,489.59	66,667.82
April	229,081.25	227,323.93	236,615.22	142,434.91	136,286.49	160,351.57	101,993.55	108,460.48	152,250.00
May	267,902.81	216,049.75	224,636.22	126,503.97	128,319.69	173,228.70	121,909.56	127,950.48	
June	374,199.30	228,889.80	246,399.13	175,922.47	132,160.41	111,218.28	126,270.80	87,566.12	
June (2)		279,563.29	202,903.78	155,089.52	143,870.07	212,852.44	155,010.08	136,161.26	
		9,753.59							
Medicaid Pay	2,208,856.98	2,807,412.83	2,622,428.80	1,989,633.76	1,546,000.66	1,733,298.31	1,504,050.72	1,454,585.07	877,985.01
TOTAL	704,460.84	742,443.68	788,982.19	553,523.98	542,278.28	445,437.88	26,551.56	202,738.74	61,762.42
	2,913,317.82	3,549,856.51	3,411,410.99	2,543,157.74	2,088,278.94	2,178,736.19	1,530,602.28	1,657,323.81	939,747.43
Med. Loc. Match	161,568.09	170,279.46	180,953.07	110,657.07	95,542.20	82,464.82	7,612.00	58,122.66	17,706.51
CSA Local Share	1,013,202.68	1,287,760.27	1,202,908.08	826,992.80	616,075.51	716,796.97	642,150.99	633,091.05	381,376.72
# Children Served	103	96	95	105	114	116	97	75	84
							(unduplicated youth served YTD)	(unduplicated youth served YTD)	

May

Agenda

Attachments

Johnson, Amber (VDSS)

From: Reiner, Scott (CSA)
Sent: Tuesday, April 15, 2014 4:31 PM
To: Reiner, Scott (CSA)
Subject: Update on Intensive Care Coordination and High Fidelity Wraparound
Attachments: Verification of Intensive Care Coordination in the CSA Data Systems.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Good afternoon CPMT Chairs,

I am writing to bring you up to date with regard to activities of the Wraparound Center of Excellence here at the Office of Comprehensive Services. While we are aware that communication regarding the Wraparound Center of Excellence activities has not been consistent, we are invested in providing more regular communication moving forward. The Office of Comprehensive Services remains committed to the delivery of Intensive Care Coordination and the Wraparound model and is engaged in several activities that you will want to be aware of:

- At the Office of Comprehensive Services, Anna Antell and I have assumed responsibility for the management and coordination of all Center of Excellence related activities.
- I am pleased to announce that we have entered into an agreement with the Youth and Family Training Institute (YFTI) to be our training and technical assistance partner for High Fidelity Wraparound. YFTI (an affiliate of the University of Pittsburgh) has been the lead provider in Pennsylvania's effort to implement the Wraparound model in their localities. Their staff is highly experienced and they are customizing their approach for us as we are committed to providing training and consultation services that are reflective and respectful of how Virginia's system of care is configured. You can learn more about YFTI at their website at <http://www.yftipa.org>. In conjunction with YFTI, the following activities are planned or in process of planning:
 - There will be three Wraparound Facilitator training events that will occur in May and June with over 150 public (CSB) and private providers signed up to participate (these trainings are currently full). These trainings will meet the initial July 1, 2014 deadline for Wraparound training for ICC facilitators established by the State Executive Council. These trainings are three days in length and an additional two days will be offered in the Fall of 2014 to complete the training requirement for providers. Additional training opportunities will be available in the Fall.
 - We are introducing a two-day training event for Supervisors of ICC/Wraparound beginning in Northern Virginia in June and continuing at regional locations in the Fall, as well as a more advanced Wraparound Coaches program. Please keep an eye out for further details about the supervisor training and related provider requirements.
 - Training for Family Support Partners, Youth Support Partners, and Booster/Advanced Training sessions for Wraparound Facilitators who have completed the initial Wraparound Facilitator training are also being planned. This includes the over 125 providers who were trained last year.
- We are beginning to develop a plan to gather information on the status of ICC and Wraparound and the impact of training on practice. As part of those efforts, we are requesting your attention to two matters:
 - Attached to this e-mail is information about how ICC is being captured through the CSA data set and asking your attention to ensuring that your locality's ICC activities are being accurately reported. **Please review this memo and your local data with your CSA Coordinator.**
 - We have developed a brief survey for CSA Coordinators and CPMT Chairs that can be found at: <https://www.surveymonkey.com/s/V2KWSDJ>. It would be highly appreciated if you would take a few

minutes to complete this survey (which is totally anonymous) in order to provide your feedback as we refocus our efforts.

We are excited to be reinvigorating our activities at the Wraparound Center of Excellence. You can expect more regular communications from us and we hope to be receiving your input, suggestions and questions. Please do not hesitate to contact Anna or I should you have any questions or suggestions as we move forward.

Scott

Scott Reiner, Assistant Director
Office of Comprehensive Services
804-662-9082
scott.reiner@csa.virginia.gov
www.csa.virginia.gov

TO: CSA Coordinators
FROM: Scott Reiner, Assistant Director
Office of Comprehensive Services
DATE: April 16, 2014
RE: Verification of Intensive Care Coordination in the CSA Data Systems

As you are aware, CSA has focused considerable recent attention and resources on the provision of quality intensive care coordination (ICC) services. These efforts include the issuance of new policy by the State Executive Council and extensive training activities on High Fidelity Wraparound through the Center of Excellence at the Office of Comprehensive Services.

While evaluation of these efforts is in its very early stages, understanding utilization patterns for ICC is an essential starting point. To that end, one of the indicators reported by the Office of Comprehensive Services on its Performance Dashboard relates to the utilization of Intensive Care Coordination (ICC). Specifically, the indicator represents the number of children reported as receiving ICC in the reporting period as a percentage of the number of children reported as receiving residential services. The data from the most recent reporting period (10/1/13 – 12/31/13) is attached for your review. The large majority of localities are showing zero (0) ICC cases. In order for a case to count as ICC, the Service Program Type – SPT 3 (Intensive Care Coordination) must be entered in the Data Set. If that SPT is not used, ICC will not be reported. Based on our knowledge of the activities going on in many localities, it appears likely that ICC is not being properly reported in many instances.

As you can easily surmise, if the service is not correctly reported, any conclusions that may be drawn from the data will be incorrect. I am asking that you review the data from your locality. If you have not been correctly entering the SPT 3 code for ICC, please begin to do so immediately. As the dashboard is created on a quarterly basis, it may take several months for improved reporting practices to be seen and it is therefore critical that the service be reported accurately as soon as possible. Please contact me if you have questions about the data as reported in the dashboard.

Thank you for your cooperation in our shared efforts to accurately report on and evaluate the services provided through CSA. This allows us to better understand service utilization and effectiveness with the goal of improved outcomes for children, families and communities.

Agency Performance Dashboard
October - December 2013

Percent of youth receiving Intensive Care Coordination against all youth placed in residential settings

FIPS	Locality	# ICC	# Resid.	%	FIPS	Locality	# ICC	# Resid.	%
3	Albemarle	14	36	38.89%	99	King George	0	18	0%
510	Alexandria	0	7	0%	101	King William	0	7	0%
5	Alleghany	0	11	0%	103	Lancaster	0	7	0%
7	Amelia	0	0	0%	105	Lee	0	2	0%
9	Amherst	4	17	23.53%	678	Lexington	0	3	0%
11	Appomattox	5	6	83.33%	107	Loudoun	0	17	0%
13	Arlington	5	32	15.63%	109	Louisa	5	11	45.45%
15	Augusta	10	15	66.67%	111	Lunenburg	0	6	0%
17	Bath	0	0	0%	680	Lynchburg	1	26	3.85%
515	Bedford City	0	0	0%	113	Madison	0	14	0%
19	Bedford County	0	8	0%	683	Manassas City	0	9	0%
21	Bland	0	3	0%	685	Manassas Park	0	2	0%
23	Botetourt	0	7	0%	690	Martinsville	0	0	0%
520	Bristol	1	24	4.17%	115	Mathews	0	1	0%
25	Brunswick	0	2	0%	117	Mechlenburg	0	15	0%
27	Buchanan	0	20	0%	119	Middlesex	0	1	0%

121	Montgomery	0	5	0%
125	Nelson	0	6	0%
127	New Kent	0	4	0%
700	Newport News	6	5	100.00%
710	Norfolk	0	33	0%
131	Northampton	0	0	0%
132	Northumberland	0	0	0%
720	Norton	0	1	0%
135	Nottoway	0	14	0%
137	Orange	0	12	0%
139	Page	0	6	0%
141	Patrick	0	0	0%
730	Petersburg	1	22	0%
143	Pittsylvania	2	14	14.29%
735	Putnam	0	1	0%
740	Portsmouth	6	7	85.71%
145	Powhatan	0	11	0%
147	Prince Edward	0	7	0%
149	Prince George	0	2	0%
153	Prince William	0	63	0%

29	Buckingham	0	8	0%
530	Buena Vista	0	7	0%
31	Campbell	0	13	0%
33	Caroline	1	14	7.14%
35	Carroll	0	10	0%
36	Charles City	0	5	0%
37	Charlotte	0	5	0%
540	Charlottesville	4	32	12.50%
550	Chesapeake	7	7	100.00%
41	Chesterfield	0	20	0%
43	Clarke	0	4	0%
570	Colonial Heights	0	0	0%
580	Covington	0	7	0%
45	Craig	1	1	100.00%
47	Culpeper	0	25	0%
49	Cumberland	0	4	0%
590	Danville	0	15	0%
51	Dickenson	0	6	0%
53	Dinwiddie	4	11	36.36%
57	Essex	0	8	0%

155	Pulaski	0	20	0%
750	Radford	0	10	0%
157	Rappahannock	0	10	0%
760	Richmond City	9	50	18.00%
159	Richmond County	0	2	0%
770	Roanoke City	13	28	46.43%
161	Roanoke County	0	15	0%
163	Rockbridge	0	13	0%
165	Rockingham	0	31	0%
167	Russell	0	9	0%
775	Salem	0	6	0%
169	Scott	0	1	0%
171	Shenandoah	0	16	0%
173	Smyth	0	6	0%
175	Southampton	0	3	0%
177	Spotsylvania	17	61	27.87%
179	Stafford	0	28	0%
790	Staunton	5	9	55.56%
800	Suffolk	0	8	0%
181	Surry	0	2	0%

1300	Fairfax/Falls Church	62	107	57.94%
61	Fauquier	0	18	0%
63	Floyd	0	7	0%
65	Frivanna	0	17	0%
620	Franklin City	0	3	0%
67	Franklin County	29	28	100.00%
69	Frederick	0	10	0%
630	Fredericksburg	0	3	0%
640	Galax	0	3	0%
71	Giles	0	4	0%
73	Gloucester	0	6	0%
75	Goochland	0	2	0%
77	Grayson	0	7	0%
79	Greene	0	6	0%
1200	Greensville/Emporia	0	4	0%
83	Halifax	0	11	0%
650	Hampton	2	36	5.56%
85	Hanover	1	13	30.77%
660	Harrisonburg	0	24	0%
87	Henrico	0	27	0%

89	Henry	0	5	0%
91	Highland	0	0	0%
670	Hopewell	0	8	0%
93	Isle of Wight	0	3	0%
95	James City	5	4	0%
97	King & Queen	0	2	0%

183	Sussex	0	1	0%
185	Tazewell	0	5	0%
810	Virginia Beach	0	60	0%
187	Warren	7	8	87.50%
191	Washington	5	20	25.00%
820	Waynesboro	5	9	55.56%
193	Westmoreland	6	8	0%
840	Williamsburg	0	1	0%
840	Winchester	0	8	0%
195	Wise	0	12	0%
197	Wythe	0	11	0%
199	York	3	7	42.86%

CSA REPORTING—SUPPLEMENTAL ALLOCATION REQUEST—FY14

CSA SUPPLEMENTAL ALLOCATION REQUEST FORM—FY14

DATE	April 24, 2014
FIPS/LOCALITY	# 840 - Winchester Base Rate: 0.4587
CONTACT PERSON	Donna Veach
TELEPHONE	540 686-4826
E-MAIL ADDRESS	donna.veach@dss.virginia.gov
REPORT #	1

We certify that the information provided in this request for a supplemental allocation is accurate, and that the costs within the request were unanticipated and are required costs for specific mandated children pursuant to Section 2.2-5211.C of the Comprehensive Services Act. All cases have been assessed, where required, by the Family Assessment and Planning Team and comply with the provisions of the Code of Virginia, the CSA Manual, and the Appropriations Act.

THIS REQUEST IS FOR FISCAL YEAR FY14					
		Case Count (a)	Actual FY14 Expenditures (b)	Projected Additional FY14 Expenditures (c)	Total Actual+Projected FY14 Expenditures (b + c = d)
1. MANDATED SERVICES / RESIDENTIAL					
1a.	Foster Care - IV-E children in Licensed Residential Congregate Care ; pool expenditures for costs not covered by IV-E (i.e., non room-and-board)	2	30,083.00	13,650.00	43,733.00
1b.	Foster Care - all others in Licensed Residential Congregate Care	2	47,796.00	20,449.00	68,245.00
1c.	Residential Congregate Care – CSA Parental Agreements ; DSS Noncustodial Agreements	0	0.00	0.00	0.00
1e.	Educational Services - Congregate Care	8	323,072.00	144,494.00	467,566.00
i.	MANDATED SERVICES / RESIDENTIAL SUBTOTAL (Sum of lines 1a. through 1c. and 1e.)	12	400,951.00	178,593.00	579,544.00
2. OTHER MANDATED SERVICES					
2a.	Treatment Foster Care – IV-E	9	153,311.00	66,878.00	220,189.00
2a.1	Treatment Foster Care	7	208,536.00	15,459.00	221,995.00
2a.2	Treatment Foster Care – CSA Parental Agreements ; DSS Noncustodial Agreements	0	0.00	0.00	0.00
2b.	Specialized Foster Care – IV-E ; Community Based Services	0	0.00	0.00	0.00
2b.1	Specialized Foster Care	0	0.00	0.00	0.00
2c.	Family Foster Care – IV-E ; Community Based Services	13	13,930.00	22,824.00	36,754.00
2d.	Family Foster Care Maintenance only	4	12,710.00	2,664.00	15,374.00
2e.	Family Foster Care – Children receiving maintenance and basic activities payments; independent living Stipend/Arrangements	5	31,749.00	7,630.00	39,379.00
2f.	Community - Based Services	44	82,215.00	55,842.00	138,057.00
2f.1	Community Transition Services – Direct Family Services to Transition from Residential to Community	0	0.00	0.00	0.00
2g.	Special Education Private Day Placement	3	27,214.00	26,791.00	54,005.00
2h.	Wrap-Around Services for Students With Disabilities	0	0.00	0.00	0.00
2i.	Psychiatric Hospitals/Crisis Stabilization Units	0	0.00	0.00	0.00
ii.	SUBTOTAL (Sum of lines 1+2a+2a1+2a2+2b+2b1+2c+2d+2e+2f+2f1+2g+2h+2i)	97	928,616.00	376,681.00	1,305,297.00
iii.	Less Projected Refunds for the Fiscal Year:				69,781.00
iv.	Net Estimated Mandated Expenditures for the Fiscal Year: Line ii.-Line iii.				1,235,536.00

Comments:
 This request is due to the decrease in CSA funding allocation for FY2014. This supplemental request aligns the CSA budget with historical spending trends. Increased costs related to residential placements have necessitated this request.
 Effective with fiscal year 2008 supplemental requests, any locality whose Estimated mandated spending in fiscal year 2014 will exceed

their fiscal year 2013 actual expenses by more than 10% is required to include a statement in the comment portion of the supplement indicating the reason(s) for the increase.

CSA SUPPLEMENTAL ALLOCATION REQUEST FORM—FY14

DATE	April 24, 2014
FIPS/LOCALITY	# 840 - Winchester Base Rate: 0.4587
CONTACT PERSON	Donna Veach
TELEPHONE	540 686-4826
E-MAIL ADDRESS	donna.veach@dss.virginia.gov
REPORT #	1

We certify that the information provided in this request for a supplemental allocation is accurate, and that the costs within the request were unanticipated and are required costs for specific mandated children pursuant to Section 2.2-5211.C of the Comprehensive Services Act. All cases have been assessed, where required, by the Family Assessment and Planning Team and comply with the provisions of the Code of Virginia, the CSA Manual, and the Appropriations Act.

THIS REQUEST IS FOR FISCAL YEAR FY14					
		Rate	Local Share	State Share	Totals
A.	Current Total Pool Allocation: Total dollar amount of pool funds allocated for FY14 which includes initial-allocation and any approved supplemental allocations. This includes mandated and non-mandated pool funds available. Initial Allocation : 1,194,697.00 Supplements Added : 0.00	-	548,007.51	646,689.49	1,194,697.00
B.	Current Non-Mandated Protected Amount: Total dollar amount of current non-mandated protected funds for FY14.	0.4587	0.00	0.00	0.00
C.	Projected Non-Mandated Costs for FY14: Amount of Actual plus Projected Non-Mandated expenditures for FY14. (RESIDENTIAL/CONGREGATE CARE) See Pool Fund Expenditures Report - Row 1D.	0.5734	0.00	0.00	0.00
C1.	Projected Non-Mandated Costs for FY14: Amount of Actual plus Projected Non-Mandated expenditures for FY14. (COMMUNITY BASED) See Pool Fund Expenditures Report - Row 3	0.2294	0.00	0.00	0.00
D.	Unused Non-Mandated Protected Funds Available: (Line B - Line C-Line C1)	-	0.00	0.00	0.00
E.	Mandated Funds Available: This number represents the existing allocated funds available for the mandated population. (Line A - Line B + Line D)	-	548,007.51	646,689.49	1,194,697.00
F.	Net Projected Mandated Expenditures Needed for the Fiscal Year: This number should be the actual mandated total dollar amount that your locality projects that it will need to pay for actual mandated expenses incurred through the end of June 30, 2014. (From Line IV)	-	-	-	1,235,536.00
G.	Congregate Care (Sum of lines 1a+1b+1c)	0.5734	64,208.19	47,769.81	111,978.00
H.	Other mandated - neutral rate (Sum of lines 1e+2a+2a1+2a2+2b+2b1+2d+2e+2g+2h+2i)	0.4587	467,189.62	551,318.38	1,018,508.00
I.	Other mandated - 50% less (Sum of lines 2c+2f+2f1)	0.2294	40,101.64	134,709.36	174,811.00
J.	Total Estimated FY14 Expenditures (Sum of lines G. through I.)	-	571,499.45	733,797.55	1,305,297.00
K.	Less Projected Refunds for the Fiscal Year	0.4587	31,999.37	37,761.63	69,761.00
L.	Supplemental Allocation Funds Requested (Additional Mandated Funds Needed): (Line J- Line K-Line A+Line C+Line C1)	-	-8,507.43	49,346.43	40,839.00

IMPORTANT!

All signatures indicated on the cover page are required. Documentation must be submitted demonstrating that the supplemental allocation being requested is only for mandated (or "sum sufficient") children, and that reasonable projections have been made to estimate the amount of funds needed.

May

Financials

CSA Pool Reimbursement Request Report Worksheet

Date: May 27, 2014

Period Ending: May 30, 2014

Chart A

Part 1 - Expenditure Description

Part 1 - Expenditure Description	Number of Clients	Gross Total Expenditures	Expenditure Refunds	Net Total Expenditures
1. Congregate Care/Mandated & Non-Mandated Residential Services				
1a. Foster Care - IV-E Child in Licensed Residential Congregate Care	1	1,417.50		1,417.50
1b. Foster Care - all other in Licensed Residential Congregate Care		0.00	217.96	-217.96
1c. Residential Congregate Care - CSA Parental Agreements; DSS Non-Custodial		0.00		0.00
1d. Non-Mandated Services/Residential/Congregate Care		0.00		0.00
1e. Educational Services - Congregate Care	3	26,815.18		26,815.18
2. Other Mandated Services				
2a. Treatment Foster Care - IV-E	9	21,148.24	60.00	21,088.24
2a.1 Treatment Foster Care	1	5,116.00	51,314.61	-46,198.61
2a.2 Treatment Foster Care - CSA Parental Agreements; DSS Non-Custodial		0.00		0.00
2b. Specialized Foster Care - IV-E; Community Based Services		0.00		0.00
2b.1 Specialized Foster Care		0.00		0.00
2c. Family Foster Care - IV-E; Community Based Services	6	568.00	300.00	268.00
2d. Family Foster Care Maintenance Only	2	1,332.00	1,449.15	-117.15
2e. Family Foster Care - Children Receiving Maintenance/Basic Activities; IL	3	3,803.66	267.00	3,536.66
2f. Community Based Services	9	14,658.54	759.00	13,899.54
2f.1 Community Transition Services		0.00		0.00
2g. Special Education Private Day Placement	2	9,651.23		9,651.23
2h. Wrap-Around Services for Students With Disabilities		0.00		0.00
2i. Psychiatric Hospitals/Crisis Stabilization Units		0.00		0.00
3. Non-Mandated Services/Community Based	2	510.00		510.00
4. Grand Totals: Sum of categories 1 through 3	38	85,020.35	54,367.72	30,652.63

Part 2 - Expenditure Refund Description (reported in line 4)

Vendor Refunds and Payment Cancellations	300.00
Parental Co-Payments	
Payments made on behalf of the child (SSA, SSI, VA benefits)	1,565.00
Child Support Collections through DCSE	504.11
Pool prior-reported expenditures re-claimed under IV-E	51,314.61
Other (Reclass to IL)	684.00
Total Refunds (must agree with line 4)	54,367.72

Chart B

Active Pool Report Preparers
 Nancy Valentine (540) 686-4838
 Donna Veach (540) 686-4826
 Amber Johnson (540) 686-4823
 Karen Farrell (540) 686-4832

CSA Reports
 Pool Reimbursement Reports
 FY14 Transaction History for Winchester - FIPS 840
 Pended Forms are not on this report

Transaction History

Match Rate: 0.4587
 Status Period End Date Filed Total Amount
 State Local

Beginning Balance \$1,218,121.00 \$659,331.00 \$558,790.00

Pool Reimbursement History

Date	Period	End	Filed	Total	Amount
07/31/2013	08/02/2013			\$166.42	\$493.75 (\$327.33)
08/31/2013	09/05/2013			\$70,156.19	\$40,942.14 \$29,214.05
09/30/2013	10/01/2013			\$76,193.02	\$44,898.67 \$31,294.35
10/31/2013	11/01/2013			\$76,052.90	\$47,385.06 \$28,667.84
11/30/2013	12/02/2013			\$109,379.65	\$62,089.91 \$47,289.74
12/31/2013	01/07/2014			\$103,368.41	\$57,125.30 \$46,243.11
01/31/2014	02/04/2014			\$108,602.83	\$59,713.28 \$48,889.55
02/28/2014	03/05/2014			\$115,147.77	\$63,686.43 \$51,461.34
03/31/2014	04/01/2014			\$66,667.82	\$38,763.54 \$27,904.28
04/30/2014	05/01/2014			\$152,250.00	\$81,510.21 \$70,739.79
05/31/2014	06/02/2014			\$30,652.63	\$19,820.25 \$10,832.38
Expenditure Totals					
				\$908,637.64	\$516,428.54 \$392,209.10

Supplement History
 04/25/2014 \$40,839.00 \$49,346.00 (\$8,507.00)
 Supplement Totals \$40,839.00 \$49,346.00 (\$8,507.00)

CSA System Balance \$350,322.36 \$192,248.46 \$158,073.90

Transaction History without WRAP Dollars

Match Rate:	Status Period End	Date Filed	Total Amount	State	Local
0.4587			\$1,194,697.00		
Beginning Balance					
			\$646,652.00	\$548,045.00	

Pool Reimbursement History

	Status Period End	Date Filed	Total Amount	State	Local
-	07/31/2013	08/02/2013	\$166.42	\$493.75	(\$327.33)
-	08/31/2013	09/05/2013	\$64,626.19	\$37,948.75	\$26,677.44
-	09/30/2013	10/01/2013	\$74,333.02	\$43,891.85	\$30,441.17
-	10/31/2013	11/01/2013	\$75,432.90	\$47,049.45	\$28,383.45
-	11/30/2013	12/02/2013	\$107,904.65	\$61,291.49	\$46,613.16
-	12/31/2013	01/07/2014	\$102,858.41	\$56,849.24	\$46,009.17
-	01/31/2014	02/04/2014	\$108,302.83	\$59,550.89	\$48,751.94
-	02/28/2014	03/05/2014	\$115,147.77	\$63,686.43	\$51,461.34
-	03/31/2014	04/01/2014	\$65,267.82	\$38,005.72	\$27,262.10
-	04/30/2014	05/01/2014	\$152,250.00	\$81,510.21	\$70,739.79
-	05/31/2014	06/02/2014	\$30,652.63	\$19,820.25	\$10,832.38
Pool Reimbursement Expenditure Totals					
			\$896,942.64	\$510,098.03	\$386,844.61

Supplement History

	Status Period End	Date Filed	Total Amount	State	Local
	04/25/2014		\$40,839.00	\$49,346.00	(\$8,507.00)
Supplement Totals					
			\$40,839.00	\$49,346.00	(\$8,507.00)

CSA System Balance (Non-WRAP):

\$338,593.36 \$185,899.97 \$152,693.39

Transaction History WRAP dollars only

Match Rate:	Status Period End	Date Filed	Total Amount	State	Local
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WRAP Allocation Additions History

08/01/2013	\$19,138.00	\$10,358.00	\$8,779.00
10/25/2013	\$4,286.00	\$2,319.00	\$1,966.00

WRAP Allocation Additions Totals

\$23,424.00 \$12,677.00 \$10,745.00

Pool Reimbursement History - WRAP only

-	07/31/2013	08/02/2013	\$0.00	\$0.00	\$0.00
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Wrap-Around Services for Students with Disabilities
2013 - 2014

Chart C

Child	7	2	9	11	13	12	6	TOTAL SPENT
Agency Worker	WPS-NREP Clatter	WPS-NREP Clatter	WPS-NREP Clatter	WPS Kish	WPS Kish	WPS-NREP Clatter	NWCSB Hines	
JUL								0.00
AUG	1,620.00	260.00	480.00	40.00	400.00	2,490.00	240.00	5,530.00
SEP	1,260.00		600.00					1,860.00
OCT			180.00				440.00	620.00
NOV	1,140.00			80.00	255.00			1,475.00
DEC		130.00		40.00	340.00			510.00
JAN		130.00			170.00			300.00
FEB								0.00
MAR				100.00		1,300.00		1,400.00
APR								0.00
MAY								0.00
JUN								0.00
TOTAL/CHILD	4,020.00	520.00	1,260.00	260.00	1,165.00	3,790.00	680.00	11,695.00
				Beginning Balance				23,424.00
				Disbursed				11,695.00
				Encumbered				210.00
				Remaining Funds				11,519.00

June Agenda Attachments

CSA Forms

City of Winchester CSA Required Checklist

Child's Name:

FAPT/FTM/IDT (*circle one*)

Date of Meeting:

Items	Required	Yes	No	Comments
Winchester CSA Referral Form	Yes	<input type="checkbox"/>	<input type="checkbox"/>	
Eligibility Determination Form(s)	Initial Referral	<input type="checkbox"/>	<input type="checkbox"/>	
FTM Report (<i>FTM only</i>)	FTM only	<input type="checkbox"/>	<input type="checkbox"/>	
FTM Signature Sheet (<i>FTM's only</i>)	FTM only	<input type="checkbox"/>	<input type="checkbox"/>	
Service/Care Plan	Yes	<input type="checkbox"/>	<input type="checkbox"/>	
FAPT/FTM Budget Request Form Include all services/funding sources	Yes	<input type="checkbox"/>	<input type="checkbox"/>	
Progress Report from Service Provider (<i>must be current</i>)	At Review	<input type="checkbox"/>	<input type="checkbox"/>	
CANS	Yes	<input type="checkbox"/>	<input type="checkbox"/>	
Consent to Exchange Information	Yes	<input type="checkbox"/>	<input type="checkbox"/>	
Parental Co-Pay Screening Form & Agreement	Initial Referral	<input type="checkbox"/>	<input type="checkbox"/>	
CSA Brochure (<i>signed</i>)	Initial Referral	<input type="checkbox"/>	<input type="checkbox"/>	
As Needed:				
CSA Update & Communication Form (<i>Service Update and Changes</i>)		<input type="checkbox"/>	<input type="checkbox"/>	
Certificate of Need (<i>Medicaid Facilities</i>)		<input type="checkbox"/>	<input type="checkbox"/>	

**Purchase Orders will not be processed until required paperwork is provided to the CSA office.*

City of Winchester CSA Budget Request Form

Child's Name:

Case Manager:

Meeting Type: FAPT FTM IDT (check one)

Date of Meeting:

Client	Service	Provider	Unit Cost	Frequency/Months of Service	Total Cost	Funding Source

Date Services Starts:

Total cost to CSA: _____

Date Services Ends:

Date of next FAPT, FTM, IDT Review: _____

Review Schedule: 3 months or less 6 months or less Annual Review

Signature of Case Manager

Date

Signature of Case Manager's Supervisor

Date

Signature of FAPT Chair/FTM or IDT Facilitator

Date

Signature of CPMT Chair

Date

CSA Office Use Only	Date CSA office received:
Copayment Status:	
Mandate Type:	

CITY OF WINCHESTER CSA REFERRAL FORM

Initial ___

Review ___

Date of Referral	Lead Agency
Family Team FAPT IDT	Worker Name
Mandate Type	Worker Phone
Last UR date:	Worker Email

CHILD DEMOGRAPHIC INFORMATION

Child Name:	Current Address:
Gender: M F	DOB:
Hispanic: Y or N	SSN #:
Race:	STI #:
Medicaid: Y or N	DJJ #:
Child's School:	IEP: Y or N
Grade:	Type:
Primary reason for referral:	IVE eligible: Y or N
Medication currently taking:	

FAMILY DEMOGRAPHIC INFORMATION

Mother:	Father:	Caretaker/Custodian:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Hispanic Y or N	Hispanic Y or N	Hispanic Y or N
Race:	Race:	Race:
SSN:	SSN:	SSN:
Medicaid Y or N	Medicaid Y or N	Medicaid Y or N
Insurance Y or N	Insurance Y or N	Insurance Y or N
Legal Custody Y or N	Legal Custody Y or N	Legal Custody Y or N
Other significant people in child's life:		Address/Phone:

FAMILY ENGAGEMENT

Rights/Responsibilities material provided Y or N	Inclusion of those youth considers "family" Y or N
Family-driven decision making Y or N	Avoided redundant meetings Y or N
Family Strengths:	Youth Strengths:

1) Case narrative and Supporting Information:

(Must include presenting issue, child/family history, previous interventions/outcomes, strengths, interests, and needs of family, reason for referral for CSA funding)

2) Progress toward goals (*required at review*):

3) Recommendations:

Lead Worker Signature: _____ **Date:** _____
Agency Supervisor: _____ **Date:** _____

Individual Service Plan/Care Plan

Family Name:

Case Manager:

Date:

Need(s)	Ways to meet needs	Plan of Action/Services	Challenges/Barriers	Person(s) Responsible	Outcome
1.					Date of Review: Accomplished: Did not complete: Change: Still in Progress:
Outcome: Short Term Goal: Long Term Goal:					
2.					Date of Review: Accomplished: Did not complete: Change: Still in Progress:
Outcome: Short Term Goal: Long Term Goal:					
3.					

System of Care Principles
 Family Voice and Choice • Natural Supports • Community-Based • Collaboration • Team Based
 Culturally Competent • Persistence • Outcome-Based • Individualized • Strength-Based

						Date of Review: Accomplished: Did not complete: Change: Still in Progress:
Outcome: Short Term Goal: Long Term Goal:						
4.						Date of Review: Accomplished: Did not complete: Change: Still in Progress:
Outcome: Short Term Goal: Long Term Goal:						
5.						Date of Review:

System of Care Principles
 Family Voice and Choice • Natural Supports • Community-Based • Collaboration • Team Based
 Culturally Competent • Persistence • Outcome-Based • Individualized • Strength-Based

					Accomplished: Did not complete: Change: Still in Progress:
Outcome: Short Term Goal: Long Term Goal:					

Date of Next Meeting:

System of Care Principles
 Family Voice and Choice • Natural Supports • Community-Based • Collaboration • Team Based
 Culturally Competent • Persistence • Outcome-Based • Individualized • Strength-Based

City of Winchester CSA Copayment Screening Form

- * Exclusion/Waiver Ineligible
- * Fee Waived:
 - Home Energy Asst Program
 - SNAP
 - TANF
 - SSI Disability Only Income
 - Free and Reduced Lunch
 - Housing Choice Voucher Program
- * No Copay:
 - IEP
 - DCSE

Eligible for Co-Payment Assessment: Yes/No
Assessed Co-payment Amount: \$ _____

Child's Name: _____

Screening Date: _____

Caregiver #1: _____ Caregiver #2: _____

Employment Status: _____ Employment Status: _____

Employer: _____ Employer: _____

Income Sources: _____ Income Sources: _____

Gross Monthly Income: _____ Gross Total Monthly Income: _____

Verification Source: W-2 Paystub Other: _____
Verification Source: W-2 Paystub Other: _____

Household Size: _____ Household Size: _____

Does the household qualify/receive any of the following? *(Check all applicable boxes)*

- Home Energy Assistance Program
- SNAP
- TANF
- SSI Disability Only Income
- Free and Reduced Lunch
- Housing Choice Voucher Program

Collection Agreement

I/we, the undersigned, do hereby agree to honor the terms of this parental co-payment agreement. I/we agree to report any changes in income, family size or treatment expenses to the CSA Office. If the level of service changes, the co-payment amount will be reassessed based on the new level of services. I/we understand that I am expected to pay the assessed copayment amount to the service provider. If the parental co-payment is not paid, services may be terminated and any action necessary to collect the debt will be determined by the service provider. In this case, the CSA Office will be notified of overdue payment and any action determined appropriate by the service provider.

Parent/Guardian #1 Signature Date

Parent/Guardian #2 Signature Date

Case manager Date

City of Winchester
Determination of Eligibility for CSA Funded Services

Child's Name: _____

DOB: _____

Parents/Guardians Name: _____

Date: _____

Has the child been court ordered to FAPT? Yes No

Is the child currently living with their parent/legal guardian? Yes No

**To be eligible for CSA funding, the youth must meet one or more of the following criteria:
Specific behaviors must be documented in the provided space below.**

- 1. The child or youth has emotional or behavior problems that: *(Youth must meet all three criteria, eligible for non-mandated services)*
 - have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted; and
 - are significantly disabling and are present in several community settings, such as at home, in school or with peers; and
 - require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies

- 2. The child or youth has emotional or behavior problems, or both, and currently is in, or at imminent risk of entering, purchased residential care. In addition, the child or youth requires services or resources that are beyond normal agency services or routine collaborative processes across agencies; and requires coordinated services by at least two agencies *(Eligible for non-mandated service)*.

- 3. The child or youth requires placement for purposes of special education in approved private school educational programs as indicated by the child's IEP *(Mandated)*.

- 4. The child or youth has been:
 - Placed in foster care through a parental agreement by a public agency designated by the community policy and management team and his parents or guardians *(CHINS Eligibility Checklist must be completed by FAPT and Parental Agreement must be signed, Mandated)*

 - Entrusted to a local social services agency by his parents or guardian *(Non-Custodial Agreement, Temporary Entrustment, Permanent Entrustment, Mandated)*; or

 - Committed to the agency by a court of competent jurisdiction for the purposes of placement as authorized COV§63.2-900 *(DSS has Custody, Mandated)*.

 - Determined to be in need of foster care prevention services because they are at risk of removal from the home or meets CHINS Interagency Guidelines *(as designated by the court or*

through FAPT- If FAPT, the Community Based Foster Care Prevention Eligibility Determination must be completed).

5. Child receives special education services within the public school and meets criteria for CSA WRAP services below. *(Documentation must show a clear connection between student's disability and behaviors exhibited in the home or community. Services cannot be provided in the school setting.)*

- The special education mandate cited in §2.2-5211 B1 may be utilized to fund non-residential services in the home and community for a student with a disability when the needs associated with his/her disability extend beyond the school setting and threaten the student's ability to be maintained in the home, community, or school setting."

IEP Disability(s): _____

Document Behaviors Exhibited: _____

Signatures

_____ Team Chair/Facilitator	_____ Date
_____ Team Member	_____ Date

**City of Winchester CSA
Community-Based Foster Care Prevention Eligibility Determination**

Child Name: _____

DOB: _____

Please sign off on the appropriate eligibility, based on the criteria in each section:

Eligibility A: Foster Care Prevention – Abuse and Neglect

- The child is eligible for Foster Care Prevention Services because they are at risk of removal from their home and placement into foster care due to abuse or neglect as defined by COV §63.2-100. (Explain below)*
- or*
- The child would come into foster care if the service(s) are not provided. (Explain below)*

Explain: _____

 Print Name

 Signature

 Date

Eligibility B: Foster Care Prevention – CHINS (Child in Need of Services)

The child is eligible for Foster Care Prevention Services because they are at risk of removal from their home and placement into foster care due to meeting all 4 CHINS criteria below.

Criterion 1 *The child meets the statutory definition of a “child in need of services,”: by Court or by FAPT*

- Specifically, “the child’s behavior, conduct, or condition presents or results in a serious threat to the well being and physical safety of the child, or the well-being and physical safety of another person if the child is under the age of 14 (COV, §16.1-228).

Criterion 2 *has emotional and/or behavioral problems where either:*

- a. the child’s problems:
 - have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted; and
 - are significantly disabling and are present in several community settings, such as at home, in school or with peers; and
 - require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies
- or*
- b. the child is currently in, or at imminent risk of entering, purchased residential care; and requires services or resources that are beyond normal agency services or routine collaborative processes across agencies; and requires coordinated services by at least two agencies.

Criterion 3 *The child requires services:*

- a. to address and resolve the immediate crisis that seriously threatens the well being and physical safety of the child or another person; and
- b. to preserve and/or strengthen the family while ensuring the safety of the child and other persons; and
- c. the child has been identified by the Team as needing:
 - services to prevent or eliminate the need for foster care placement. Absent these prevention services, foster care is the planned arrangement for the child

Criterion 4 *The goal of the family is to maintain the child at home.*

 FAPT Chair Print Name

 CSA Coordinator Print Name

 FAPT Chair Signature

 Date

 CSA Coordinator Signature

 Date

AUTHORIZATION TO USE AND EXCHANGE INFORMATION

Introduction

Specified information can be shared among ALL of the agencies listed below, if the individual or his authorized representative agree, without having to obtain any additional signed authorization from the individual. The *Authorization to Use and Exchange Information* form was developed for use by the following agencies:

- Local departments of social services
- Area agencies on aging
- Centers for independent living
- Community services boards
- Department of Correctional Education
- Department of Youth and Family Services
- Health department clinics and programs
- Service delivery areas for the Workforce Investment Act
- Local/Regional Departments of Rehabilitative Services/Disability Services Boards
- Local school systems
- Regional offices, Department of Corrections
- Regional outreach offices, Department for the Deaf and Hard of Hearing
- Regional offices, Department for the Blind and Vision Impaired
- Virginia Employment Commission Offices

The “referring agency” is defined as the agency that initiates the completion of the *Authorization to Use and Exchange Information* form with the individual. The referring agency may use the form to request or to transmit information to other agencies. Agencies may be considered either a “referring” or an “other” agency, depending upon which agency is contacted first by the individual. If all parties agree, additional public and private agencies, facilities, and organizations may be included.

Agencies are assured that, when properly executed, this is a legally valid form that meets not only their own agency’s state and federal requirements, but also those of the other participating agencies. The *Authorization to Use and Exchange Information* form has been reviewed by the Office of the Attorney General to assure compliance with federal and state confidentiality requirements. Agencies may choose to use a different uniform release form that addresses their individual needs if it meets the state and federal confidentiality and release of information statutory and regulatory requirements of ALL involved agencies.

Purpose of the Authorization to Use and Exchange Information Form

The *Authorization to Use and Exchange Information* form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs and should be used along with the referring agency’s specific procedures for obtaining a valid authorization to exchange information. It also can be used to assist agencies obtain information needed from other agencies to determine an individual’s eligibility for services or benefits. The completed form should reflect that the individual (or his or her representative) controlled the choices and understood the process. When using this form, always keep in mind the importance of individual wishes, individual choices, and individual comprehension of the process.

Agency staff and the authorizing person shall first determine whether the individual might be eligible for services or benefits provided by other agencies. This determination should be based upon the needs, interests, and circumstances of the individual as well as staff’s knowledge of other agencies’ services or benefits and eligibility requirements.

Referring agency staff shall explain the following to the individual:

- Potential services and benefits that might be available from other agencies.
- What information these agencies might need and for what purpose(s).
- The purpose of the form.
- The consequences of signing or not signing this authorization.
- Key provisions and protections (e.g., revocation, access to agencies’ written record).

Staff shall make every attempt to ensure that the authorizing person understands the provisions of the form and should make appropriate efforts to accommodate the special needs of the authorizing person. If the authorizing person is unable

to read or is blind or visually impaired, staff shall read the form to him or her. Interpreters should be made available for people who do not speak English and for those who are deaf or hearing impaired. If the authorizing person does not appear to comprehend the meaning of the form, it should be explained. If staff have ANY doubts that the authorizing person is not comprehending the purpose and provisions of the form, they should ask the authorizing person questions about the form (what the form allows the agency to do, etc.).

Based upon these answers, if staff determine that the authorizing person is NOT comprehending the purpose and provisions of the form, staff should follow their agency's procedures for assuring that the form is signed by a legally authorized authorizing person who fully comprehends the purpose and provisions of the form. The signature of an authorizing person who does NOT comprehend what he or she is signing is not valid.

If the authorizing person agrees, the form should be completed. This should be done by the authorizing person, wherever possible. The authorizing person must sign the form and insert the date in the indicated place. Staff explaining the form to the authorizing person must sign the form in the indicated place. For those agencies with procedures requiring a witness (e.g., for a person who cannot write), space is provided for a witness to sign the form. The witness must observe the authorizing person signing or placing a mark on the form and then must sign as indicated. The referring agency must give a copy of the completed form to the authorizing person.

Sharing Information with Other Agencies

It is important for the referring agency to notify the other listed agencies that they are parties to this agreement to exchange information. This notification can be by telephone or through written correspondence. This notification must be entered into the individual's record. If the referring agency wants to receive information from other agencies, it must provide a copy of the signed authorization form with its initial request for information from each listed agency.

Government Data Collection and Dissemination Practices Act

To ensure compliance with the Government Data Collection and Dissemination Practices Act each time information is disclosed by any of the listed agencies, staff of the disclosing agency must enter the following information into the individual's record:

- Name of the agency and the name of the individual receiving the information.
- Type and source of the information disclosed.
- Reason or purpose for the disclosure.
- Date the information was disclosed.

This requirement can be met by using a disclosure log (a sample can be found in the User's Manual: Virginia Uniform Assessment Instrument, Appendix B) or through the agency's own record keeping policies and procedures.

NOTE: The authorizing person has the right to review the records of disclosure of the referring and other agencies upon request during the agencies' normal business hours.

Agency Record Keeping Policies and Procedures

Referring Agency: The original signed copy of the *Authorization to Use and Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Other Agencies: A copy of the *Authorization to Use and Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Renewing or Amending the Authorization Form

For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his or her authorized representative specifies an expiration date, event or condition that will occur prior to one year from the date of signature.

Revocation of Authorization

Authorization to exchange information will expire on the date or condition agreed to by the authorizing person. However, anytime prior to the expiration, the authorizing person may choose to revoke or cancel this authorization either with all or with selected agencies.

The authorizing person may revoke his or her authorization by informing any of the involved agencies in writing, by telephone, or in person. This notification must be noted on the back of the *Authorization to Use and Exchange Information* form and signed and dated by the agency staff person receiving the request to revoke the authorization.

If the authorizing person exercises the option of revoking his or her authorization (in entirety or with selected agencies) to share information under the agreement, the agency receiving this notice shall inform all other listed agencies that are authorized to exchange information under the agreement of the revocation of the authorization.

Individuals Who Refuse to Sign the Authorization Form

It is absolutely essential that the individual understand and appreciate what will happen as a result of signing this form. The individual also needs to understand that there is no requirement to sign this form, but that not signing the form will result in specific consequences. If the form is not signed, the individual must deal with each agency individually to obtain needed information, and/or the agency may not be able to provide services. If the form is signed, the process for applying for and receiving services may be easier for both the individual and the involved agencies.

When Not to Use This Form

The *Authorization to Use and Exchange Information* form should not be used with:

- Individuals who do not comprehend the purpose and substance of the authorization form; or
- Individuals for whom drug or alcohol abuse diagnostic or treatment information is being shared. In these cases, a separate authorization form (attached) should be used.

Can Other Interagency Authorization Forms Be Used?

Agencies should accept the *Authorization to Use and Exchange Information* form as a legally valid form. However, they may choose to use a different authorization form that addresses their individual needs IF it meets the state and federal confidentiality statutory and regulatory requirements of ALL the involved agencies.

COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS)

(FULL PRINTED NAME OF INDIVIDUAL)

(INDIVIDUAL'S ADDRESS) (INDIVIDUAL'S BIRTH DATE) (INDIVIDUAL'S SSN - OPTIONAL)

My relationship to the individual is: [] Self [] Parent [] Power of Attorney [] Guardian
[] Other Legally Authorized Representative

I want the following confidential information about the individual to be exchanged:

- Yes No Assessment Information
Yes No Medical Diagnosis
Yes No Educational Records
Yes No Financial Information
Yes No Mental Health Diagnosis
Yes No Psychiatric Records
Yes No Benefits/Services Needed, Planned, and/or Received
Yes No Medical Records
Yes No Criminal Justice Records
Yes No Employment Records
Yes No Substance Abuse Records
Yes No All of the Above

Other Information (write in): _____

I want _____

(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

and the following entities to be able to use and exchange this information among themselves:

- Yes No Identify By Name
[] Dept. of Juvenile Justice
[] Dept. of Social Services
[] Community Service Board
[] Local Health Dept.
[] Physicians
[] Private Providers

Other: _____

I want this information to be exchanged ONLY for the following purpose(s):

- [] Service Coordination and Treatment Planning [] Eligibility Determination
[] Other: _____

I want this information to be shared by the following means: (check all that apply)

- [] Written Information [] In Meetings or By Phone [] Computerized Data [] Fax

I want to share additional information received after this authorization is signed: [] Yes [] No

This authorization is effective: _____ (DATE)

This authorization is good until: [] My service case is closed. [] Other: _____

For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his authorized representative specify an expiration date, event or condition that will occur prior to one year from the date of signature.

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed. However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): _____ Date: _____
(AUTHORIZING PERSON OR PERSONS)

Person Explaining Form: _____ (Name) (Address) (Phone Number)

Witness (If Required): _____ (Signature) (Address) (Phone Number)

**COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION**

Full Printed Name of Individual: _____

FOR AGENCY USE ONLY

AUTHORIZATION HAS BEEN:

- Revoked in entirety
 Partially revoked as follows:

NOTIFICATION THAT AUTHORIZATION WAS REVOKED WAS BY:

- Letter (Attach Copy) Telephone In Person

DATE REQUEST RECEIVED: _____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

(AGENCY REPRESENTATIVES FULL NAME AND TITLE)

(AGENCY ADDRESS)

(PHONE NUMBER)

Instructions for Completing the *Authorization to Use and Exchange Information Form*

PURPOSE - The "Authorization to Use and Exchange Information" form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs. It also can be used to assist agencies to obtain information needed from other agencies to determine an individual's eligibility for services or benefits.

This form should be viewed as the end product of a discussion between the worker and the individual or the individual's authorized representative which documents the individual's decision on when and what type of information can be released or obtained. This form should NOT BE USED with an individual who does not comprehend the purpose and substance of the Authorization Form.

WHEN PROPERLY EXECUTED, THIS IS A LEGALLY VALID DOCUMENT FOR EXCHANGING INDIVIDUAL INFORMATION. TO BE PROPERLY EXECUTED ALL STATEMENTS MUST BE COMPLETED WITH THE APPROPRIATE INFORMATION AND/OR BY CHECKING THE APPROPRIATE YES OR NO BOX.

AUTHORIZING PERSON OR PERSONS - Enter the full name of the person/persons authorizing the exchange of information.

NAME OF INDIVIDUAL - Enter the full name of the individual about whom the information will be shared.

INDIVIDUAL'S ADDRESS, BIRTHDATE, SOCIAL SECURITY NUMBER (SSN) - Enter the individual's address, date of birth, and social security number (SSN). NOTE: Section 2.2-3808 of the *Code of Virginia* makes it unlawful to require an individual's social security number in order to obtain benefits or services unless a specific law allows the agency to require it.

RELATIONSHIP TO INDIVIDUAL - Check the authorizing person's relationship to the individual. Note: A legally valid authorization requires that one of the listed relationships be present.

INFORMATION TO EXCHANGE - Check the appropriate box next to the information the individual wishes to exchange among the listed agencies. If necessary, write in any other information the individual wishes to exchange. NOTE: If the individual wishes to limit some of the information to be exchanged in any category, the limitations must be recorded on the back of the form. An individual may want to exchange most, but not ALL, of the specific information checked "Yes" (e.g., a reference to past psychiatric hospitalization contained in psychiatric records). If the individual wants some specific parts of a record to remain confidential, the referring agency MUST exclude this information when that record is shared with the other agencies).

REFERRING AGENCY AND STAFF CONTACT PERSON - Enter the name and address of the agency which initiates the completion of the form. The staff contact person is the name of the staff person who discussed/explained the use of the form with the individual and, if appropriate, assisted the individual in completing the form.

SHARING AGENCIES - Check the type of agencies with which the information will be exchanged. If more space is needed, additional agencies can be listed on the back of the form. The authorizing person(s) must place his or her signature or initials beside the name(s) of each agency listed on the back. The referring agency should notify the listed agencies that they are parties to the AUTHORIZATION TO EXCHANGE INFORMATION. This notification can be by telephone or written correspondence. This notification must be recorded in the individual's record. If the referring agency wants to obtain information from the listed agencies, it must provide a copy of the signed authorization form. The copy may be mailed or faxed.

PURPOSE OF EXCHANGE - Check the appropriate box(es) or enter other purposes in the designated space.

HOW THE INFORMATION IS EXCHANGED - Check all appropriate boxes.

SHARING OF NEW INFORMATION - The individual can limit the exchange of information contained in the record as of the date of the authorization by checking the NO box. Information not in the record after the authorization is signed can be exchanged by checking the YES box.

EXPIRATION - The length of time the authorization is valid should bear a relationship to the individual's participation in a project, service plan or treatment plan, and should be the individual's choice. The authorization form may NOT be valid

“forever”, “indefinitely” or for extremely long periods of time. Unless the individual specifies a particular date or circumstances, acceptable length of time would be “until placement” or “until my case is closed”. For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his authorized representative specify an expiration date, event or condition that will occur prior to one year from the date of signature.

SIGNATURES - The authorizing person(s) must sign and date the form. A copy of the signed authorization form must be given to the authorizing person(s). If the authorizing person cannot write he or she will put his or her mark (i.e., initials, an “X”) in the signature space. The staff person explaining the form to the authorizing person(s) must sign the form and enter identifying information and a telephone number. If the agency procedures require a witness to an authorizing person’s mark, space is provided for his or her signature. The witness must observe the authorizing person sign or place a mark on the form.

REVOCATION OF AUTHORIZATION - The authorization to exchange information will expire on the date or circumstances agreed to by the authorizing person(s). The authorizing person(s) may revoke all or part of the authorization at any time prior to the expiration by notifying any of the involved agencies. This notification can be by telephone, in writing, or in person. This notification to revoke must be documented on the back of the authorization form by checking the appropriate boxes and entering the applicable information.

NOTIFICATION OF REVOCATION - The agency receiving the revocation notice must notify in writing all listed agencies of the individual’s revocation of his or her authorization, either entirely or partially. Notification must be recorded in the case record.

RENEWING OR AMENDING THE CONSENT AUTHORIZATION FORM - The referring agency can renew or amend (e.g., by adding additional agencies) the original signed copy of the *Authorization to Use and Exchange Information* form by having the authorizing person complete and sign a new form. The referring agency must give a copy of the new form to the authorizing person and forward a copy of the new form to each of the listed agencies. For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his or her authorized representative specifies an expiration date, event or condition that will occur prior to one year from the date of signature.

Winchester City CSA Sliding Fee Scale

Monthly Payment	Household Size							
	2	3	4	5	6	7	8	
Non-Residential	under 34,999	under 38,999	under 42,999	under 46,999	under 49,999	under 53,999	under 56,999	
\$10.00	39,000	42,000	45,000	48,000	52,000	55,000	59,000	
\$20.00	\$30.00	45,000	48,000	51,000	54,000	57,000	61,000	
\$25.00	\$38.00	48,000	51,000	54,000	57,000	60,000	63,000	
\$30.00	\$45.00	51,000	54,000	57,000	60,000	63,000	66,000	
\$40.00	\$60.00	54,000	57,000	60,000	63,000	66,000	69,000	
\$50.00	\$75.00	57,000	60,000	63,000	66,000	69,000	72,000	
\$60.00	\$90.00	60,000	63,000	66,000	69,000	72,000	75,000	
\$70.00	\$105.00	63,000	66,000	69,000	72,000	75,000	78,000	
\$85.00	\$127.50	66,000	69,000	72,000	75,000	78,000	81,000	
\$100.00	\$150.00	69,000	72,000	75,000	78,000	81,000	84,000	
\$115.00	\$172.50	72,000	75,000	78,000	81,000	84,000	87,000	
\$130.00	\$195.00	75,000	78,000	81,000	84,000	87,000	90,000	
\$145.00	\$217.50	78,000	81,000	84,000	87,000	90,000	93,000	
\$160.00	\$240.00	81,000	84,000	87,000	90,000	93,000	96,000	
\$175.00	\$262.50	84,000	87,000	90,000	93,000	96,000	99,000	
\$190.00	\$285.00	87,000	90,000	93,000	96,000	99,000	102,000	
\$205.00	\$307.50	90,000	93,000	96,000	99,000	102,000	105,000	
\$220.00	\$330.00	93,000	96,000	99,000	102,000	105,000	108,000	
\$235.00	\$352.50	96,000	99,000	102,000	105,000	108,000	111,000	
\$250.00	\$375.00	99,000	102,000	105,000	108,000	111,000	114,000	
\$265.00	\$397.50	102,000	105,000	108,000	111,000	114,000	117,000	
\$280.00	\$420.00	105,000	108,000	111,000	114,000	117,000	120,000	
\$295.00	\$442.50	108,000	111,000	114,000	117,000	120,000	123,000	
\$310.00	\$465.00	111,000	114,000	117,000	120,000	123,000	126,000	
\$325.00	\$487.50	114,000	117,000	120,000	123,000	126,000	129,000	
\$340.00	\$510.00	117,000	120,000	123,000	126,000	129,000	132,000	
\$355.00	\$532.50	120,000	123,000	126,000	129,000	132,000	135,000	
\$370.00	\$555.00	123,000	126,000	129,000	132,000	135,000	138,000	
\$385.00	\$577.50	126,000	129,000	132,000	135,000	138,000	141,000	
\$400.00	\$600.00	129,000	132,000	135,000	138,000	141,000	144,000	
\$415.00	\$622.50	132,000	135,000	138,000	141,000	144,000	147,000	
\$430.00	\$645.00	135,000	138,000	141,000	144,000	147,000	150,000	
\$445.00	\$667.50	138,000	141,000	144,000	147,000	150,000	153,000	
\$460.00	\$690.00	141,000	144,000	147,000	150,000	153,000	156,000	
\$475.00	\$712.50	144,000	147,000	150,000	153,000	156,000	159,000	
\$490.00	\$735.00	147,000	150,000	153,000	156,000	159,000	162,000	
\$505.00	\$757.50	150,000	153,000	156,000	159,000	162,000	165,000	
\$520.00	\$780.00	153,000	156,000	159,000	162,000	165,000	168,000	
\$535.00	\$802.50	156,000	159,000	162,000	165,000	168,000	171,000	

Note: For income limits over this scale, parent fees for non-residential services will increase by \$15.00/month and parent fees for residential services will increase by \$30.00/month for every \$3000.00 increase in annual gross income.

**CERTIFICATION OF NEED FOR ADMISSION TO
COMMUNITY-BASED RESIDENTIAL SERVICES FOR CHILDREN**

Resident Name: _____ Placing Agency: _____

- 1. Explain how ambulatory/outpatient care does not meet the specific treatment needs of the recipient.**

- 2. Explain how proper treatment of the recipient's psychiatric condition requires services in a community-based residential program.**

- 3. Explain how the services can reasonably be expected to improve the recipient's condition or prevent regression so that the services will no longer be needed.**

- ❖ *Billing eligibility may only be determined by the most recent date on this form.*
- ❖ *For CSA children who are Medicaid recipients, this form must be completed and signed by the local CSA interdisciplinary team or FAPT (3 signatures) and signed by a physician.*
- ❖ *For Non-CSA children who are Medicaid recipients, this form must be completed and signed by the LMHP and a physician.*
- ❖ *The physician cannot be the treating physician at the facility to which the child will be admitted. If the child is in acute care, the acute care physician may complete the CON.*
- ❖ *For a recipient who applies for Medicaid while a resident at the facility, the certification must be made by the LMHP and a physician.*

Team Signatures:

1. _____ Date _____ 3. _____ Date _____
2. _____ Date _____ 4. _____ Date _____

Physician Signature: _____ Date: _____

LMHP Signature (if applicable): _____ Date _____

Winchester Department of Social Services (Name of Lead Agency)
Family Team Meeting Report

Family Name: _____ Case No: _____

Team Vision Statement: _____

Date of Meeting: _____
Date of Next FTM: _____

90 Day Review Date Due: _____

Child: _____ DOB: _____
Child: _____ DOB: _____

Parents/Caregiver(s): _____

Reason for/Purpose of Meeting: *(check all that apply)*

- Very High or High Risk Child Assessment
- Emergency Removal or At Risk of Out of Home Placement
- Placement Preservation/Change of Placement/Disruption or Dissolution of Adoption
- Prior to a Change of Goal
- Requested by a Parent (birth, foster, adoptive, or legal guardian), Youth, or Social worker
- Other *(please explain)*

Reason for Department's Current Involvement: *(check one)*

- CHINS
- Delinquency
- Foster Care Prevention (not CHINS or Delinquency Related)
- Entrustment/Noncustodial
- Abuse & Neglect
- Foster Care

Funding:

Yes—Funding Authorized Type: CSA Mandated CSA Non-Mandated

Date of last CANS assessment: _____

Presenting Issue: *(Reason for Family Team Meeting)*

•

Strengths

Youth:

•

Parent(s)/Family:

•

System of Care Principles

- Family Voice and Choice • Natural Supports • Community-Based Collaboration • Team Based • Culturally Competent • Persistence Outcome-Based • Individualized • Strength-Based

Family Vision Statement (finish this statement):

"Life will be better when..."

- 1.
- 2.
- 3.
- 4.
- 5.

RECOMMENDATIONS:

-

Family Team Members in Attendance: *(include name and relationship)*

-

Family Team Members invited but not in attendance: *(include name and relationship)*

Date of Next Team Meeting:

-

System of Care Principles
Family Voice and Choice • Natural Supports • Community-Based
Collaboration • Team Based • Culturally Competent • Persistence
Outcome-Based • Individualized • Strength-Based

Winchester Family Team Meeting Signature Sheet

Family Name: _____

Date: _____

Signing this sheet verifies that you were present during the Family Team Meeting (FTM) and that you actively participated in its development with guidance and input from the team. The Family Team Care Plan will serve as a written contract between family members, the Winchester Department of Social Services and family team members. ***Please sign legibly.*** After signing, please check whether you *agree* or *disagree* with the plan that was developed or outcome that was decided by the team.

Your signature on this document also verifies that you understand that everything discussed in this FTM is considered as private and will not be discussed with persons outside of this team unless a *Consent to Release Information* form has been signed by the family, the youth/family is under a court order, **abuse or neglect has been alleged, or a person is a danger to self or others.**

Parent/Custodian	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Parent/Custodian	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Parent/Custodian	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Parent/Custodian	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Youth	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Natural Support	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Social Worker	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Natural Support	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Social Worker	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Natural Support	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Guardian Ad Litem	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	School Representative	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Attorney	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	School Representative	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Attorney	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	School Representative	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Attorney	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	School Representative	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Probation Officer	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Other	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Service Provider	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Other	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Service Provider	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	Other	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree
Service Provider	Date	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	FTM Facilitator	Date		

Supervisor's initials/date: _____

System of Care Principles
 Family Voice and Choice • Natural Supports • Community-Based
 Collaboration • Team Based • Culturally Competent • Persistence
 Outcome-Based • Individualized • Strength-Based